MRSA INFECTION ARTICLE

Recently, correctional staff from several facilities have voiced their concern about MRSA infections involving incarcerated inmates, generating a number of questions. I have attempted to address the most common questions here. Greater understanding and knowledge about this type of infection will hopefully result in less anxiety amongst our staff and fewer cases in the inmate population.

What is MRSA?

MRSA (short for Methicillin Resistant Staphylococcus aureus) refers to a Staph bacteria that has acquired resistance to certain antibiotics. This resistance means that some antibiotics normally used to treat Staph bacteria in the past will not be effective. There are common oral antibiotics, however, that can effectively treat MRSA. In general, Staph bacteria infections have always been rather common in the incarcerated population, but this type of antibiotic resistance is a fairly new development.

How does a MRSA infection present?

Most MRSA infections in the community and in a jail/prison setting present as skin or soft tissue infections, especially "boils" or abscesses. Early on, it may have the appearance of a spider bite. Later, the infected area is red, swollen, and painful and there may be pus or other drainage. Serious MRSA infections, the kind that has attracted the attention of the media, occur in already compromised, sick patients. Because of this, MRSA is a more serious problem in a hospital setting as opposed to a community, including places such as military housing, college dorms, or prisons. In DOC, MRSA-infected patients are usually first seen in a jail setting at or shortly after intake. In other words, most of our new MRSA cases originate from the community. Not surprisingly, MRSA has been an occasional problem affecting inmates in the infirmary setting as well.

Does everyone who has MRSA on or in their body have active infection?

No. Some people carry MRSA in their nose or throat (nasopharyngeal carriage) but, in this area, infection is uncommon. These persons are called asymptomatic carriers and they are "colonized" with MRSA. While they do not have an active infection, they can spread the bacteria to others or even to themselves, e.g. skin follicles of the leg. This is the reason why MRSA infections can be recurrent in some individuals and how infection can spread to others from an unknown source.

Has MRSA infection become more common in the inmate population over the past few years?

Yes. In fact, MRSA infection was considered unusual a number of years ago even in hospitals. Now, MRSA infections have become much more common in the community, including DOC, and especially in hospitals and health-care facilities. Facilities where large groups of people live and recreate together, such as college dorms, day-care centers, military barracks, prisons, and schools are all areas where MRSA infection has become much more common.

Has MRSA been a problem for correctional employees over the past few years?

Not so far. Although I have seen an increasing number of MRSA infections over the past few years, I am not aware of any outbreaks involving correctional officers. The spread of MRSA is most likely to occur between individuals that have frequent, close contact. Inmates that live together, work together, and play sports together have the type of contact that can spread MRSA. Correctional officers do not have this type of contact unless they are responding to inmate altercations, cell extractions, or other activity that carries the risk of close, personal contact.

How can correctional staff protect themselves against MRSA infection?

By far, the most important measures are good handwashing practices and the wearing of gloves when inmate contact is anticipated. These basic measures will effectively stop MRSA spread as well as other potential pathogens such as HIV and viral hepatitis.

In addition, the DOC Medical Units have been instructed to call me if MRSA has been confirmed in any inmate. I will then review several issues regarding these cases personally, including antibiotic administration, wound care, and temporary housing changes if appropriate.

I welcome any questions from DOC staff concerning this issue, now and in the future.