

- Carolina. *Infect Control Hosp Epidemiol* 2000;21:39-40.
35. Behrman AJ, Shofer FS. Tuberculosis exposure and control in an urban emergency department. *Ann Emerg Med* 1998;31:370-375.
  36. Blumberg HM, Sotir M, Erwin M, Bachman R, Shulman JA. Risk of house staff tuberculin skin test conversion in an area with a high incidence of tuberculosis. *Clin Infect Dis* 1998;27:826-833.
  37. Christie CD, Constantinou P, Marx ML, et al. Low risk for tuberculosis in a regional pediatric hospital: nine-year study of community rates and the mandatory employee tuberculin skin-test program. *Infect Control Hosp Epidemiol* 1998;19:168-174.
  38. LoBue PA, Catanzaro A. Effectiveness of a nosocomial tuberculosis control program at an urban teaching hospital. *Chest* 1998;113:1184-1189.
  39. Louthier J, Rivera P, Feldman J, Villa N, DeHovitz J, Sepkowitz KA. Risk of tuberculin conversion according to occupation among health care workers at a New York City hospital. *Am J Respir Crit Care Med* 1997;156:201-205.
  40. Zahnnow K, Matts JP, Hillman D, et al. Rates of tuberculosis infection in healthcare workers providing services to HIV-infected populations: Terry Beirn Community Programs for Clinical Research on AIDS. *Infect Control Hosp Epidemiol* 1998;19:829-835.
  41. Ball R, Van Wey M. Tuberculosis skin test conversion among health care workers at a military medical center. *Mil Med* 1997;162:338-343.
  42. Bangsberg DR, Crowley K, Moss A, Dobkin JF, McGregor C, Neu HC. Reduction in tuberculin skin-test conversions among medical house staff associated with improved tuberculosis infection control practices. *Infect Control Hosp Epidemiol* 1997;18:566-570.
  43. Boudreau AY, Baron SL, Steenland NK, et al. Occupational risk of *Mycobacterium tuberculosis* infection in hospital workers. *Am J Ind Med* 1997;32:528-534.
  44. Manusov EG, Bradshaw RD, Fogarty JP. Tuberculosis screening in medical students. *Fam Med* 1996;28:645-649.
  45. Sinkowitz RL, Fridkin SK, Manangan L, Wenger PN, Jarvis WR. Status of tuberculosis infection control programs at United States hospitals, 1989 to 1992. *Am J Infect Control* 1996;24:226-234.
  46. Bailey TC, Fraser VJ, Spitznagel EL, Dunagan WC. Risk factors for a positive tuberculin skin test among employees of an urban, midwestern teaching hospital. *Ann Intern Med* 1995;122:580-585.
  47. Fraser VJ, Kilo CM, Bailey TC, Medoff G, Dunagan WC. Screening of physicians for tuberculosis. *Infect Control Hosp Epidemiol* 1994;15:95-100.
  48. Trends in tuberculosis morbidity: United States, 1992-2002. *MMWR* 2003;52:217-220, 222.

---

## Medical News

EDITED BY GINA PUGLIESE, RN, MS; MARTIN S. FAVERO, PHD

### Strategy to Prevent Nosocomial Spread of Methicillin-Resistant *Staphylococcus aureus* in an Endemic Setting

The effectiveness and feasibility of a comprehensive strategy to reduce nosocomial transmission of methicillin-resistant *Staphylococcus aureus* (MRSA) in a highly endemic setting have not yet been proved. Limited benefits and the high cost of such programs are the main concerns. Tomic et al. from Golnik, Slovenia, prospectively evaluated the effect of an aggressive infection control program on transmission of MRSA in the University Clinic of Respiratory and Allergic Diseases. All patients with MRSA carriage during 5 years (January 1, 1998, through December 31, 2002) were included and categorized into imported or hospital-acquired cases.

MRSA was recovered from 223 hospitalized patients; 142 cases were imported and 81 were acquired at the institution. After introduction of the comprehensive infection control program in 1999, the annual incidence of MRSA carriage per 1,000 admissions increased from 4.5 in 1998 to 8.0 in 1999 ( $P = .02$ ), and remained stable there-

after. During this period, the proportion of MRSA cases acquired in the institution decreased from 50.0% in 1999 to 6.1% in 2002 ( $P < .001$ ), whereas the proportion of MRSA cases transferred from other hospitals ( $P < .001$ ) and nursing homes ( $P = .03$ ) increased. All 19 MRSA carriers with three sets of follow-up cultures were successfully decolonized. The authors concluded that, with a comprehensive infection control program, it was possible to reduce nosocomial transmission of MRSA in a highly endemic setting. With good hand hygiene using alcohol handrub, early detection, isolation, and a decolonization strategy, containment of MRSA was achievable, despite a high rate of transferred patients with MRSA.

FROM: Tomic V, Svetina Sorli P, Trinkaus D, Sorli J, Widmer AF, Trampuz A. Comprehensive strategy to prevent nosocomial spread of methicillin-resistant *Staphylococcus aureus* in a highly endemic setting. *Arch Intern Med* 2004;164:2038-2043.