



What to do when experts disagree (or there is no evidence....)

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CASE

- 73 year old male admitted to CCU for heart failure for two weeks
- Transferred to medicine awaiting placement
- Foley catheter, uses bedpan
- Develops a fever and is worked up



Continued

- Urine culture grows *Klebsiella pneumoniae*, resistant to 3rd generation cephalosporins, reported as an ESBL
- How would you manage this patient from an infection control perspective?



Discussion points

- Would your opinion change if:
 - The patient was an outpatient in the ED?
 - If the isolate was carpenem resistant?
 - If the patient was on the transplant ward?
 - If the patient was confused and incontinent?
 - If you saw a second isolate in another patient
 - on the same ward?
 - In the same room?



Discussion

- When would you call public health?

Unpublished Survey

	Yes	No*	'Maybe so'
Admission Screen (Y/N)	10% universal	60%	30% Risk Factor
Roomate Contact Screening (y/n)	50%	50%	
Isolate Class A/C/Both	20% A/C	30%	50% Class A only

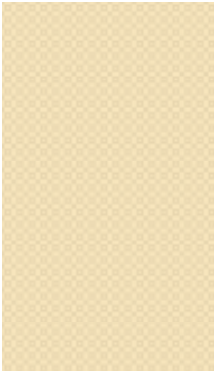
* with rare exception

Courtesy of K Katz

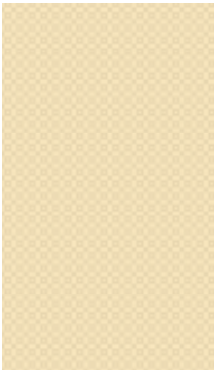
27. Screening Patients/Residents for ESBL-producing Bacteria

Local epidemiology should govern decision-making regarding routine screening of patients/residents for ESBL-producing bacteria. If the local incidence of ESBL-producing bacteria is high, there is some value to routinely screening patients, particularly those admitted to ICUs.^{143, 146, 147}

An effective and consistent approach to surveillance is an important measure to prevention and control the spread of ESBLs. In an ESBL outbreak, protocols should be in place for screening patients in close proximity to colonized/infected patients (e.g., roommates) who may have been exposed or who have risk factors for ESBL acquisition^{28, 145}. Surveillance for ESBLs should be part of quality indicator reporting.¹⁴⁵



**Guidance for Control of Infections
with Carbapenem-Resistant
or Carbapenemase-Producing
Enterobacteriaceae in Acute Care
Facilities**



CDC guidelines, MMWR, March 2009

Is There a Double Standard for Carbapenem Resistant Enterobacteriaceae vs ESBLs?

Surveillance

- All acute care facilities should review clinical culture results for the preceding 6–12 months to determine whether previously unrecognized CRE have been present in the facility.
 - If this review identifies previously unrecognized CRE, a point prevalence survey (a single round of active surveillance cultures) should be performed to look for CRE in high-risk units (e.g., intensive care units, units where previous cases have been identified, and units where many patients are exposed to broad-spectrum antimicrobials).
 - If this review does not identify previously unrecognized CRE, monitoring for clinical infections should be continued.
- If CRE or carbapenemase-producing *Klebsiella* spp. or *E. coli* are detected from one or more clinical cultures OR if the point prevalence survey reveals unrecognized colonization, the facility should investigate for possible transmission by:
 - Conducting active surveillance testing of patients with epidemiologic links to a patient with CRE infection (e.g., patients in the same unit or who have been cared for by the same health-care personnel).
 - Continue active surveillance periodically (e.g., weekly) until no new cases of colonization or infection suggesting cross-transmission are identified.