sion mainly is via hospital staff. MRSA remains endemic in most of Australia's large urban teaching hospitals; occasional outbreaks also occur, especially in intensive-care areas. The level of MRSA infection often is indicative of the total rate of nosocomial infection within an institution and may reflect overcrowding, heavy workloads, and understaffing of wards.

Standard precautions, isolation and cohorting of infected and colonized patients, screening of staff, handwashing campaigns, nasal eradication policies, and increased staff education all have been tried, with variable success. There is no universal formula, and local problems require local solutions plus commitment of local resources.

Dr. McDonald suggests that preventing surgical infection with MRSA first requires the application of surgical principles and then compliance with the national recommendation against routine prophylaxis with vancomycin.

FROM: McDonald M. The epidemiology of methicillin-resistant *Staphylococcus aureus:* surgical relevance 20 years on. *Aust N Z J Surg* 1997;67:682-685.

Laboratory Identification of VRE

Investigators from the CDC recently reported the findings of a study to determine whether hospital-based clinical laboratories conducting active surveillance for vancomycin-resistant enterococci (VRE) in three San Francisco Bay-area counties (San Francisco, Alameda, and Contra Costa counties) were reporting vancomycin resistance accurately.

Five vancomycin-resistant enterococcal strains and one vancomycin-susceptible ß-lactamase-producing *Enterococcus* were sent to 31 (97%) of 32 laboratories conducting surveillance. Each strain was tested by the laboratory's routine antimicrobial susceptibility testing method. An *Enterococcus faecium* strain with high-level resistance to vancomycin (minimum inhibitory concentration [MIC], 512 µg/mL) was reported correctly as resistant by 100% of laboratories; an *E faecium* strain with moderate-level resistance (MIC, 64 µg/mL) was reported correctly as resistant by 91% of laboratories; two strains of *Enterococcus faecalis* with low-level resistance (MIC, 32 µg/mL) were reported correctly as resistant by 97% and 56% of laboratories, respectively. An *Enterococcus gallinarum* strain with intrinsic low-level resistance (MIC, 8 µg/mL) was reported correctly as intermediate by 50% of laboratories. A ß-lactamase-producing *E faecalis* isolate was identified correctly as susceptible to vancomycin by 100% of laboratories and as resistant to penicillin and ampicillin by 68% and 44% of laboratories, respectively; all 23 (74%) laboratories that tested for ß-lactamase recognized that it was a ß-lactamase producer.

This survey indicates that, for clinically significant enterococcal isolates, laboratories in the San Francisco Bay area accurately identify high-level vancomycin resistance; however, there are problems in detecting low-to-moderate level vancomycin resistance. The authors suggest that increasing accuracy of detection and prompt reporting of these isolates and investigation of cases are the next steps in the baffle for control of the spread of vancomycin resistance.

FROM: Rosenberg J, Tenover FC, Wong J, Jarvis W, Vugia DJ. Are clinical laboratories in California accurately reporting vancomycin-resistant enterococci? *J Clin Microbial* 1997;35:2526-2530.

Conference on Emerging Infectious Diseases

The Centers for Disease Control and Prevention, the Council of State and Territorial Epidemiologists, the American Society for Microbiology, and the CDC Foundation, together with more than 50 other co-sponsors, will present the International Conference on Emerging Infectious Diseases on March 8-11, 1998, in Atlanta, Georgia. The purpose of the conference is to encourage the exchange of scientific and public health information on global emerging infectious disease issues, increase awareness, identify program gaps, and enhance partnerships in addressing emerging infectious diseases.

The meeting will consist of plenary sessions, symposia, roundtables with invited speakers, presentations on emerging infection activities, oral and poster presentations based on submission of an accepted abstract, and exhibits. Major topics will include current work on surveillance, epidemiology, research, communications, training, and prevention and control of emerging infectious diseases, as well as topics related to emergency preparedness and response.

Abstracts should address new, re-emerging, or drug-resistant infectious diseases that affect human health, and such topics as foodborne diseases, antimicrobial resistance, infectious diseases transmitted by animals and arthropods, infections acquired in healthcare settings, infectious diseases in immunodeficient persons, infectious diseases in hard-to-reach and other at-risk populations, infectious causes of chronic diseases, blood safety, host genetics, vaccines, global climate change, and immigration and travel.

Deadline for submission of abstracts is October 31, 1997. Register early as attendance will be limited to 2,500 participants. Additional information on abstract submission and registration can be obtained at www.asmusa.org, by sending an e-mail message to meetinginfo@asmusa.org, or by calling 202-942-9248. Proceedings of the conference will be published in the *Emerging Infectious Diseases* journal.

Additional news items in this issue: TB Skin-Test Conversion Rates Among Exposed Hospital Workers, page 824; Pyrogenic Reactions Following Cardiac Catheterization, page 871.

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