

Editorial comments on JACM, Vol 16, No. 2, July-Dec 2014

Going through the 16th volume of JACM, I could find some important original articles, which need some comments.

The enteropathogenic *Yersinia* have been relatively recently recognised as a cause of disease and the understanding of their pathogenesis and epidemiology is evolving. Major clinical syndromes associated with these organisms are enterocolitis, mesenteric adenitis, terminal ileitis, septicaemia, and various immune reactive conditions, especially reactive arthritis. Different disease expressions predominate in different age groups. Even though the organism is widely distributed and isolated from multiple environmental sources it is described as an infrequent cause of diarrhoea. Hence, it is not routinely processed when a stool culture is performed for acute or chronic diarrhoea. Overuse of antibiotics and an increasing number of immunosuppressed patients has led to many commensals being detected as pathogens and awareness should be created among treating physicians. Even though, the rate of isolation was low, the study was highlighting the significance of searching for this pathogen, especially when an epidemic occurs.

Resistance to carbapenems is a matter of great concern now. Carbapenem resistance results from reduced level of drug accumulation, increased expression of pump efflux or production of plasmid-mediated or chromosomally mediated metallo beta-lactamases (MBL). Since these genes are associated with mobile genetic elements there can be a rapid dissemination in the clinical setting. Therefore, detection and surveillance of MBL producers have become a matter of major importance both for selection of appropriate therapeutic schemes and implementation of infection control measures. Modulation of the factors that enhance the spread of MBL producing enterobacteriaceae in community is difficult as these factors are multiple

and associated with lack of hygiene, overuse and over the counter use of anti bacterial drugs and increased worldwide travel. The actual prevalence in India is not known, but estimated to be very high. The study on MBL producing Enterobacteriaceae has estimated the prevalence in that setting and such studies from different states of India are welcome.

Staphylococcus aureus continues to be the most common pathogen in bone and joint infections, followed by gram-negative bacilli. A good number of methicillin-resistant *Staphylococcus aureus* (MRSA) is associated with bone and joint infections. It is very important to recognize that because infection control measures including systematic screening of patients before surgery reduce the MRSA infection rate by 50%. Screening patients as part of an infection control programme is an effective measure to contain the spread of multi-drug resistant organisms.

In health care settings MRSA infections are associated with greater length of stay, higher mortality and increased cost. Most MRSA infections are nosocomial in origin and manifest themselves as complications of health care procedures or complicate underlying disorder. Hence, MRSA decolonization is recommended when appropriate only (high-risk patients, special care units, MRSA outbreaks etc.). The practice of decolonisation of all staphylococcal carriers is to be discouraged.

The review article gives a very informative insight to clinicians like me regarding histoplasmosis as an emerging problem. As such all the case reports are also keeping up a good standard and highlight rare problems.

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