

Prevalence of colonisation with vancomycin-resistant enterococci (VRE) among haemodialysis outpatients in Victoria: implications for screening

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TO THE EDITOR: Patients with end-stage renal failure are a key risk group for colonisation and infection with vancomycin-resistant enterococcus (VRE). Consequently, many renal units in Australia screen these patients regularly for VRE colonisation, to assist with infection control and treatment.¹⁻³ Screening protocols are usually applied equally to inpatients and outpatients, even though the risk of VRE colonisation among outpatients (and therefore the cost-benefit of such screening) has not been clearly defined.

To assess the prevalence of faecal VRE colonisation among haemodialysis outpatients, we conducted a cross-sectional survey of outpatients attending 12 Victorian in-centre haemodialysis units — Austin Health (four units), Southern Health (three units) and five regional haemodialysis units (Bendigo, West Gippsland, La Trobe Valley, Central Gippsland and Bairnsdale). Patients attending these units represent about a third of the state's in-centre haemodialysis population. The study was approved by the ethics committee at each hospital, and written informed consent was obtained from all participants. All patients who attended the units between 1 October 2001 and 3 April 2002 were invited to participate.

VRE faecal carriage was assessed by three rectal swabs and one faecal specimen taken on at least three separate occasions. Specimens were inoculated onto Enterococcosel agar (BBL, Sparks, USA) containing 6 µg/mL vancomycin. All cultures were processed by standard methods for VRE identification, as described previously.^{2,3}

Of 345 available haemodialysis patients, 269 (78%) consented to participate in the study (205 [76%] metropolitan, and 64 [86%] regional; participation rate per centre, 70%–91%). The 269 patients repre-

sented approximately 30% of Victorian in-centre haemodialysis patients. Overall, 74% of participants had assessment of all three rectal swabs and a faecal specimen. VRE faecal colonisation was found in three of the 269 participants (1.1%) — two were from separate metropolitan hospitals, and one from a regional centre. All isolates were *Enterococcus faecium vanB* (the most common type of VRE in Australia).³ None of these three patients were known to be previously colonised.

This 1.1% prevalence was substantially lower than the 3.0%–4.6% prevalence previously described in renal inpatients in Melbourne,^{2,3} and the 10% rate reported in the United States (where 33% of dialysis centres have one or more VRE-positive patients).^{1,4} Statistical comparisons of this study with our previous two Australian studies^{2,3} should be undertaken cautiously, as screening methods differed in specimen frequency, type and number. Bearing in mind this caveat, the rate of faecal VRE carriage was significantly lower among the haemodialysis outpatients in our current study compared with renal inpatients in a 1997 study by Grayson et al² (3/269 v 9/194; $P=0.02$ by χ^2 test), but less definitely so when compared with renal inpatients in the 1998–1999 study of Padiglione et al³ (3/269 v 22/739; $P=0.09$, by χ^2 test). Since the outpatient study, screening surveys at our hospital have shown intermittent high rates of colonisation in renal inpatients and environmental contamination (unpublished data).

Given our findings in outpatients, we believe future VRE screening protocols in Australian hospitals should focus primarily on inpatients, rather than faecally continent outpatients, who have both a low rate of colonisation and low potential risk for VRE transmission or acquisition. Good compliance with practical infection control guidelines remains important to avoid widespread dissemination of VRE in our haemodialysis centres.⁵

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Effectiveness and side effects of thiazolidinediones for type 2 diabetes

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TO THE EDITOR: We read with interest the article by Hussein and colleagues on their experience with thiazolidinediones (TZDs).¹ These agents are only approved by the Pharmaceutical Benefits Scheme as part of dual therapy. We wish to present our experience of adding TZDs to metformin and sulfonylureas — hence, triple therapy — in patients with suboptimally controlled type 2 diabetes mellitus.

1 Characteristics of our 28 patients at baseline

Variable	Mean (range)
Age (years)	57.4 (31–74)
Weight (kg)	96.3 (56–137)
Body mass index (kg/m ²)	34.6 (24–50.3)
Duration of diabetes (years)	11 years (1–48)
Glycohaemoglobin (HbA _{1c}) level (%)	9.0 (7.1–10.4)

2 Changes in glycohaemoglobin (HbA_{1c}) level and weight compared with baseline values

