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cal colonization and infection in a long-term care facility. Ann *Intern Med.* 1991;114:107-114.

The authors were asked to respond to this letter.

We appreciate Dr. Mylotte's observations about his experience with methicillin-resistant *Staphylococcus aureus* (MRSA) in a long-term care veteran's affairs (VA) facility in Buffalo, New York. We absolutely agree that the population studied is very important. Results in a VA long-term care facility attached to an acute-care hospital and staffed by house officers from the university may be very different from those in a private, predominantly female pop ulation in a community nursing home with no house staff coverage.

Whether one should try to eradicate colonization with MRSA depends on the situation. For example, we have found a monthly MRSA colonization rate of 22.7 ± 1%, but an overall infection rate over the course of one year of only 2.6% (9 of 341 patients prospectively followed.) [1] Thus, risk of infection in our facility is low; in addition, most of our MRSA are resistant to TMP/SMX and ciprofloxacin,[2] so the choice of oral antibiotics to eliminate the carrier state is low. We do not have data on the number of infections surveyed by Dr. Mylotte or the types of patients (intermediate care presumably implies a sicker cohort than we followed), but he has noted many more infections each month than we ever have had. In this circumstance, it may be very reasonable to try to eradicate MRSA from the facility, presumably by culturing all residents and treating all those who are positive for MRSA.

It would be interesting to know if Dr. Mylotte has established modes of transmission within his long-term care facility. When we looked closely at transmission in our facility, we found multiple different phage types and little evidence of direct patient-to-patient transmission within a given room.' Thus, cohorting and isolation may not be as important in a facility such as ours and would be exceedingly difficult to carry out.

We are assessing prospectively the role of long-term mupirocin for elimination of the MRSA carrier state in the long-term care setting. Although we know it is effective in the short-term to eliminate MRSA carriage,[3] the risk of long-term usage is the development of resistance, which we and others have already noted. Whether mupirocin's use will lead to a decrease in the number of infections in the long-term care setting is under study, but currently is not known.

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