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Did CA-MRSA Bacteremia Exist in Taiwanese Patients With End-Stage Renal Disease?

To the Editor—In a recently published study, Lin et al.[1] attempted to distinguish between the clinical characteristics of patients infected with community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA) and those of patients infected with healthcare-associated (HA-MRSA). The study population consisted of patients who were receiving peritoneal dialysis or hemodialysis. This fact contradicts the present definition for CA-MRSA, because MRSA detected in persons with healthcare-associated risk factors, such as dialysis, within 1 year before onset of MRSA infection is not considered to be community acquired.[2]

One of the other criteria adopted by Lin and colleagues for identifying CA-MRSA and HA-MRSA was staphylococcal cassette chromosome (SCC) *mec* typing. They identified MRSA strains with SCCmec types IV or V as community acquired and MRSA strains with SCCmec types II or III as healthcare acquired. The designation of the source of MRSA acquisition by means of SCCmec typing may be misleading. In 2007, researchers at National Taiwan University Hospital (Taipei, Taiwan), the site of the study by Lin et al.,[1] reported that SCCmec type III predominated during 1999–2004, whereas SCCmec types IV and V predominated during 2005.[3] Others have also reported changes in the predominant SCCmec types over time.[4] Therefore, this use of SCCmec typing may not be an accurate method for distinguishing between HA-MRSA and CA-MRSA.

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Reply to Tsai et al.

To the Editor—We agree with Tsai et al.[1] that staphylococcal cassette chromosome (SCC) mec typing may not be sensitive enough and specific enough to accurately classify methicillin-resistant *Staphylococcus aureus* (MRSA) infections as either healthcare associated (HA) or community associated (CA). In addition to the different molecular epidemiologic characteristics of CA-MRSA strains in Taiwan, the evidence of continued spread of CA-MRSA strains into hospital settings[2-4] and the detection of SCCmec type IV in a HA-MRSA strain, namely EMRA-15 (ST22-IV), which is endemic in many hospitals throughout the world, lead to occasional confusion regarding the definitions of CA-MRSA and HA-MRSA infections.[5,6] However, molecular epidemiological definitions based on SCCmec typing and phylogenetic analyses of the MRSA isolates are still regarded as the most reliable means for distinguishing between HA-MRSA and CA-MRSA strains.[5] In fact, MRSA strains carrying different SCCmec types are biologically different. The rationale for defining isolates carrying SCCmec types IV and V as CA-MRSA is based on the relatively small size of its genetic components, which facilitates the survival of CA-MRSA in the community setting.[7,8] On the contrary, antibiotic selective pressure and cross-transmission in the nosocomial setting contribute to the survival of MRSA isolates