β -lactamases and now also are able to inactivate third-generation, as well as second-generation, cephalosporins. Such resistance may now be spread by plasmid transfer to community-acquired organisms such as *Salmonella*.

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TOPIC: VANCOMYCIN-RESISTANT ENTEROCOCCI

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The increasing incidence of vancomycin-resistant *Enterococcus faecium* (VRE) in New York City has been described in several studies, beginning in 1989, when the New York City Department of Health documented 360 patients with VRE from almost 47% of the city's hospitals.¹ A second survey, published by the New York City Department of Health in 1993, indicated that cases of VRE had occurred in all but two small surgical hospitals in the city.²

The incidence of VRE in New York State, while lagging behind New York City, has increased in a similar fashion: more than 50% of counties have documented cases in the past three years (D. M. Ackman, personal communication). Preliminary analysis of data collected by the Centers for Disease Control and Prevention regarding the incidence of VRE in the US indicate that New York City, similar to its role in the epidemics of HIV and multidrug-resistant tuberculosis, remains the country's epicenter of VRE infection. In the US, the majority of VRE cases have been seen in tertiary care hospitals, predominantly in intensive care units.³

International studies regarding VRE have accompanied a concern that associated infections may not remain a nosocomial phenomenon. Reports from Great Britain indicate that 2% of patients in general practices that have not utilized antibiotics and that have not been admitted to a hospital are carriers of VRE.⁴ In addition, VRE has been isolated in human waste sewage from treatment plants in five major cities in both the United Kingdom and Europe.^{5,6} The VRE organisms also have been isolated in Europe from fecal samples from farm animals, mostly pigs and poultry.⁷

Suggestions for infection control policies to decrease the incidence of VRE were published in the February 1995 edition of *Infection Control and Hospital*

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Epidemiology. These policies included classic infection control strategies, such as hand washing and isolation, and included attempts to restrict the use of vancomycin. Several questions regarding infection control strategies remain, including (1) What are the most effective means of altering behavior surrounding hand washing or antibiotic prescription practices? (2) What disinfectants are most effective against this organism? (3) What effect does the use of lotions after hand washing have on the growth and transference of VRE?

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