Published on *American Council on Science and Health* (https://www.acsh.org)

More on the antibiotic crisis: Could our government possibly screw up worse than this?

By ACSH Staff — November 14, 2013

[1]We at ACSH have warned repeatedly about the nightmarish scenario that continues to unfold as more and more bacteria become resistant to previously-effective antibiotics, bringing us to the precipice of the pre-penicillin era where common infections such as strep throat and pneumonia were killers.

Our Dr. Josh Bloom whose recent commentaries on this topic were published in The New York Post [2]and The Wall Street Journal [3] has maintained that much of the blame for this can be laid at the feet of the FDA, which effectively derailed antibiotic R&D in the 1990s by instituting unrealistic and unnecessary policies for the development of antimicrobial drugs.

But, according to Kevin T. Kavanagh and colleagues, writing in the October 10th issue of Antimicrobial Agents and Chemotherapy [4], the FDA had plenty of help from the Centers for Disease Control and Prevention (CDC) in making the colossal mess in which we now find ourselves. And much of this mess was (and is) preventable.

Their commentary entitled A Perspective on How the United States Fell behind Northern Europe in the Battle against Methicillin-Resistant Staphylococcus aureus, points out the huge disparity in MRSA infection rates in hospitals between the two regions 5 percent for Northern Europe vs. 50(!) percent for the U.S. How is this possible?

Dr. Bloom has his opinion Sheer ineptitude, with a side order of laziness.

The main thrust of the Kavanagh piece is that much can be done to control the spread of MRSA, which is, of course far better than treating it.

The authors note, It has been just over 10 years since the 2003 [Society for Healthcare Epidemiology of America-Healthcare Infection Control Practices Advisory Committee] of the [CDC] report recommended surveillance as an integral part of efforts to control the looming methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant Enterococcus epidemic. Health care policy in the United States underwent an abrupt change, deviating from Northern Europe and no longer considering ADI (active detection (surveillance) and isolation essential for

controlling the epidemic of [multiple drug resistant organisms].

In other words, we stopped screening and isolating MRSA infected patients and are now paying the price.

ACSH advisor, Dr. David Shlaes comments, The debate surrounding the US practices regarding MRSA in hospitals has always been the active detection (screening by culture on admission), and isolation vs simple surveillance. Countries in Northern Europe have practiced the former for years and their MRSA rates have been 5% or less of all Staph aureus isolates compared to the US where we have relied only on overall surveillance and encouragement of handwashing (compliance rates generally low). Our MRSA rates are 30-65%. While it remains controversial as to whether this particular approach is responsible for the low rates in Northern Europe and our more relaxed approach resulted in the higher rates here, it is clear that it was easier and cheaper to ignore the European approach. Sometimes you get what you pay for.

We encourage you to read the Kavanagh paper. It will make your blood boil.
