Review

**Staphylococcus aureus** and surgical site infections: benefits of screening and decolonization before surgery

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**Summary**

Surgical site infections (SSIs) are among the most common healthcare-associated infections, and contribute significantly to patient morbidity and healthcare costs. *Staphylococcus aureus* is the most common microbial cause. The epidemiology of *S. aureus* is changing with the dissemination of newer clones and the emergence of mupirocin resistance. The prevention and control of SSIs is multi-modal, and this article reviews the evidence on the value of screening for nasal carriage of *S. aureus* and subsequent decolonization of positive patients pre-operatively. Pre-operative screening, using culture- or molecular-based methods, and subsequent decolonization of patients who are positive for meticillin-susceptible *S. aureus* and meticillin-resistant *S. aureus* (MRSA) reduces SSIs and hospital stay. This applies especially to major clean surgery, such as cardiothoracic and orthopaedic, involving the insertion of implanted devices. However, it requires a multi-disciplinary approach coupled with patient education. Universal decolonization pre-operatively without screening for *S. aureus* may compromise the capacity to

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Introduction

Worldwide, the prevalence of healthcare-associated infections (HAIs) is approximately 4.5—15.5% in hospitalized patients. These infections are strongly associated with the resource setting, and the estimated incidence in acute care hospitals in the USA and Europe is 4.5 and 7.1 per 100 hospitalized patients, respectively, corresponding to 1.7 and 4.1 million affected patients. Allegranzi et al. conducted a meta-analysis on endemic HAIs in resource-poor countries, and documented a rate as high as 15.5 per 100 hospitalized patients.

In resource-rich countries, surgical site infections (SSIs) are the third most common cause of HAIs, but in income-poor settings, they are the most common HAI. The incidence of SSIs varies according to operative procedure, with an overall rate of 5.6% in income-poor countries, 2.6% in the USA and 1.6% in Germany. The incidence of SSIs after major clean surgical procedures differs according to the procedure, with 10.8% for cardiac surgery, 7% for vascular procedures, 4.4% for orthopaedic procedures and 4.8% for breast surgery. Staphylococcus aureus is the most common cause, and nasal colonization with S. aureus is the most important independent risk factor for the development of an SSI in clean surgery. The rate of S. aureus SSI is two to nine times higher in carriers than in non-carriers.

The impact of SSIs includes significant morbidity and mortality, and increased direct healthcare costs. The mean postoperative length of stay (LOS) is 10 days for SSIs, with a resultant additional healthcare cost of €19 billion for European health services. In the USA, it is estimated that out of 80 million procedures carried out annually, SSIs occur in approximately 1.9%, and account for 69,475 HAIs. Jenks et al. calculated the economic cost for additional LOS due to SSIs in the UK to be 23 days for cardiac procedures, 10 days for vascular procedures, 17 days for hip replacement, and three days for breast surgery, reflecting healthcare-acquired costs of £11,003, £2480, £3214 and £1469, respectively. In a multicentre study of 659 surgical patients, Anderson et al. compared patients with meticillin-resistant Staphylococcus aureus (MRSA) SSIs or meticillin-susceptible S. aureus (MSSA) SSIs with uninfected controls. While meticillin resistance was not associated with increased mortality, it was associated with 10 days of additional hospitalization. Patients with SSIs also required more visits by hospital providers (46/89 vs 61/178 for patients without SSIs; P=0.008), had greater need for home help (55/89 vs 84/178; P=0.009), and had a greater requirement for medical equipment (33/89 vs 39/178; P=0.008).

There are various strategies to minimize SSIs, and these can be classified as those interventions occurring before, during and after surgery. One is to decolonize patients with S. aureus, especially before elective surgery. However, another approach recommends that all patients due for surgery should be decolonized without prescreening for S. aureus.

A literature review was conducted regarding recent changes in the epidemiology of S. aureus, especially MRSA, and the consequences of screening and decolonization of patients who were positive for S. aureus. Relevant studies published in PubMed from 2000 to February 2016 were reviewed, as well as key studies published before this time using the following search terms: surgical site (wound) infection, S. aureus, MRSA, surveillance, screening, surgery, decolonization, cost effectiveness and related topics. Emphasis was placed on sourcing and reviewing original papers describing controlled clinical trials or quasi-experimental studies involving interventions to prevent SSIs due to S. aureus. In addition, the reference lists of papers were reviewed to determine if there were other studies that should be included, but which were not detected in the original literature search.

Changing epidemiology of MRSA and its implications

Regarding the molecular epidemiology of S. aureus, one must distinguish between its genomic background based on a relatively stable core genome, and the gain or loss of mobile elements, including the MRSA-determining SCCmec element, whereby evolution of both do not necessarily correlate. Due to MRSA being a major nosocomial pathogen with more limited therapeutic options compared with MSSA, there have been more reports on MRSA subsequent to its worldwide emergence. This holds true despite MSSA accounting for the majority of S. aureus bloodstream infections (BSIs). In contrast to other pathogens, such as pneumococci or meningococci, the population structure of S. aureus is highly clonal, and while there is an overlap between the genetic backgrounds of MRSA and MSSA, the latter are more genetically diverse and more widespread geographically. Despite a decrease in the prevalence of MRSA in several countries, the global impact of MRSA on healthcare systems continues with significant morbidity, mortality and associated socio-economic burden.

Changes in clonal lineages

There is often an erroneous view that MRSA represents a uniform subpopulation of S. aureus. While this is justified for many, but not all, MRSA control measures, therapeutic aspects and antibiotic stewardship concerns require a differentiated approach. In fact, MRSA comprise a multitude of more or less epidemiologically successful clonal lineages with huge differences in resistance patterns and virulence factors. Thus, local infection prevention and control specialists and clinicians caring for patients should know the current and emerging MRSA strains. Regular screening of patients at risk for MRSA and the characterization of isolates is therefore mandatory in providing details of the local, national and international epidemiology.

While some pandemic or epidemic lineages may persist globally or locally for years, others may emerge or disappear in resource-rich countries, surgical site infections (SSIs) are the third most common cause of HAIs, but in income-poor settings, they are the most common HAI.
over a few years. For decades, multi-resistant, healthcare-associated (HA) MRSA was synonymous with MRSA. However, the sudden arrival of hitherto less significant lineages, and the subsequent epidemiological success of community-associated (CA) and livestock-associated (LA) MRSA lineages within a few short years, are prime examples of the adaptability of MRSA as a pathogen. Moreover, there are two, not necessarily linked, molecular evolutionary processes: (i) the macro- and micro-evolution of the clonal lineage itself, as traceable by genotyping methods (e.g. multi-locus sequencing, spa typing or whole-genome sequencing); and (ii) the uptake and loss of evolution of the genetic element encoding meticillin resistance on the staphylococcal cassette chromosome mec (SCCmec). Different types and subtypes of the SCCmec element may occur in the same clonal lineage, and different clonal lineages may harbour identical SCCmec elements. These mobile elements not only determine beta-lactam resistance, with the exception of newer cephalosporins with MRSA activity, but also carry additional genes encoding virulence factors and/or resistance to non-beta-lactam antibiotics, metals (e.g. cadmium, copper) and metalloids (arsenic). Consequently, knowledge of commonly occurring SCCmec is relevant for clinical decisions.

New clonal MRSA lineages may be epidemiologically different, such as those occurring in patients not previously thought to be at risk of acquisition, or there may be different routes of transmission. They may even carry fewer common virulence factors, with the consequence of reduced rates of infection, or they may exhibit different resistance patterns. The recent global spread of CA-MRSA lineage USA300, which carries the prophage-located Panton-Valentine leucocidin (PVL), is a good example of this. This toxin and altered genome-encoded toxins, such as alpha-toxin and phenol-soluble modulins, have been associated with previously uncommon MRSA-caused infections such as necrotizing pneumonia and necrotizing fasciitis/myositis. In contrast to classical HA-MRSA, CA-MRSA can occur in young healthy individuals. The causative strains are typically not multi-resistant, and therefore there are more therapeutic options. Moreover, knowledge of special MRSA clonal lineages known to be associated with PVL or other virulence factors (e.g. pyrogenic toxin, superantigens, exfoliative toxins) may also influence clinical management, such as the use of immunoglobulins in addition to antibiotics.

The ongoing spread of the most successful LA-MRSA clonal complex (CC) CC398 has a number of important features: it has novel transmission routes as a zoonotic pathogen; it exhibits resistance to arsenic, cadmium, copper and/or zinc; and it is usually tetracycline resistant, an important consideration for empiric treatment. The proportion of CC398 in Europe ranges from <10% to >30% in pig-dense regions. As with CA-MRSA, the differing epidemiology of LA-MRSA and their introduction into hospitals has led to changed guidelines for MRSA screening. Individuals with professional livestock contact are at risk for MRSA colonization, and are considered to need screening in some countries. There is increasing evidence for the transmission of LA-MRSA in the human population without known contacts with livestock or involvement in agriculture.

Another new challenge is the discovery of MRSA isolates containing a novel SCCmec, type XI, encoding the highly divergent mecC, originally described as mecCA42, which shares only 70% DNA homology with mecA. Particularly challenging is the laboratory detection and identification of mecC-MRSA, as well as the determination of meticillin resistance. A livestock origin is probable for these mecC strains. While the prevalence of mecC-MRSA is currently <1% amongst humans, this gene and its related variants are widely distributed in S. aureus and coagulase-negative staphylococci recovered from wild and companion animals. To detect major outbreaks earlier and to identify potentially fatal clones, changes in antibiotic resistance and virulence properties should be monitored regularly amongst hospital and community isolates. Different clonal lineages may present typical resistance patterns or may be equipped with certain virulence factors, such as PVL-positive CA-MRSA. This is vital for optimal empiric therapy (i.e. to choose agents that act on protein biosynthesis to inhibit toxin production). Moreover, knowledge on the composition of the circulating clones is crucial for the investigation of MRSA transmission events, to determine populations at risk (e.g. farm workers colonized with LA-MRSA), and to quickly recognize those strains that may cause diagnostic difficulties.

Resistance to mupirocin and other topical agents

Administration of mupirocin to the nares and chlorhexidine (CHG) to the skin represents the cornerstone of decolonization in patients colonized with MRSA. The polyketide antibiotic, mupirocin, is a naturally occurring antibiotic compound produced by the soil bacterium Pseudomonas fluorescens as a mixture of pimaricin acids A, B, C and D. Its rapid hydrolysis in body fluids and its low activity at higher pH levels leads to rapid breakdown in tissues, and precludes systemic administration. Thus, it was developed as a topical antibiotic primarily for bacterial infections of the skin. While initial in-vitro studies confirmed good activity against clinical isolates of S. aureus, Kavi et al. described that its frequent use/abuse, including its use without prescription in some countries, has been quickly followed by resistance and even outbreaks of mupirocin-resistant MRSA.

There are currently two categories of mupirocin resistance: (i) chromosomal low-level mupirocin resistance (LMupR) with minimum inhibitory concentrations (MICs) from 8 to 64 (up to 256) µg/mL; and (ii) plasmid-borne high-level mupirocin resistance (HMupR) with MICs ≥512 µg/mL. Isolates carrying both LMupR and HMupR resistance have been described. Low-level mupirocin resistance occurs via a variety of amino acid changes in the native isoleucyl-tRNAsynthetase due to non-synonymous mutations in the respective gene, ileS. While the mutation frequency is approximately 10⁻⁸ to 10⁻⁹ per bacterium per generation, administration of mupirocin mimics the effect of amino acid starvation, which results in an increase in the mutation rate. The clinical significance of LMupR in terms of decolonization has yet to be determined. This is in contrast to the more clinically significant HMupR, which is generated by the acquisition of the plasmid-located mupA (ileS-2) gene encoding another isoleucyl RNA synthetase. Respective plasmids can be conjugative, and the mupA gene is flanked by insertion sequences, both of which may facilitate HMupR exchange between plasmids and staphylococcal isolates. Particularly worrying are in-vivo transfers of mupA plasmids within different clonal lineages of S. aureus, as well as between S. aureus and Staphylococcus epidermidis. There is evidence that such conjugative transfer of HMupR from
Global threat of mupirocin resistance in staphylococci: selection of studies published in the past decade

<table>
<thead>
<tr>
<th>Country</th>
<th>Source</th>
<th>Species</th>
<th>Source Species</th>
<th>LMupR (%)</th>
<th>HMupR (%)</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>Nasal swabs from ICU and orthopædic surgery patients</td>
<td>S. aureus</td>
<td>MSSA</td>
<td>0.0</td>
<td>0.0</td>
<td>75</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CoNS</td>
<td></td>
<td>1.9</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>Various clinical specimens</td>
<td>S. aureus (MRSA)</td>
<td></td>
<td>16.7</td>
<td>36.1</td>
<td>76</td>
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<tr>
<td>USA</td>
<td>Mainly deep swabs from outpatients with SSSls</td>
<td>S. aureus</td>
<td></td>
<td>1.8</td>
<td>8.7</td>
<td>77</td>
</tr>
<tr>
<td>France</td>
<td>Catheter-associated BSIs in very preterm neonates</td>
<td>CoNS</td>
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<td>2.0</td>
<td>58.8</td>
<td>73</td>
</tr>
<tr>
<td>UK</td>
<td>Nasal swabs from elderly care home residents</td>
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<td></td>
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<td>3.9</td>
<td>65</td>
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<td>France</td>
<td>Various clinical specimens, mainly from</td>
<td>S. aureus (MRSA)</td>
<td></td>
<td>0</td>
<td>0.8</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td>BSIs and osteoarticular infections</td>
<td>CoNS</td>
<td></td>
<td>0.8</td>
<td>5.6</td>
<td></td>
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<tr>
<td>Brazil</td>
<td>Mainly BSIs</td>
<td>S. haemolyticus</td>
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<td>1.6</td>
<td>7.8</td>
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<td>Netherlands</td>
<td>Blood culture isolates</td>
<td>CoNS</td>
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<td>5.5</td>
<td>12.8</td>
<td>63</td>
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<tr>
<td>China</td>
<td>Various clinical specimens</td>
<td>S. aureus (MRSA)</td>
<td></td>
<td>0.0</td>
<td>6.6</td>
<td>79</td>
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<tr>
<td>Germany</td>
<td>Various clinical specimens</td>
<td>S. aureus (MSSA)</td>
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<td>0.5</td>
<td>0.0</td>
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<tr>
<td></td>
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<td>S. aureus (MRSA)</td>
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<td>6.9</td>
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<tr>
<td></td>
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<td>S. epidermidis</td>
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<td>17.5</td>
<td>4.0</td>
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<tr>
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<td>S. haemolyticus</td>
<td></td>
<td>2.4</td>
<td>0.0</td>
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<td>Ireland</td>
<td>Blood, wound and MRSA screening specimens</td>
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<td></td>
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<td>S. aureus (MSSA)</td>
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<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CoNS</td>
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</tr>
<tr>
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<td>S. aureus</td>
<td></td>
<td>7.0</td>
<td>0.9</td>
<td>82</td>
</tr>
</tbody>
</table>

BSIs, bloodstream infections; CoNS, coagulase-negative staphylococci; HMupR, high-level mupirocin resistance; ICU, intensive care unit; LMupR, low-level mupirocin resistance; MSSA, meticillin-resistant S. aureus; MRSA, meticillin-susceptible S. aureus; SSSls, skin and skin structure infections.

* Designated as ‘mupirocin intermediate’ in some publications.
Impact of decolonization on *S. aureus* surgical site infections

**Evidence**

A recent systematic literature analysis has confirmed key components in the prevention and control of MRSA and the evidence underpinning them. According to macro-epidemiological data and mathematical models, infection control measures that do not incorporate screening may fail to reduce MRSA spread effectively, most likely due to a failure in the full implementation of targeted infection control measures.

Decolonization with mupirocin has been shown to be effective in reducing SSIs due to antibiotic-resistant and susceptible *S. aureus*. Lee et al. undertook a prospective control study on clean surgery wards with a combination of MRSA screening, contact precautions and decolonization which resulted in decreased MRSA rates. Many of the studies involved elective cardiothoracic and prosthetic joint surgery. While some focused on MRSA, many of the measures implemented were effective in reducing both MRSA and MSSA.

Other studies describing a series of measures, including screening and decolonization, have shown these measures to be effective. Schweizer et al. undertook a study to reduce SSIs among patients undergoing cardiac, hip and knee surgery in nine US states involving 20 hospitals. Adherence to the protocol was 83%, and there was a significant decline in *S. aureus* infections in both orthopaedic and cardiothoracic surgery. van Rijen et al. showed that screening patients undergoing cardiothoracic or orthopaedic surgery for *S. aureus* nasal carriage, with a subsequent decolonization protocol, resulted in a substantial reduction in hospital costs. In another study, the nares were screened at least one week before orthopaedic surgery using rapid polymerase chain reaction (PCR) for both MRSA and MSSA. Positive patients completed a five-day decolonization protocol with 2% nasal mupirocin twice per day and daily bathing with CHG before surgery in their home. If a repeat nasal specimen was MRSA positive, contact precautions (CPs) were introduced in the operating room and nursing units, and all such patients received adjusted surgical prophylaxis to cover for MRSA, such as a glycopeptide. Approximately 96% of 7338 patients were screened before elective orthopaedic surgery and, following decolonization of carriers, the SSI rate fell significantly to 0.19% compared with historical controls, for whom the rate was already low at 0.45%.

In a systematic review of 19 studies involving orthopaedic patients screened for *S. aureus* and decolonized if positive, Chen et al. showed an overall reduction in SSI rates ranging from 13% to 200%, including a reduction in *S. aureus* SSI rates from 40% to 200%, and a reduction in MRSA SSI rates from 29% to 149%. Finally, in a Swiss study of 12 surgical wards when rapid screening for MRSA was undertaken pre-operatively amongst a variety of surgical specialties, 94% of 10,844 patients were screened. However, a combination of screening and decolonization of positive patients did not lead to a reduction in MRSA SSIs. In this study, CPs were only introduced after a positive result and not on suspicion, there was significant movement of patients between care units, and not all high-risk patients were screened.

Bode et al. conducted a randomized clinical trial with a treatment group that was screened by rapid PCR at the time of admission. While no positive MRSA screens were noted, 18.8% were positive for MSSA. Positive patients received a five-day course of mupirocin/CHG for decolonization during hospitalization; negative patients received placebo (nasal ointment and regular soap). The SSI rate was 3.4% in the treatment group compared with 7.7% in the placebo group, with a reduction in mean hospital stay of almost two days.

Reduced costs are also associated with screening and decolonization in some areas of elective surgery. van Rijen et al. performed an economic evaluation of the Dutch study referred to above. Despite the additional costs of screening and decolonization, the reduced infection rate meant that €2841 was saved per cardiothoracic patient and €955 was saved per orthopaedic patient in the screened patients. Furthermore, the same authors recorded a reduction in one-year mortality from 7% to 3% in patients undergoing clean procedures (i.e. cardiothoracic, orthopaedic, vascular and others). All the economic models in a review of 19 studies involving orthopaedic patients favoured the implementation of an *S. aureus* decolonization protocol.

**Logistical issues**

*S. aureus* decolonization regimens require a multi-disciplinary approach with the support of hospital administrators, nursing personnel, surgeons, hospital hygienists, medical microbiologist/infectious disease specialists and ancillary staff. The programme challenges include:

- appropriate diagnostics in the microbiology laboratory or in other testing settings, the training of staff, and the communication of positive screen results and their significance;
- a system to facilitate pre-operative screening using nasal screening tests and ensuring patient compliance;
- creation of a multi-disciplinary group to include the pre-admission unit, presurgery unit, operating room, post-operative care unit, hospital hygienists, medical microbiologists/infectious disease specialists, and pharmacy/nursing/ancillary departments; and
- support or development of information systems for the rapid reporting of positive and negative screening results to patients, caregivers and relevant departments.

A patient education programme is essential, and the key features are outlined in Table II.

Another benefit of early detection is the potential for a greater focus on environmental contamination with MRSA and its eradication. Villamaria et al. sampled 32 non-contact precaution rooms (NCPRs) and 68 contact precaution rooms (CPRs). They found a higher burden of MRSA in the CPRs, as might be expected. The detection of MRSA in NCPRs may be due to residual contamination from prior occupants due to inadequate cleaning, or the shedding of MRSA from patients with intermittent colonization or extranasal colonization not detected at admission. Hardy et al. conducted a study in a nine-bed intensive care unit over 14 months that showed widespread contamination of the hospital environment with MRSA, and highlighted the need for more effective cleaning of the environment to eliminate MRSA.
Consequences of universal decolonization

There is debate about whether universal decolonization in the absence of screening is easier and more effective. Courville et al. compared selective screening with decolonization of positive patients alone, universal screening with decolonization of positive patients, and no screening but universal decolonization. While decolonizing all patients was the best strategy to maintain a low rate of MRSA, screening was cost-effective in certain categories of patients, but the risk of mupirocin resistance remained. In a study using a Dutch database of patients undergoing prosthetic joint or cardiopulmonary surgery, selective decontamination (assuming 100% compliance) was calculated to prevent seven SSIs from a base case of 14, and save €47,746 per 1000 patients; in contrast, decontamination of all patients prevented 11 infections and saved €178,970 per 1000 patients. Other economic models have made a strong case for screening and decolonization in cardiac surgery; vascular surgery; and heart, lung and transplant surgery. For cardiac surgery, the incremental cost-effectiveness ratio was under $15,000 per quality-adjusted life year, and was less than $50,000 for vascular surgery. Decolonization without prior screening of all patients in other clinical settings is a component of some MRSA control strategies (i.e. a horizontal infection prevention and control measure). In a large cluster-randomized trial conducted by Huang et al. in US intensive care units, the application of mupirocin to the nares in combination with daily CHG bathing of all patients (i.e. universal decolonization) reduced all BSIs, but not MRSA BSIs or MRSA rates overall. However, the emergence of mupirocin resistance was not investigated.

The widespread use of mupirocin can engender resistance, and mupirocin resistance has been reported in some studies of MRSA decolonization. In a Brazilian teaching hospital, Vivoni et al. showed that resistance peaked at 65% of MRSA isolates when patients were treated empirically, but resistance rates fell when mupirocin was restricted to MRSA-colonized patients alone. In a Swiss hospital, a hospital-wide policy to decolonize MRSA carriers with intranasal mupirocin application started in 1994. The proportion of MRSA blood culture isolates with mupirocin resistance, mostly level-resistance, increased from 0% in 1999 to 95% in 2005, and was 89% in 2008. The increased resistance levels correlated with mupirocin use during those periods. There is therefore a clear correlation between empirical mupirocin use and the emergence of mupirocin resistance amongst MSSA, MRSA and S. epidermidis. Finally, in a simulation based on real hospital data, Deeny et al. recently confirmed that a ‘screen and treat’ strategy maintains a low level of mupirocin resistance, whereas ‘universal mupirocin use’ leads to an increase in mupirocin resistance in 50–75% of simulations. Additional issues to consider are that universal decontamination in the absence of screening is likely to result in suboptimal data on resistance, the potential emergence of new but unrecognized clones, and, finally, the absence of the opportunity to adjust pre-operative antibiotic prophylaxis to cover for MRSA in patients who screen positive.

Conclusions

SSIs due to S. aureus are significant in terms of patient outcome, and consume precious healthcare resources. This is particularly true in orthopaedic and cardiothoracic surgery. The pre-operative identification of carriers of MSSA and MRSA, followed by decolonization before surgery, is associated with reduced SSI rates and cost savings. Recent studies confined to intensive care units have advocated universal decolonization, and have shown reductions in overall SSI rates and healthcare costs. While there may well be a case for such a horizontal infection prevention strategy in critically ill patients who may be colonized with multi-drug-resistant microbes, it should be considered with caution elsewhere because of the risk of the emergence of resistance. Screening and selective decolonization of patients positive for S. aureus have the benefits of preventing SSIs, helping to contain costs, monitoring changes in circulating isolates of MSSA and MRSA, and minimizing the emergence of resistance.

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References


96. Spagan M, Gulszynski D. Stop SSIs in their track. OR Nurse 2010;4:38–42.


