Letters to the Editor

Prior Publication of Data

To the Editor:

I am writing in response to the recent Infection *Control and Hospital Epidemiology* editorial policy statement regarding duplicate publication.' In the same issue of *Infection Control and Hospital Epidemiology*, we published a manuscript relating to healthcare workers' occupational exposures to blood and other body fluids.2 We had published previously a paper describing the same data base as an invited paper in an acquired immunodeficiency syndrome (AIDS) issue of a subspecialty nursing journal.[3] We were simply trying to disseminate this information to populations of individuals who might benefit from it.

In light of the new editorial policy statement, I thought we should make certain that *Infection Control and Hospital Epidemiology* was aware of the invited publication in the *Journal of Nurse Midwifery*. Had we had access to the policy statement prior to submission or publication of our paper, we would have submitted the earlier paper with our *Infection Control and Hospital Epidemiology* submission.

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Methicillin-Resistant Staphylococcus aureus in Long-Term Care Facilities

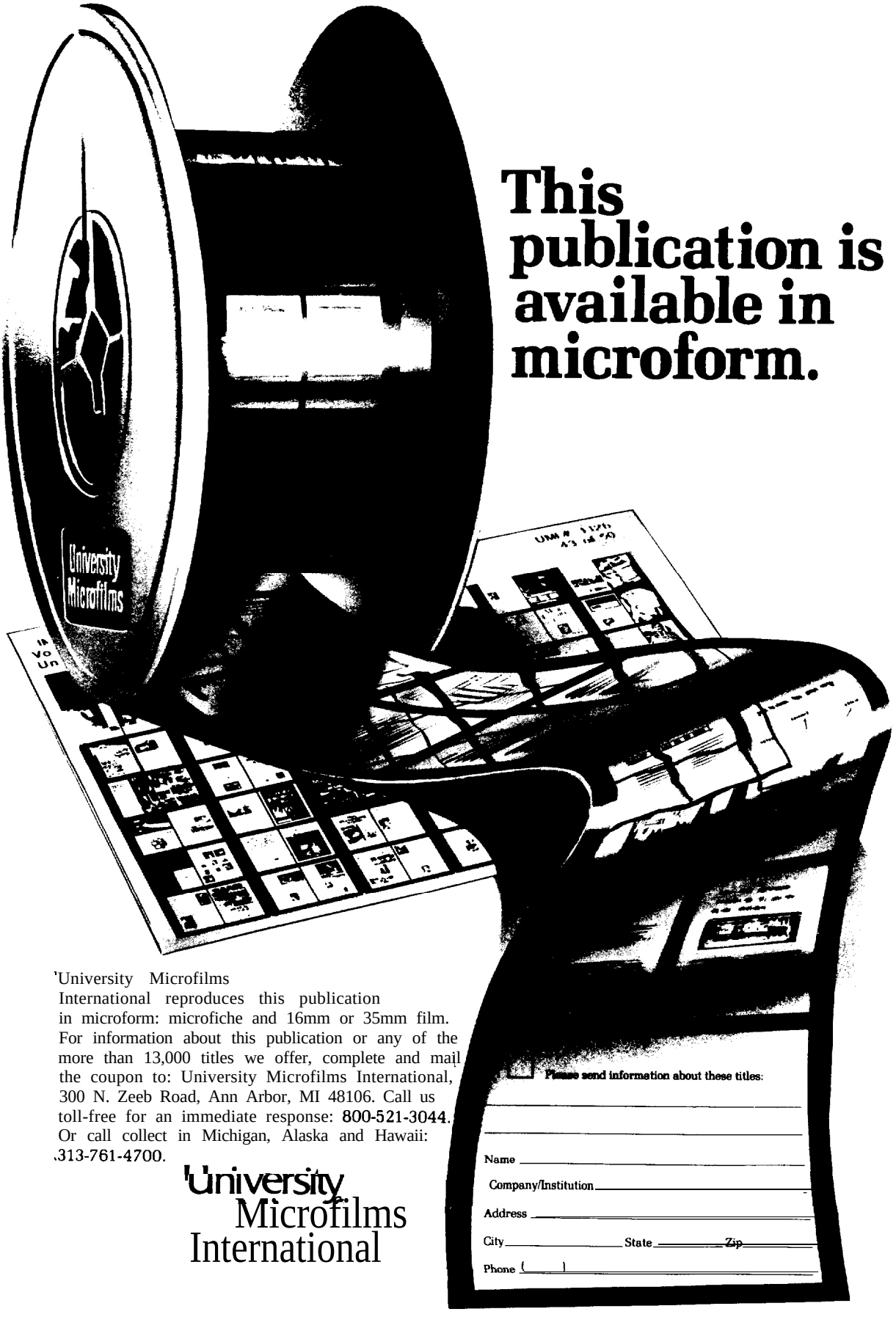
To the Editor:

The recent article "Methicillin-resistant *Staphylococcus aureus* (MRSA) in Long-Term Care Facilities" by Kauffman and colleagues' provides an excellent review of the available information about this problem. In addition, they point out the many questions that remain unanswered about MRSA in long-term care facilities.

As an infectious diseases consultant, hospital epidemiologist, and infection control consultant to two nursing homes, I have had considerable experience with MRSA. My experience parallels, for the most part, that described by Kauffman and associates. However, I would like to emphasize the point made by these investigators about variations in findings depending on the population studied. Kauffman et al appropriately point out that their findings in a veterans' hospital-based nursing home population may not be applicable to patients in a private nursing home. This is an extremely important point for several reasons. First, the population in most nursing homes is predominantly female (mentioned by Dr. Kauffman) unlike the pre-

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TABLE
MONTHLY FREQUENCY OF *S AUREUS* INFECTIONAT A VMAC

Month/Year	No. Episodes MSSA	No. Episodes MRSA
October 1989	2	11
November	2	5
December	5	12
January 1990	5	11
February	5	12
March	6	11
April	3	7
May	3	12
June	2	7

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dominantly male veteran population. Second, it should by emphasized that hospital-based nursing homes may have a greater chance of admitting patients with MRSA than private nursing homes. This is because hospital-based homes receive most of their patients from one facility (the parent hospital). This situation easily can perpetuate MRSA among nursing home residents if the parent institution has a problem with MRSA. Third, there has been recent documentation that substantial changes have taken place in the types of patients admitted to non-veterans' affairs long-term care facilities in the 1980s.[2] For example, patients entering nursing homes that serve those who need medical and skilled nursing care after treatment for acute conditions were found to have greater clinical needs in 1986 compared to those in 1982. This may be creating an even more susceptible population for MRSA colonization/infection. I am not aware of such information for veterans in nursing home settings.

Kauffman et al pose the question 'Will decreasing the number of patients colonized with MRSA in an institution decrease the risk of spread and the number of infections within that facility?' Intuitively, the answer is "yes"; however, this is not known with any certainty. In the acute hospital setting, however, the burden of staphylococcal infection is increased in the presence of MRSA, over and above the endemic rate of infection due to methicillin-susceptible S *aureus* (MSSA).[3] This also may be true in the long-term care setting, as recently reported by Muder and colleagues[4] in a veterans' affairs long-term care facility. In another unpublished study I participated in at a veterans affairs hospital providing primarily intermediate and long-term care, MRSA infections added to the number of staphylococcal infections occurring in the institutions as well (Table). Although I have shown only information for a very recent period in the table, this phenomenon can be documented beginning in January 1988. This type of finding suggests to me that at least in some long-term care settings, eliminating the reservoir of MRSA (colonized patients) may be important.

Based on this experience, I would have to disagree with the authors' statement that "routine use of antibiotics in an attempt to eradicate MRSA carriage should be discouraged." Although we have stressed specific isolation procedures and cohorting patients with MRSA in a hospital-based nursing home, we only gained control of the problem by finally eradicating MRSA using systemic and topical therapy. Unfortunately, this tends to be a short-lived situation because the parent institution is overrun with MRSA. Nevertheless, we have been able to minimize MRSA and resultant infections with eradication procedures with minimal toxicity and minor resistance prob lems.

In conclusion, Kauffman and associates have summarized the problem of MRSA in long-term care facilities well. Those of us dealing with MRSA on a daily basis are using various methods to try to deal with this organism. It has a special ecologic niche among humans. We are cognizant of the increasing antibiotic resistance among MRSA strains. Nonetheless, the overriding concern, in my opinion, is to decrease/eliminate the reservoir of MRSA because, at least in some institutions, it has markedly increased the burden of staphylococcal infection with its associated morbidity and mortality.

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SOME PEOPLE TAKE DRUG ABUSE **TO** HEART.



Most cocaine users are so dedicated to the drug that what it does to their hearts never enters their minds. They don't realize that every time they use cocaine, they put themselves at risk for such potentially fatal cardiovascular complications as hypertensive crisis.. . myocarditis.. .myocardial infarction . . .ventricular tachycardia.. .ventricular fibrillation.. . even cardiac arrest.

Chances are, at least some of these people are your patients. And many of them may feel more comfortable telling a nurse what they can't-or won't-tell a doctor. That's why your role becomes critical in helping suspected drug abusers understand what illegal drug use does to their bodies.

As key members of the health care team, nurses can make a difference in helping to curb drug abuse, and in preventing some of its deadliest consequences. The next time you suspect a patient may be using cocaine-or *any* illegal substance—have a heart-to-heart talk about the damage these drugs can do.

A short talk can go a long way.

Partnership for a Drug-Free America

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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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