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

doi 10.1308/003588405X60650

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

antimicrobials for disease control and growth promotion in animals has been paralleled by an increase in resistance in those bacteria (that can spread from animals, often through food, to cause infections in humans).² There is concern that vancomycin resistant enterococci (VRE) may transfer resistance to *Staphylococcus aureus*.³

A European Union blanket ban on the use of antibiotics is not due to start until 2006, which is some 9 years after the issue was highlighted by the World Health Organization in 1997. Sweden banned growth promoters in 1987 and Denmark in 1998.⁴ Evidence from Germany confirms that withdrawal of avoparcin as a growth promoter reduced the incidence of VRE in healthy humans (carriers) by 50% within 5 years.⁵ Despite all the evidence, a search on the <bbc.co.uk> website reveals no articles on the subject in the first 4 years of this century. Why is there a silence of the real problem behind the MRSA story? Money!

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COMMENT ON

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Weale AR, Edwards AG, Lear PA, Morgan JDT. From meeting presentation to peer-review publication – a UK review. *Ann R Coll Surg Engl* 2006; **88**: 52–6

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Presentation to peer-review publication

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The Vascular Society of Great Britain and Ireland (VSGBI) achieved the highest conversion of presentation to publication (53.6%) on review of four surgical meetings.¹ We assessed the VSGBI conversion rate and calculated a conversion rate of 59.4% over 2 years, confirming this as a high quality meeting. A meta-analysis across different specialties and regions demonstrated a conversion rate of 51%.²

There are numerous limitations in the methods used by Weale *et al.*¹ To gain the most accurate results from an electronic database search, the investigator must have a detailed knowledge of the structure of the database and how it is indexed.³ Second, studies comparing electronic search methods with direct author contact revealed the electronic search underestimates conversion rate by 15.5%.³ Third, only 88% of manuscripts arising from meetings are published within 3 years;^{2,4} the search in the above article was performed at 28 months.¹ Finally, numerous inconsistencies exist between abstracts and subsequent publications, including changes in title and authorship,⁵ the basis of their search.¹

Weale and colleagues did not examine the type of study that led to publication.¹ We found 20.6% of publications were prospective observational studies, and 74.6% arose from centres with university affiliations, findings corroborated by other studies.^{3,5}

Although the methods are limited, we agree that the VSGBI meetings are of high quality.

Acknowledgements

Our data quoted in this letter have also been submitted as a manuscript to the *Annals of the Royal College of Surgeons of England* to be considered for full-text publication.

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