CAMRSA Clinical Policy

Attention: All Physicians and Healthcare Providers NEW CLINICAL POLICY

Effective: May 15th, 2005

Wound cultures required for abscesses that are incised and drained in the Emergency Department

Background:

Methicillin-resistant *Staphylococcus aureus* (MRSA) has recently been described in community-acquired infections (CA-MRSA). Studies indicate that this pathogen is actually a new strain of MRSA with different molecular features than the traditional healthcare-associated MRSA (HC-MRSA). It appears to be more virulent than the traditional organisms that cause these infections.

The incidence of such CA-MRSA infections is unknown but a recent study in an urban ED population showed a 39% incidence during the time period studied. Because this pathogen can be spread from person to person and is more virulent than other organisms causing soft tissue infections, it is prudent that we have an idea of the prevalence of this organism in our ED population to enable us to provide more effective treatment and to decrease the spread to healthcare workers and close contacts of the patient.

Procedure:

Culture all abscesses that are incised and drained in the adult, pediatric and minor trauma emergency departments and in Urgent Care. Use the green top culture tube. Order a culture of the material as "wound culture – *location*", indicating the appropriate body part or location on the order.

Treat all patients as you currently do, including the use of antibiotics and requirement for return visits. If the culture is positive for methicillin-resistant *Staphylococcus aureus*, the patient will be called and asked to return to the emergency department for re-examination if not improving since the last visit for that infection.

If the patient returns for further treatment, wound checks, or due to a call back, please look up the culture results on Webcis. Use the results as you normally would to help guide your antibiotic choice (*if indicated*) or to change the current antibiotic regimen (*as indicated*). Do not initiate antibiotics based on culture results alone. There should be a clinical indication to start antibiotics. The culture should only guide your choice of antibiotic. If it is sensitive to multiple agents, Bactrim should be your first-line choice. If there is a contraindication to Bactrim, start Clindamycin AND call the lab and ask them to run a "D test" on the Clindamycin to ensure there is not resistance. Fluoroquinolones *should not* be prescribed. Linezolid is an option, however, this should be prescribed *only* in consultation with an Infectious Disease specialist.