outcomes of interest will need to be developed by assessing the performance of these thresholds in a wide array of hospitals.

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Community-Acquired Methicillin-Resistant *Staphylococcus aureus*

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Infections caused by methicillin-resistant *Staphylococcus aureus* (MRSA) infections are increasing in prevalence in adults and children. Community-acquired MRSA infections in children have occurred primarily in individuals with recognized predisposing risks. Community-acquired MRSA infections in the absence of identified risk factors have been reported infrequently. Researchers from the University of Chicago Hospitals recently conducted a study to determine whether community-acquired MRSA infections in children with no identified predisposing risks are increasing and to define the spectrum of disease associated with MRSA isolation.

The study involved a retrospective review of the medical records of hospitalized children with *S aureus* isolated between August 1988 and July 1990 and between August 1993 and July 1995.

The number of children hospitalized with community-acquired MRSA disease increased from 8 in 1988 through 1990 to 35 in 1993 through 1995. Moreover, the prevalence of community-acquired MRSA without identified risk increased from 10 per 100,000 admissions in 1988 through 1990 to 259 per 100,000 admissions in 1993 through 1995 ($P<.001$), and a greater proportion of isolates produced clinical infection. The clinical syndromes associated with MRSA in children without identified risk were similar to those associated with community-acquired methicillin-susceptible *S aureus.* Notably, 7 (70%) of 10 community-acquired MRSA isolates obtained from children with an identified risk were nonsusceptible to at least two drugs, compared with only 6 (24%) of 25 isolates obtained from children without an identified risk ($P=.02$).

The researchers concluded that the prevalence of community-acquired MRSA among children without identified risk factors is increasing. In addition, resistance in isolates from children without identified risk was limited to methicillin, in contrast to the multidrug resistance characterizing most nosocomially acquired MRSA strains and community-acquired MRSA from children with identified risk. The authors noted that because the community-acquired isolates obtained from children without identified risk usually were susceptible to clindamycin, they do not use empirical vancomycin.

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