Letters and comments

Contributors to this section are asked to make their comments brief and to the point. Letters should comply with the instructions to authors at <http://www.rcseng.ac.uk/publications/annals/authorinstructions.html>. Tables and figures should only be included if absolutely essential and no more than five references should be given. The Editor reserves the right to shorten letters and subedit contributions to ensure clarity.

COMMENTS ON

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M Spiegelman. MRSA – Why treat the symptoms and not the disease? *Ann R Coll Surg Engl* 2005; **87**: 452–3

COMMENT 1

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Friendly bacteria for MRSA prevention? An oral and maxillofacial perspective

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Basic principles state that antiseptics, skin preparation and exemplary scrubbing technique are paramount to the prevention of infection. This does not prevent MRSA wound infections. It is time to look for 'novel' methods of preventing postoperative wound infection. Inappropriate antibiotic use selects antibiotic-resistant strains.

Many epithelial surfaces are colonised with bacteria, while deeper tissues of the body are sterile. Skin inoculation with commensals has little effect compared with inoculation into deep tissues where infection ensues. Antibiotic prophylaxis is not required for 'clean' skin wounds or 'dirty' intra-oral procedures not involving bone removal. They are necessary for deeper surgical wounds. Bacteria enter wounds during surgery, or migrate through the wound afterwards. Skin preparation alters the skin flora, possibly preventing competitive inhibition of opportunistic pathogens.

Intra-oral operations are generally performed without preparing the mouth. The rate of postoperative infection is exceptionally low. Therefore, would skin wound infection rates decrease if skin flora were left intact?

Sterile tissues should remain sterile, but should the skin remain colonised? Would re-colonising skin with commensal bacteria after skin preparation and surgery prevent the growth of pathogens? Oral and maxillofacial surgeons and dentists have, in effect, been doing this for years, by not altering the normal flora of the oral epithelium.

COMMENT 2

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Resistance and the frequent exposure to antibiotics

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I think the author has missed the point about MRSA and has failed to see the bigger picture and think outside the box. The real cause of resistance is a frequent exposure to antibiotics. This, however, does not occur in hospital. Ask 10 random hospital doctors, of any grade, to list names of antibiotics and most will struggle after naming about seven. Ask them how many they have prescribed in the last 12 months and the list shrinks to 4 or 5. Outside of intensive care, exposure to exotic antibiotics by patients in hospitals is unusual. The exposure takes place elsewhere.

As a house officer in medicine in 1998, I recall that to prescribe Ciprofloxacin required a consultant's signature. In the same year, I read reports of Ciprofloxacin being blanket fed to broiler chickens to prevent salmonella infections. Anyone eating these chickens had exposure to these antibiotics. There are other similar examples relating to mastitis in dairy cows.

In addition, in the last decade, awareness of the growth-promoting effect of antibiotics in well animals has further increased the wide-spread use of antibiotics in farm animals. In North America and Europe an estimated 50% in tonnage of all antimicrobial production is used in food-producing animals and poultry flocks.¹ Such wide-spread use of