

Potential conflicts of interest. H.H. reports that he has received research support from Steris, Pfizer (Ireland), and Cepheid and has received lecture and other fees from Novartis, AstraZeneca, Astellas, and Pall Medical. All other authors report no conflicts of interest relevant to this article.

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Infect Control Hosp Epidemiol 2015;36(7):856–857

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Reply to O’Riordan et al

To the Editor—We appreciate the letter from O’Riordan et al¹ in response to our article on the cost benefit of methicillin-resistant *Staphylococcus aureus* (MRSA) screening followed by contact precautions in the hospital setting.² We agree that MRSA screening can have an important role as part of infection and control measures. We would like to take the opportunity to highlight 2 important considerations related to cost and benefits of MRSA screening: (1) who is paying for the intervention and who realizes the benefit—that is, the economic perspective, and (2) what we are doing with the MRSA screening data, and particularly what is the resultant intervention efficacy.

Our analysis demonstrated that universal MRSA screening followed by contact precautions would reduce hospital-associated MRSA infections but would result in costs to a hospital. Our findings of increased costs to the hospital remained robust, regardless of number of body sites tested or MRSA identification method. These results are consistent with the literature, including the excellent references presented by O’Riordan et al,¹ and support the notion that hospital-wide, universal surveillance followed by contact precautions would incur significant costs to a single hospital.

Interestingly, if we look at how universal MRSA screening followed by contact precautions impacts the healthcare system as a whole, the program could result in cost savings.^{3,4} The fundamental dilemma is that the costs of hospital-based screening and isolation are borne by the individual hospital performing the screening, but the individual benefits of screening may be reaped only later or by external beneficiaries (eg, other hospitals or non-hospital-based care entities). We suggest that the payment and incentive structure in the US system should be changed to support the expenditures necessary for infection prevention programs to realize both local and regional benefit.

Another key finding from our study was that our results were sensitive to the efficacy of the MRSA intervention. Our intervention efficacy estimates were based on the assumption that MRSA screening results were used to apply contact precautions after a positive test result. We did not model a strategy of preemptive isolation or MRSA decolonization programs.⁵ Using a more efficacious intervention would have resulted in our model having lower costs for hospitals and potentially cost saving for the hospital.

We would like to highlight a recent analysis of the Randomized Evaluation of Decolonization versus Universal Clearance to Eliminate (REDUCE) MRSA trial that confirmed that a strategy

of using MRSA screening results for targeted decolonization resulted in lower costs compared with screening followed by contact precautions.⁶ Perhaps most interestingly, the same analysis demonstrated that a strategy of universal decolonization without MRSA screening had the lowest intervention costs and best efficacy.⁶ The results suggest that MRSA screening may not be required in an intensive care unit setting with universal chlorhexidine bathing. Although the REDUCE MRSA trial is based on intensive care unit costs and benefits, ongoing work is being conducted to explore the impact of decolonization and need for MRSA screening in the broader hospital setting.

Overall, we agree with O’Riordan and colleagues¹ in their assessment of the literature to support “generally advocating” for MRSA screening as it relates to “infection and control measures.” In particular, understanding the changing epidemiology of MRSA is not fully possible without screening. Depending on the context, available resources, and comparison group, the available data support a benefit to the overall healthcare system for MRSA screening followed by contact precautions. Nevertheless, additional work is needed to understand the role of MRSA screening in the context of additional “infection and control measures,” particularly in the context of universal decolonization where screening may not be required.

ACKNOWLEDGMENTS

Financial support. None reported.

Potential conflicts of interest. J.A.M. reports that he received support from the National Institutes of Health/National Center for Research Resources / National Center for Advancing Translational Sciences University of California, Los Angeles CTSI (grant KL2TR000122). J.A.M., S.M.B., B.Y.L., S.S.H., and L.G.M. report that they received support from the Agency for Healthcare Research and Quality (grant RC4AI092327). S.M.B. and B.Y.L. received support from the Agency for Healthcare Research and Quality (grant R01HS023317). S.S.H. reports that she is conducting a clinical trial for which participating hospitals receive contributed product from Sage Products and Molnlycke.

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Infect Control Hosp Epidemiol 2015;36(7):857–858

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An Adult Returned Traveler from Dubai Hospitalized with an Influenza-Like Illness (ILI): Middle East Respiratory Syndrome (MERS) or Influenza? Infection Control Implications from a Near MERS Case

To the Editor—Middle East respiratory syndrome (MERS) is a zoonotic pneumonia caused by coronavirus (MERS-CoV) that emerged from the Middle East. MERS presents as an influenza-like illness (ILI) that is difficult clinically to differentiate from influenza (Table 1).¹ When a woman, recently returned from Dubai, was admitted with an ILI, we still had concerns of possible Ebola in returning travelers and we were in the midst of an influenza A (H₃N₂) epidemic. This potential case of MERS vs influenza emphasized the importance of appropriate infection control (IC) precautions.²

Some 10 days after returning from Dubai, a 41-year-old woman became ill. It was not known whether she had transited West Africa. She visited a practitioner complaining of chills, myalgias, sore throat, dry cough, and nausea/vomiting. The practitioner informed the local Department of Health (DOH) that she could be a MERS case, and DOH suggested evaluation at our hospital. She was admitted to the Emergency Department as a potential MERS case and was placed on airborne and contact precautions; then she was transferred to the Infectious