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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