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Re: Prevalence of hospital-acquired infection in a Moroccan university hospital

To the Editor:

The comprehensive point-prevalence study at the Ibn Sina University Hospital in Rabat, Morocco,¹ to assess the existing hospital-acquired infection (HAI) was innovative. Such studies would be advantageous in other academic and nonacademic hospitals. Nevertheless, workups involving clinicians, clinical microbiologists, and epidemiologists and scrutiny of clinical and radiologic findings would not be feasible in nonacademic establishments. Chances of HAI surveillance would be low in private sector hospitals in developing countries. Alternatively, a culture-based surveillance for HAI ought to be a valid proxy. That was evident at the Sant Parmanand Hospital, Delhi, India, a private, 140-bed, multispecialty, tertiary care hospital.

Effective October 2002, all bacterial culture-positive hospitalized patients are being categorized as hospital- or community-acquired infection, depending on the time interval between time of admission and collection of pathologic specimens. Samples positive on culture after 2 to 3 days of hospitalization are labeled as "hospital acquired." An infection control team comprising clinicians, clinical microbiologist, and infection control/microbiology technicians would review such cases regularly. HAI cases are quantified monthly per 100 hospitalized cases. The team briefs management through the hospital director. The culture report including susceptibility profiles is communicated to the personnel responsible for patient care.

During the initial 6-month period October 2002 to March 2003, HAI patients averaged 0.98 per 100 admissions, SE 0.26. The annual averages \pm SE for the subsequent 12-month periods were 0.26 ± 0.07 , 0.4 ± 0.04 , 0.44 ± 0.04 , and 0.4 ± 0.04 , respectively. During 2005, there were 54 episodes of HAI recorded in 49 patients. The sites were urinary tract infections in 18 cases; pulmonary tissues in 16 cases, and blood and purulent

material in 10 cases each. Isolates included *Escherichia coli* strains, 16; *Klebsiella* species, 13; *Staphylococcus aureus*, 13; *Proteus* species, 7; *Pseudomonas* species, 3; and a solitary *Paracolon* species. As in Rabat,¹ local HAI infection was dominant in the urinary tract, and gram-negative bacteria and not gram-positive bacteria were the dominant offenders.

The average HAI incidence in the first 6 months of surveillance could be regarded as the basic scenario in the hospital. Culture-based surveillance would appear to lower the HAI in the subsequent 4-year interval: analysis of variance, $P < .0001$. Although hospital management was not approached for additional budget, motivated infection control team members ensured prompt communication of relevant data to clinicians. There has been no secondary spread of infection. A similar strategy of a motivated team of clinicians and microbiology personnel should effectively address HAI, even with rather inadequate fiscal support.

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Outbreak of *Burkholderia cepacia* bacteremia in immunocompetent children caused by contaminated nebulized sulbutamol in Saudi Arabia

To the Editor:

From early spring 2003 through May 2004, hospitals across Saudi Arabia and the Gulf Cooperation Council States experienced outbreaks of *Burkholderia cepacia* nosocomial infections secondary to the use of contaminated multidose albuterol nebulization solutions that were manufactured and distributed in the Gulf Region. After an exhaustive investigation, the National Guard's Department of Infection Prevention and Control identified the cause of the outbreak, and triggered a regional recall of the contaminated product in April 2004 after

which there were no further cases. The National Guard Hospital outbreak investigation, case descriptions and definitions, supporting laboratory data, and infection control recommendations were the subject of a detailed paper that was authored by the National Guard Infection Prevention and Control group. The paper was published in the pages of this journal in April 2005.¹

Last month, another iteration of this outbreak appeared, also in the pages of this journal.² Although the authors chose a title that focuses on *B cepacia* bacteremia in immunocompetent children, the content is largely reflective of our paper. The authors also claim to be the first to diagnose the national outbreak. Nowhere is our original article referenced or highlighted. This was unlikely to have been an inadvertent oversight; *American Journal of Infection Control* (AJIC) enjoys wide readership among infection control professionals, and the outbreak was publicized widely. Although it is possible that the authors did not inform AJIC of, nor made any reference to, the original article with the eventual duplication in the journal, it indicates an oversight on the part of article reviewers.

Priority claims are discouraged according to consensus standards that govern editorial policy for biomedical journals.³⁻⁶ One of the basic principles in medical writing is to acknowledge and recognize the work of others, especially when the work addresses the same subject matter, was published well in advance in the same journal, and is indexed in Pubmed. The readers of AJIC reasonably expect to see only high-quality original articles by authors who observe consensus guidelines that, at a minimum, acknowledge other investigators' work. The efforts of our group should have been acknowledged.

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The need for international benchmark for health care-associated infections

To the Editor:

We appreciate the comments and questions from Dr. Memish.¹ From a group of 18 limited resources countries, we reported data from 98 intensive care units (ICUs), 60% of which were from Latin America, 20% from Asia, 17% from Europe, and 2% from Africa.² We presented their data in a format similar to that of the US National Healthcare Safety Network (NHSN) to facilitate benchmarking of hospitals from limited resources countries with a standard also from limited resources countries, as well and with those of high-income countries, such as the United States. The International Nosocomial Infection Control Consortium (INICC) device-associated infection (DAI) rates in medical surgical ICUs were higher than corresponding Centers for Disease Control and Prevention (CDC)-NHSN rates: central line-associated bloodstream infections (CLAB) rates were 3.7 times higher, ventilator-associated pneumonia rates were 5.5 times higher, and catheter-associated urinary tract infection rates were 1.9 times higher.²

INICC members used CDC-National Nosocomial Infection Surveillance (NNIS) system definitions from 1998-2007.³ In 2008, the INICC began using CDC-NHSN definitions,⁴ with 1 exception: The INICC continues to use the definition of clinical sepsis (CSEP) for adult and pediatric patients to categorize CLABs that lack laboratory confirmation to remain consistent with our findings from the past 10+ years. Eliminating CSEP would result in an inaccurate reduction of CLAB rate attributable only to a change in our definition of CLAB.

In limited resources hospitals, blood cultures are not done as frequently as in high-income hospitals, and we believe it is important to capture those likely CLABs where blood cultures were not obtained to provide the most comprehensive estimate of CLABs in our hospitals.