In the context, we invited the hospital administrations to participate in a 2-year project (2001-2002) that had the following objectives: to verify the incidence of nosocomial legionellosis in those hospitals contaminated with L. pneumophila other than serogroup 1 or with non-pneumophila species of Legionella, where only regular ordinary maintenance without decontamination measures would be carried out; and to monitor environmental contamination levels without decontamination measures.

In agreement with the medical departments of the hospitals participating in the project, the following protocol was set up. First, preliminary evaluation of environmental contamination was done. No environmental decontamination intervention was initiated at the central or peripheral parts of the water distribution system. Hospitals performed normal maintenance, defined as systematic interventions at distal outlets, instant hot water heaters, tanks (where present), air conditioning units, and cooling towers. There was semiannual monitoring of the water distribution system to identify spontaneous colonization. Also, hospitals performed active surveillance for Legionella infection for all cases of nosocomial pneumonia identified by clinical, radiological, and laboratory criteria. If a patient had pneumonia with onset at least 2 days after admission to the hospital, urine specimens were collected and examined for Legionella antigen; if the results were negative, the test was repeated 5-7 days later. Testing was performed using the Biotest Legionella Urine Antigen EIA kit.

**Table.** Distribution of Pneumonia Cases at the 20 Study Hospitals, by Patient Age

<table>
<thead>
<tr>
<th>Age, y</th>
<th>No. (%) of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;40</td>
<td>17 (5)</td>
</tr>
<tr>
<td>40-59</td>
<td>48 (14)</td>
</tr>
<tr>
<td>60-80</td>
<td>159 (45)</td>
</tr>
<tr>
<td>&gt;80</td>
<td>128 (36)</td>
</tr>
</tbody>
</table>

**LETTERS TO THE EDITOR**

In the late 1990s, following outbreaks of isolated cases or clusters of legionellosis in several Turin hospitals, the district attorney’s office ordered all hospitals in its jurisdiction to monitor their water distribution systems. In response, Piedmont hospitals initiated surveillance and control measures to fully decontaminate their water distribution systems, regardless of whether legionellosis cases had occurred at the facility. Our department’s involvement in evaluating the effectiveness of the decontamination interventions enabled us to gain a fairly complete picture of the situation at 36 hospitals, 35 of which were contaminated (61% of samples tested positive for Legionella species, with bacterial loads ranging from 100-10,000 cfu/L). Of the Legionella species isolated, Legionella pneumophila occurred most frequently; among the most common circulating serogroups were serogroup 6 (found at 15 hospitals), serogroup 3 (found at 12 hospitals), and serogroup 1 (found at 11 hospitals). Other species isolated (Legionella micdadei, Legionella steigerwaltii, and other unidentified strains) were consistently associated with L. pneumophila.

Concerned about legal action the magistrate’s office could take against them if there was Legionella contamination in their water distribution systems, the hospital administrations initiated disinfection procedures recommended by guidelines (chlorination and thermal shock) or alternative methods (eg, disinfection with peracetic acid, ozone, and/or hydrogen peroxide), independently of the observed bacterial load or the presence of legionellosis cases. In the end, huge costs were incurred to obtain an effect that was as questionable as it was transient.

To the Editor—In the late 1990s, following outbreaks of isolated cases or clusters of legionellosis in several Turin hospitals, the district attorney’s office ordered all hospitals in its jurisdiction to monitor their water distribution systems. In response, Piedmont hospitals initiated surveillance and control measures to fully decontaminate their water distribution systems, regardless of whether legionellosis cases had occurred at the facility. Our department’s involvement in evaluating the effectiveness of the decontamination interventions enabled us to gain a fairly complete picture of the situation at 36 hospitals, 35 of which were contaminated (61% of samples tested positive for Legionella species, with bacterial loads ranging from 100-10,000 cfu/L). Of the Legionella species isolated, Legionella pneumophila occurred most frequently; among the most common circulating serogroups were serogroup 6 (found at 15 hospitals), serogroup 3 (found at 12 hospitals), and serogroup 1 (found at 11 hospitals). Other species isolated (Legionella micdadei, Legionella steigerwaltii, and other unidentified strains) were consistently associated with L. pneumophila.

Concerned about legal action the magistrate’s office could take against them if there was Legionella contamination in their water distribution systems, the hospital administrations initiated disinfection procedures recommended by guidelines (chlorination and thermal shock) or alternative methods (eg, disinfection with peracetic acid, ozone, and/or hydrogen peroxide), independently of the observed bacterial load or the presence of legionellosis cases. In the end, huge costs were incurred to obtain an effect that was as questionable as it was transient.

To this context, we invited the hospital administrations to participate in a 2-year project (2001-2002) that had the following objectives: to verify the incidence of nosocomial legionellosis in those hospitals contaminated with L. pneumophila other than serogroup 1 or with non-pneumophila species of Legionella, where only regular ordinary maintenance without decontamination measures would be carried out; and to monitor environmental contamination levels without decontamination measures.

In agreement with the medical departments of the hospitals participating in the project, the following protocol was set up. First, preliminary evaluation of environmental contamination was done. No environmental decontamination intervention was initiated at the central or peripheral parts of the water distribution system. Hospitals performed normal maintenance, defined as systematic interventions at distal outlets, instant hot water heaters, tanks (where present), air conditioning units, and cooling towers. There was semiannual monitoring of the water distribution system to identify spontaneous colonization. Also, hospitals performed active surveillance for Legionella infection for all cases of nosocomial pneumonia identified by clinical, radiological, and laboratory criteria. If a patient had pneumonia with onset at least 2 days after admission to the hospital, urine specimens were collected and examined for Legionella antigen; if the results were negative, the test was repeated 5-7 days later. Testing was performed using the Biotest Legionella Urine Antigen EIA kit.
(Biotest AG), which detects all serogroups of *L. pneumophila* and even other *Legionella* species. Culture of respiratory secretions when possible was recommended, as was testing for specific antibodies on admission and after 15-20 days of hospitalization.

Definitions of confirmed or probable legionellosis, as well as confirmed or possible nosocomial infection, were based on national guidelines (and clinical, radiological, and laboratory findings). The management of active surveillance was assigned to the chief of the hospital’s infection control committee who, in collaboration with the infection control nurse, collected data about patients with nosocomial pneumonia and reported this information to our department. Our department telephoned the persons responsible for surveillance once every 2 weeks to ensure consistent monitoring.

At the start, the project involved 32 hospitals; however, the number of participating facilities dropped to 24 during the first year and then to 20 during the second year. The probable reason for this was that some hospital administrations feared legal action if cases were identified and their facility’s water distribution system had not been properly decontaminated.

Surveillance involved 325,703 patients. During the first year, 178 cases of nosocomial pneumonia were reported, and 174 cases were reported during the second year. The fatality rate was 12.7% (45 deaths). As expected, the age group most affected by pneumonia was patients aged 60 years or more (Table).

The cumulative incidence of reported pneumonia was 0.13% during the first year and 0.17% during the second. The distribution of cases by hospital is shown in the Figure.

During the 2-year course of the study, only 1 case of legionellosis was identified. *L. pneumophila* serogroup 3 was isolated from bronchoalveolar lavage samples from a patient in a hospital contaminated with this microorganism. The case was defined as nosocomial legionellosis even though, according to the attending physicians, the clinical relevance was uncertain and the criteria for absolute certainty did not appear to be fully satisfied. During the study, only 17 hospitals stated that they had systematically carried out maintenance according to the instructions they received. The environmental contamination levels did not appear to be affected by maintenance measures. The frequency of *Legionella*-positive samples was more or less the same over the course of the study, as was the frequency of the species of *Legionella* isolated.

The results of our study confirm that the presence of *Legionella* in a hospital’s water distribution system does not necessarily mean cases of legionellosis will occur, nor, by the same token, does a reduction or absence of contamination guarantee that cases of legionellosis will not occur.

The incidence of nosocomial pneumonia was less than expected (0.5%-1%, according to Centers for Disease Control and Prevention figures). Nonetheless, these cases occurred at hospitals colonized by *L. pneumophila* other than serogroup 1 (ie, strains of lower pathogenicity), in which there were fewer particularly critically ill patients than in large hospitals in Piedmont. This interpretation was confirmed by the exception of hospital number 2 (Figure), in which a higher incidence was found because the hospital admits patients with infectious diseases, including human immunodeficiency virus infection.

Furthermore, retrospective analysis of the radiographic documentation from the 2-year study period confirmed that the 3 hospitals reporting no cases had followed the protocol. All 3 are part of the same hospital administration.

The concept that pneumonia surveillance is a primary and indispensable objective in the prevention and control of nosocomial legionellosis was strengthened by our data and accepted by hospital administrators. This practice limits or even eliminates costly environmental interventions that may sometimes damage the water distribution system and are always

![Figure](https://doi.org/10.1086/513118) Published online by Cambridge University Press
ineffective in the long run. Moreover, it satisfies ethical criteria, in that when a case of legionellosis is identified, adequate treatment can be instituted promptly. Regular environmental interventions to reduce the risk of infection should be reserved for departments with high-risk patients. The participating hospitals were encouraged to institute pneumonia surveillance practices, which had important implications for devising strategies to control nosocomial infections. Most hospitals continued surveillance beyond the end of the project. The practice of regular maintenance of water distribution systems was introduced and consolidated in those hospitals where it had been neglected.

We believe we have provided useful additions to the ongoing discussion about methods for preventing hospital-acquired legionnaires disease. In agreement with numerous published studies, we confirmed that \textit{L. pneumophila} other than serogroup 1 is less pathogenic than isolates from serogroup 1, and we confirmed that the presence of \textit{Legionella} in the water distribution system does not necessarily mean that cases of legionellosis will occur.

\textbf{MEMBERS OF THE LEGIONELLOSIS COLLABORATING GROUP}

G. Attanasio (Azienda sanitaria locale 2, Torino, Italy), M.L. Soranzo (Azienda sanitaria locale 3, Torino, Italy), M. Avanzato (Azienda sanitaria locale 4, Torino, Italy), N. Pasetto (Azienda sanitaria locale 6, Ciriè, Italy), A. Pasqualucci (Azienda sanitaria locale 8, Chieri, Italy), F. Chieppa (Azienda sanitaria locale 12, Biella, Italy), E. Pagani (Azienda sanitaria locale 13, Novara, Italy), O. Ossola (Azienda sanitaria locale 14, Verbania, Italy), M. Rebora (Azienda sanitaria locale 17, Cuneo, Italy), L. Bernini (Azienda sanitaria locale 19, Asti, Italy), G. Parovina (Azienda sanitaria locale 21, Casale Monferrato, Italy), C. Macchiolo (Ospedale Gradenigo, Torino, Italy), G. Guareschi (Azienda sanitaria ospedaliera Ospedale Infantile “Regina Margherita-Sant’Anna,” Torino, Italy).

\textbf{ACKNOWLEDGMENTS}

We thank Kenneth Britsch for the translation of this paper. Supported by a grant from Ministero dell’Istruzione Universitaria e Ricerca (funds COFIN 2002).

S. Ditommaso, Laurea in Scienze Biologiche; M. Giacomuzzi, BSc; C. Biasin, Laurea in Scienze Biologiche; M. Gentile, BSc; G. Maggiorotto, MD; A. Ruggenini Moiraghi, MD; C. M. Zotti, Laurea in Scienze Biologiche; and the Legionellosis Collaborating Group

From the Dipartimento di Sanità Pubblica e di Microbiologia, Università degli Studi di Torino, Turin, Italy (all authors). Members of the Legionellosis Collaborating Group are listed at the end of the text.

Address reprint requests to Savina Ditommaso, University of Turin, Department of Public Health and Microbiology, Via Santena 5 bis, Turin, Italy 10126 (savina.ditommaso@unito.it).

\textit{Infect Control Hosp Epidemiol} 2007; 28:509-511

© 2007 by The Society for Healthcare Epidemiology of America. All rights reserved. 0899-823X/2007/2804-0027$15.00. DOI: 10.1086/518096

\textbf{REFERENCES}


5 Alary MA, Joly JR. Factors contributing to the contamination of hospital water distribution systems by \textit{Legionella}. \textit{J Infect Dis} 1992; 165:565-569.


8 Craven DE, Steger KA, Barber TW. Preventing nosocomial pneumonia: state of the art and perspectives for the 1990s. \textit{Am J Med} 1991; 91: 44S-53S.
