

neonatal and pediatric intensive care units. *Am J Infect Control* 2001;29:152-157.

Girouard S, Levine G, Goodrich K, Jones S, Keyserling H, Rathore M, et al. Pediatric Prevention Network: a multicenter collaboration to improve health care outcomes. *Am J Infect Control* 2001;29:158-161.

### Antibiotic-Resistant Bacteria Among Long-Term-Care Facility Residents

There is limited information on antibiotic-resistant bacteria in community long-term-care facilities (LTCFs). Mylotte and coinvestigators have reported on a study whose objective was to obtain data on resistant organisms in residents from community LTCFs admitted to an inpatient acute geriatrics service (AGS). Two studies were performed. In the first study, bacteriology records of all admissions to the AGS for the period from November 1, 1998, through June 30, 2000, were reviewed for resistant organisms (methicillin-resistant *Staphylococcus aureus* [MRSA], vancomycin-resistant enterococci [VRE], and resistant gram-negative bacilli). In the second study, residents admitted to the AGS during a 2-month period (n=92 admissions) had surveillance cultures (nares, gastrostomy site, wounds, and urine) for resistant organisms performed within 72 hours of admission.

In the retrospective study, there were 727 admissions, of which 437 (60%) had 928 cultures within 72 hours of admission; 590 (64%) cultures grew one or more pathogens. Urine (65%) and blood (26%) cultures accounted for 91% of all cultures done. Rates of resistance by culture site were as follows: urine (resistant organism in 16.6% of 373 cultures), blood (6.7% of 60 cultures), wound (52% of 23 cultures), and sputum (40% of 20 cultures). MRSA and enterococci with high-level gentamicin resistance were the most common resistant organisms identified. No VRE were isolated; only 3% of 421 gram-negative isolates were considered resistant strains, compared with 19% ( $P<.001$ ) of gram-positive isolates. In the prospective study, 17% of 92 residents were found to have a resistant organism in 1 or more surveillance cultures; the most common resistant organisms were MRSA and high-level gentamicin-resistant enterococci. Only 1 resident was found to have VRE in a rectal swab culture; resistant gram-negative bacilli also were uncommon.

The authors concluded that, among residents of community LTCFs admitted to an AGS, resistant organisms were identified infrequently (<20% of admissions). MRSA was the most common resistant organism; VRE and resistant gram-negative bacilli were rare. These findings vary from other studies suggesting that there may be geographic variation in the epidemiology of resistant organisms among residents of community LTCFs.

FROM: Mylotte JM, Goodnough S, Tayara A. Antibiotic-resistant organisms among long-term care facility residents on admission to an inpatient geriatrics unit: retrospective and prospective surveillance. *Am J Infect Control* 2001;29:139-144.

### MRSA in Latin America: 1996 to 1998

Aires De Sousa and colleagues from the Universidade Nova de Lisboa, Oeiras, Portugal, studied 493 methicillin-resistant *Staphylococcus aureus* (MRSA) isolates recovered from 1996 to 1998 from 22 hospitals in five countries of Latin America: Argentina, Brazil, Chile, Uruguay, and Mexico. The isolates were examined for antimicrobial susceptibility and clonal type so as to define the endemic clones in those hospitals. The hybridization of *ClaI* restriction digests with the *mecA*- and Tn554-specific DNA probes combined with pulsed-field gel electrophoresis of chromosomal *SmaI* digests (*ClaI*-*mecA*::*ClaI*-Tn554::PFGE clonal types) documented not only the predominance and persistence of the Brazilian clone (XI::B::B) in Brazil (97%) and Argentina (86%) but also its massive dissemination to Uruguay (100%). Moreover, a close relative of the Brazilian clone (XI::kappa::B) was highly represented in Chile (53%), together with a novel clone (47%) (II::E'::F) resistant to penicillin, oxacillin, ciprofloxacin, chloramphenicol, clindamycin, erythromycin, and gentamicin. A unique clonal type (I::NH::M) was detected in Mexico among pediatric isolates and was resistant to penicillin, oxacillin, and gentamicin only.

This study clearly documented the very large capacity for geographic expansion and the persistence of the Brazilian clone, contributing not only to the increasing uniformity of the MRSA in South America but worldwide as well.

FROM: Aires De Sousa M, Miragaia M, Santos Sanches I, Avila S, Adamson I, Casagrande ST, et al. Three-year assessment of methicillin-resistant *Staphylococcus aureus* clones in Latin America from 1996 to 1998. *J Clin Microbiol* 2001;39:2197-2205.

### Povidone-Iodine Versus Chlorhexidine Gluconate-Impregnated Dressing for Prevention of CVC Infections in Neonates

Neonates who require a central venous catheter (CVC) for prolonged vascular access experience high rates of catheter-related (CR) bloodstream infection (BSI). Garland and coinvestigators conducted a multicenter, randomized clinical trial to ascertain the efficacy of a novel chlorhexidine-impregnated dressing (Biopatch Antimicrobial Dressing; Johnson & Johnson Medical, Arlington, TX) on the CVC sites of neonates for the prevention of catheter-tip colonization, CR BSI, and BSI without a source. The trial was conducted in six level III neonatal intensive care units. Patients studied were neonates admitted to study units who would require a CVC for at least 48 hours. Eligible infants were randomized before catheter placement to 1 of the 2 catheter-site antiseptic regimens: (1) 10% povidone-iodine (PI) skin scrub, or (2) a 70% alcohol scrub followed by placement of a chlorhexidine-impregnated disk over the catheter insertion site. A transparent polyurethane dressing (Bioclusive Transparent