Hi. I am a helpful assistant. I need your help with this text. Please read and summarize the document for me. If you need any clarification, please let me know. Please confirm if you need any further assistance. Thank you.
Proportions of MRSA in some re-
gions are far higher than were seen in Minnesota or Oregon at any time. For example, at Texas Children’s Hos-
pital in Houston 74%, of community-
associated staph infections are now MRSA. In Oregon, CA-MRSA was anecdotally reported in the late 1990s, but appears to have become widespread only recently.

THE OREGON SITUATION

To clarify the regional situation and to contribute to a national effort we as part of our Emerging Infections Pro-
gram began population- and laboratory-
based surveillance for invasive MRSA (sterile-site cultures only—e.g., blood, joint fluid) in the Portland metropolitan tri-county area in January 2004. In just the first 9 months labs reported 293 confirmed cases, of which 61 (21%) met the CA-MRSA definition (no ERs). These isolates represent only the tip of the CA-MRSA iceberg since most disease is non-invasive; our preliminary estimate of the rate of invasive CA-
MRSA is 5 cases/100,000/year.

Analysis of these fledgling data shows that the invasive CA-MRSA cases were relatively young and more likely to be smokers or injection drug users compared with HA-MRSA cases, who more often suffered from diabetes, cardiac disease, or AIDS. As expected, the percentage of isolates susceptible to clindamycin was much higher for CA-
MRSA than for HA-MRSA (50% vs. 15%).

Review of laboratory antibiotic resistance reports supports the rise of MRSA noted in the 1990s, a conven-
tion sample of 18 Oregon microbiol-
ogy laboratories from around the state showed that 11.5% of all S. aureus isolates tested (N=7,572) were MRSA. by 2003, a sample of 20 laboratories suggested that the proportion was three times as high (44%) (NCN 20,729), as depicted in the figure. Although the Portland metropolitan area had the highest rate (44%), there was significant variation among regions in Oregon.

The incarcerated are known to be at risk for CA-MRSA and Oregon has the highest incarceration rate of any state in the US with 8.5% of the population estimated 75% of staph isolated from Multnomah County inmates in 2004 were MRSA.

Diagnosis of MRSA

Optimal treatment of invasive staphy-
lococcal infections requires culture of blood or potentially infected body fluids followed by antibiotic sensitivity testing. With less serious skin infec-
tions, culture of spontaneous or inci-
sion-induced drainage is encouraged to help customize therapy. In certain popu-
lations, such as the incarcerated, CA-
MRSA is so common that culture is not always done. Pay careful attention to susceptibility testing results—particularly if the combination of clindamycin susceptibility and erythromycin resist-
ance is reported; this may indicate inducible resistance, and the lab must do the so-called ‘D-test’ to ensure clindamycin susceptibility. Another advantage of culture is detection of other pathogens, particularly S. pyo-
gen, (a.k.a. group A Streptococcus), which can mimic S. aureus disease but which must be used for treatment of CA-
MRSA, particularly TMP-S and tetracyclines.

Treatment Options for CA-
MRSA

Without any clinical trials, no evidence-
based recommendations can be made for treatment of CA-MRSA. Patients with suspected invasive staphylococcal infec-
tions requiring hospitalization now often receive empiric vancomycin, as methicillin-susceptible bacteria are isolat-
ed, then β-lactams are preferred. Should empiric outpatient treatment for skin and soft-tissue infection be directed at MRSA? The answer depends on local microbiology results and clinical experi-
ence, but many Oregon clinicians believe that MRSA is a commonly encountered pathogen. The list below has outpatient treatment recom-
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