Infections in the Compromised Host
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Disclosures

► Consultant
  ► Shionogi
  ► MicroGenDx

► Many slides courtesy of Dr. David van Duin
Overview

- The immunocompromised host
- Testing in the immunocompromised host
- HIV/AIDS
- Autoimmune diseases/biologics
- Solid organ transplant
- Stem cell transplant
- Neutropenia
- Burn

General approach to ID

- Clinical history and physical exam
  - Be thorough
  - Get outside data

- Host
  - Is their immune system normal?
  - What parts of their immune system are abnormal?

- Environment
  - Travel/military service, employment, sick contacts, animal exposures, sexual contacts, hobbies
Who is the host?

- What parts of there immune system are abnormal?
  - Genetic mutations
  - Comorbidities
  - Immunomodulators, chemotherapy, induction agents
  - Recent treatment for rejection/GVDH/disease flare
  - Prophylactic antimicrobials

Immunocompromising states

- Congenital/acquired immunodeficiency syndromes (CGD, HIV)
- Diabetes
- End-stage liver and kidney disease
- Autoimmune/rheumatologic diseases
- Solid organ transplantation
- Stem cell transplantation
- Malignancy, chemo, neutropenia
- Burns
Net state of immunosuppression

- Type, dose, and timing of immunosuppressive agents administered
- Nutritional, metabolic factors; renal dysfunction; age; comorbidities
- Breach of mucosal barriers (skin, gut); foreign bodies
- Neutropenia
- Lymphopenia
- Hypogammaglobulinemia

Making a diagnosis in immunocompromised hosts

- Clinical presentation
  - May be atypical
  - Fever or pain may be mild or absent
  - Lab changes may be subtle (ie, UA with few WBC in neutropenia)

- Imaging
  - Higher resolution imaging may be needed to detect subtle infection, particularly in the chest and sinuses
Making a diagnosis in immunocompromised hosts

- Serological tests may be unreliable
  - Antibody tests are less reliable after transplant or transfusions
  - Cross-reactivity, false-positives

- Biochemical/immunodiagnostic antigen tests
  - Not always sensitive enough (ie urine Legionella Ag)
  - Not always specific enough, cross-reactivity (ie urine Histoplasma Ag)

Making a diagnosis in immunocompromised hosts

- Molecular testing (NAA, NAT, NAAT, PCR)
  - Detects genetic material (DNA or RNA)
  - Blood, CSF, respiratory fluids, tissue biopsy, stool, urine
  - Can be quantitative (QNAT) for blood
  - Can be overly sensitive: does not always correlate with disease
  - Does not differentiate between live & dead organisms

- Histology & immunohistochemistry
  - More specific (preferred) for diagnosing tissue-invasive disease
  - “the gold standard” but not always realistic
Clinical pearls

- Reactivation of prior infection suggests a high net state of immunosuppression
  - #1 Reduce immunosuppression if possible
- Don’t get the disease: When in doubt isolate
  - Infection Control Isolation Policies
  - Handwashing may be better for non-enveloped viruses (esp. enteric viruses) and spores (Clostridium)

Preventing reactivation of latent infections

- Who to screen
  - HIV
  - Cancer chemotherapy
  - Organ transplant
  - Screening protocols may differ among above groups
- Why screen
  - Early identification and treatment
  - Provide therapy to suppress infection
Preventing reactivation of latent infections

Viral
- Cytomegalovirus (CMV)
- Epstein-Barr (EBV)
- Hepatitis (HBV, HCV)
- Herpes simplex (HSV I & II)
- HIV
- Varicella-zoster (VZV)
- BK virus (GU disease)

Bacterial
- Syphilis
- Tuberculosis

Parasitic
- *Toxoplasma gondii*
- *Strongyloides*

HIV opportunistic infections

<table>
<thead>
<tr>
<th>CD4 count</th>
<th>Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any</td>
<td>Kaposis sarcoma, pulmonary TB, VZV, bacterial pneumonia, lymphoma</td>
</tr>
<tr>
<td>&lt;250</td>
<td>PJP, esophageal candidiasis, PML, HSV</td>
</tr>
<tr>
<td>&lt;100</td>
<td>Cerebral toxoplasmosis, HIV encephalopathy, Cryptococcus, military TB</td>
</tr>
<tr>
<td>&lt;50</td>
<td>CMV retinitis, atypical mycobacteriosis</td>
</tr>
</tbody>
</table>
Biologics

Figure 1
New chemical entities and biologics approved by the FDA in the last two decades

G. de la Torre B, Albericio F. *Molecules* 2019, 24, 809.

NME = new molecular entity

# Biologics for inflammatory arthritis

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Brand name</th>
<th>Biosimilar brand name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour necrosis factor inhibitors (TNF-inhibitors)</td>
<td>Golimumab, Certolizumab, Etanercept, Adalimumab, Infliximab</td>
<td>Simponi, Cimzia, Enbrel, Humira, Remicade</td>
<td>Brenzys, Flixi, Emisima, Inflectra, Jaximab, Rensima, Reflexis</td>
</tr>
<tr>
<td>Interleukin-6 inhibitor</td>
<td>Tocilizumab</td>
<td>Actemra</td>
<td></td>
</tr>
<tr>
<td>Interleukin-1 inhibitor</td>
<td>Anakinra</td>
<td>Kineret</td>
<td></td>
</tr>
<tr>
<td>Targeting B-lymphocytes (B-cells)</td>
<td>Rituximab</td>
<td>Mabthera</td>
<td>B-cells (a type of white blood cell)</td>
</tr>
<tr>
<td>Targeting T-lymphocytes (T-cells)</td>
<td>Abatacept</td>
<td>Ocrevus</td>
<td>T-cells (a type of white blood cell)</td>
</tr>
</tbody>
</table>


# Biologics in SLE

https://doi.org/10.1155/2019/8142368
# Biologics for IBD

<table>
<thead>
<tr>
<th>Drug class</th>
<th>Ulcerative colitis</th>
<th>Crohn’s disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anti-TNF alpha</td>
<td>Infliximab (iv) Adalimumab (sc)</td>
<td>Infliximab (iv) Adalimumab (sc)</td>
</tr>
<tr>
<td>Anti-integrin</td>
<td>Vedolizumab (iv)</td>
<td>Vedolizumab (iv)</td>
</tr>
<tr>
<td>Anti-IL-12 and IL-23</td>
<td>Ustekinumab (iv and sc)</td>
<td></td>
</tr>
</tbody>
</table>

http://journalsblog.gastro.org
Solid organ transplant

2018: More transplants than ever

There were more than 10,700 deceased donors in 2018.
8th consecutive record breaking year.

Nearly 6,900 living donor transplants in 2018.
Highest total since 2005.

*Based on OPTN data as of Jan. 8, 2019. Data subject to change based on future data submission or correction.

Solid organ transplant

The Balance in Immunosuppression

CNI Toxicity
Infection

Rejection

UC Irvine Health
alemtuzumab

- Popular at UNC
- Anti-CD52
- Profound and sustained T-, B- and NK cell depletion
- Use in induction and/or rejection treatment

Peleg et al. CID 2007;44:204
Increased OI risk when alemtuzumab used for rejection

Table 3. Characteristics of organ transplant recipients who received alemtuzumab, according to the development of an opportunistic infection (OI).

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Recipients with an OI after receiving alemtuzumab (n = 56)</th>
<th>Recipients without an OI after receiving alemtuzumab (n = 491)</th>
<th>OR (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, median (range)</td>
<td>51 (16–77)</td>
<td>51 (16–82)</td>
<td>...</td>
<td>.81</td>
</tr>
<tr>
<td>Sex, female</td>
<td>28 (50)</td>
<td>196 (40)</td>
<td>1.5 (0.9–2.6)</td>
<td>.14</td>
</tr>
<tr>
<td>Transplant received</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney</td>
<td>16 (29)</td>
<td>235 (48)</td>
<td>0.4 (0.2–0.8)</td>
<td>.007</td>
</tr>
<tr>
<td>Liver</td>
<td>8 (14)</td>
<td>152 (31)</td>
<td>0.4 (0.2–0.8)</td>
<td>.01</td>
</tr>
<tr>
<td>Lung or heart/lung</td>
<td>12 (21)</td>
<td>44 (9)</td>
<td>2.8 (1.4–5.6)</td>
<td>.005</td>
</tr>
<tr>
<td>Pancreas or kidney/pancreas</td>
<td>6 (11)</td>
<td>44 (9)</td>
<td>1.2 (0.5–3.0)</td>
<td>.67</td>
</tr>
<tr>
<td>Intestinal or multivisceral</td>
<td>14 (25)</td>
<td>16 (3)</td>
<td>9.9 (4.5–21.7)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Previous transplant received</td>
<td>8 (14)</td>
<td>72 (15)</td>
<td>6.9 (4.0–2.1)</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Recipients with an OI after receiving alemtuzumab (n = 56)</th>
<th>Recipients without an OI after receiving alemtuzumab (n = 491)</th>
<th>OR (95% CI)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alemtuzumab received</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For induction therapy</td>
<td>16 (29)</td>
<td>238 (49)</td>
<td>0.2 (0.1–0.3)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>For rejection therapy</td>
<td>40 (71)</td>
<td>153 (31)</td>
<td>5.5 (3.0–10.0)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Doses of alemtuzumab received, no. (range)</td>
<td>2 (1–6)</td>
<td>1 (1–6)</td>
<td>2.3 (1.7–3.1)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Received pulse methylprednisolone</td>
<td>15 (27)</td>
<td>152 (31)</td>
<td>0.8 (0.4–1.5)</td>
<td>.5</td>
</tr>
<tr>
<td>Received ≥2 pulses of methylprednisolone</td>
<td>10 (18)</td>
<td>49 (10)</td>
<td>2.0 (0.9–4.1)</td>
<td>.08</td>
</tr>
<tr>
<td>Received another lymphocyte-depleting antibody</td>
<td>28 (60)</td>
<td>117 (24)</td>
<td>3.2 (1.8–5.6)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Timeline of infectious risk (SOT)

Common Infections in Solid-Organ Transplant Recipients

-1 Month
- Infection with antimicrobial-resistant species:
  - MRSA
  - VRE
  - Candida species (non-albicans)
  - Aspiration
  - Catheter infection
  - Wound infection
  - Anastomotic leaks and ischemia
  - Clostridium difficile colitis
  - Donor-derived infection (uncommon):
    - HSV, LCMV, rabies virus (rabies), West Nile virus, HIV, Trypanosoma cruzi
  - Recipient-derived infection (colonization):
    - Aspergillus, pseudomonas

1-6 Months
- With PCP and antiviral (CMV, HBV) prophylaxis:
  - Polymavirus BK infection, nephropathy
  - C. difficile colitis
  - HCV infection
  - Adenovirus infection, influenza
  - Cryptococcus neoformans infection
  - Mycobacterium tuberculosis infection
  - Anastomotic complications
- Without prophylaxis:
  - Pneumocystis
  - Infection with herpesviruses (HSV, VZV, CMV, EBV)
  - HBV infection
  - Infection with listeria, nocardia, toxoplasma, strongyloides, leishmania, T. cruzi

>6 Months
- Community-acquired pneumonia, urinary tract infection
- Infection with aspergillus, atypical molds, mucor species
- Infection with nocardia, rhodococcus species
- Late viral infections:
  - CMV infection (colitis and retinitis)
  - Hepatitis (HBV, HCV)
  - HSV encephalitis
- Community-acquired (SARS, West Nile virus infection)
- JC polymavirus infection (PML)
- Skin cancer, lymphoma (PMLD)
Viral infections after SOT

- Exposures
  - Donor-derived
  - Recipient-derived
  - Nosocomial
  - Community

- "net state of immunosuppression"

Fishman. NEJM 2007;357:2601
Donor-derived infections

- Positive RPR/syphilis, *Streptococcus pneumoniae* bacteremia/meningitis

- Always think donor-derived infection for fever 1-3 months after transplant with no clear source
  - Was there anything unusual about the donor?
  - Who gave the history?

- Requires a high degree of suspicion
  - Report suspicions to the OPO - they can ask around to see how the other recipients are doing

---

### Table 1

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of Donor Reports</th>
<th>Number of Recipients with Confirmed Transmission</th>
<th>Number of DDD-Attributable Recipient Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Virus</td>
<td>86</td>
<td>31</td>
<td>8</td>
</tr>
<tr>
<td>Bacteria</td>
<td>38</td>
<td>26</td>
<td>7</td>
</tr>
<tr>
<td>Fungus</td>
<td>30</td>
<td>26</td>
<td>8</td>
</tr>
<tr>
<td>Mycobacteria</td>
<td>26</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Parasite</td>
<td>21</td>
<td>13</td>
<td>4</td>
</tr>
<tr>
<td>Total infections</td>
<td>201</td>
<td>106</td>
<td>29</td>
</tr>
</tbody>
</table>

Recipient-derived infections

- Active, uncontrolled infection
  - LVAD associated bacteremia
  - Infection limited to organ to be explanted
- Colonization
- Recurrence of infectious indication for transplant
  - HCV
- Asymptomatic infection
  - Strongyloides
- Latent infection
  - TB
  - Herpes viruses (CMV, EBV, HSV, VZV)

Nosocomial infections

- Device-related
  - Line-associated blood stream infection
  - Catheter or stent associated UTI
  - Ventilator-associated pneumonia
- Surgery-related
  - Wound infection
  - Intra-abdominal abscess
- Outbreaks
- Multi-drug resistant organisms
Outbreaks

Pneumocystis in pediatric renal transplant recipients

*C. parapsilosis* after liver transplantation

Raghuram et al. Liver Transplant 2012;18:1100
Brunot et al. Transplant Proc 2012;44:2818

Aspergillus in heart surgery ICU

3 heart transplant recipients developed invasive aspergillosis

2/3 died

Mold in the walls....

Community acquired infections

- Immunosuppression does not prevent common infections...
- Manifestations may be different
- Common pathogens include:
  - Respiratory viruses (influenza)
  - Skin flora (S. aureus, streptococci)
  - Enteric flora (GNR, enterococci)
Stem cell transplant


Indications for HSCT

- Hematologic malignancies
- Selected solid malignancies
- Acquired diseases
  - eg aplastic anemia, Paroxysmal nocturnal hemoglobinuria
- Congenital diseases
  - eg Immunodeficiency syndromes (e.g. SCID)
HSCT principles:
maximizing graft vs tumor while minimizing graft vs host effects

Stem cell types

- Allogeneic vs. autologous
- Sources
  - Bone marrow
  - Mobilized peripheral blood stem cells
  - Umbilical cord blood
  - (Fetal liver cells)
Conditioning

Required Contribution of GVT Effect

- BU + CY + TBI (12 Gy)
- BU + TBI (12 Gy)
- CY + TBI (12 Gy)
- FLU + AraC
- BU + CY (± ATG)
- BU + Melphalan
- FLU + Melphalan
- FLU + Treosulfan
- FLU + BU
- TBI (2 Gy) + FLU
- TBI (2 Gy)
- CY

Intensity

Toxicity

Rezvani et al. in Transplant Infections 2009 Ed. Bowden et al.

Immune reconstitution after HSCT

- B cells, CD8 T cells
- Neutrophils, monocytes, NK cells
- Plasma cells, dendritic cells
- CD4 T cells, NKT cells

Timeline of infections

Infectious risk

<table>
<thead>
<tr>
<th></th>
<th>Higher risk</th>
<th>Lower risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant</td>
<td>allogeneic</td>
<td>autologous</td>
</tr>
<tr>
<td>Type of donor</td>
<td>Unrelated</td>
<td>related</td>
</tr>
<tr>
<td>HLA matching</td>
<td>HLA mismatch</td>
<td>HLA match</td>
</tr>
<tr>
<td>Stem cell source</td>
<td>Cord blood</td>
<td>Peripheral blood</td>
</tr>
<tr>
<td>Graft manipulation</td>
<td>T cell depletion</td>
<td>No manipulation</td>
</tr>
<tr>
<td>Conditioning regimen</td>
<td>Full intensity</td>
<td>Reduced intensity</td>
</tr>
<tr>
<td>immunosuppression</td>
<td>T cell depleting agents</td>
<td>Minimal IS</td>
</tr>
<tr>
<td>GVHD</td>
<td>Moderate-severe</td>
<td>None or mild</td>
</tr>
</tbody>
</table>

Wingard et al. Inf Dis Clin N Am 2010;24:257
Graft vs Host Disease

- GVHD requiring treatment seen in 40% of HLA-matched allo-HSCT recipients
- GVHD
  - Skin: pruritic maculopapular rash
  - GI tract: nausea, abd pain, diarrhea
  - Liver: cholestasis
- Graded based on extent of end-organ involvement
  - I mild
  - II moderate
  - III severe (~25% 5-year survival)
  - IV very severe (~5% 5 year survival)

Steroids remain first line
- Topical for skin and lung (inhaled)
- Systemic for more severe disease and other target organs

Calcineurin inhibitors

Steroid-refractory GVHD important concern


Bacterial infections after HSCT

<table>
<thead>
<tr>
<th>Type of Infectious Pathogen</th>
<th>Early Preengraftment (First 2-4 wk)</th>
<th>Early Postengraftment (Second and Third Month)</th>
<th>Late Postengraftment (After Second or Third Month)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacteria</td>
<td>Gram-negative bacteria (related to mucosal injury and neutropenia)</td>
<td>Gram-positive bacteria (related to venous catheters)</td>
<td>Encapsulated bacteria (related to poor opsonization with chronic GVHD)</td>
</tr>
<tr>
<td></td>
<td>Gram-positive bacteria (related to venous catheters)</td>
<td>Gram-negative bacteria (related to enteric involvement of GVHD, venous catheters)</td>
<td>Nocardia (related to chronic GVHD)</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>(related to neutropenia, antibiotics, antiacid medications)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Wingard et al. Inf Dis Clin N Am 2010;24:257
## Incidence of fungal infections

<table>
<thead>
<tr>
<th>Type of Infectious Pathogen</th>
<th>Early (Preengraftment First 2-4 wk)</th>
<th>Early Postengraftment (Second and Third Month)</th>
<th>Late Postengraftment (After Second or Third Month)</th>
<th>Time Independent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fungi</strong></td>
<td>Candida (related to mucosal injury and neutropenia)</td>
<td>Aspergillus, other molds and Pneumocystis jiroveci (related to GVHD)</td>
<td>Aspergillus, other molds and P jiroveci (related to GVHD)</td>
<td></td>
</tr>
<tr>
<td><strong>Herpesviruses</strong></td>
<td>HSV</td>
<td>CMV (related to GVHD and impaired cellular immunity)</td>
<td>CMV and VZV (related to GVHD and impaired cellular immunity and viral latency before transplant)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>EBV (in patients who have T-cell depleted grafts, receive ATG, or whose donor is mismatched)</td>
<td>EBV (in patients who have T-cell depleted grafts, receive ATG, or whose donor is mismatched)</td>
<td>EBV (in patients who have T-cell depleted grafts, receive ATG, or whose donor is mismatched)</td>
<td></td>
</tr>
<tr>
<td><strong>Other viruses</strong></td>
<td>BK virus (related to GVHD and cyclophosphamide in conditioning regimen)</td>
<td>Respiratory viruses (temporally tracks with community outbreaks)</td>
<td>Adenoviruses</td>
<td></td>
</tr>
</tbody>
</table>

Kontoyiannis et al. CID 2010;50:1091

Wingard et al. Inf Dis Clin N Am 2010;24:257
Pulmonary complications after HSCT


GI complications

Tuncer et al. W J Gastroenterol 2012;18:1851
CNS complications after HSCT

Aspergillus outbreak in HSCT
Febrile neutropenia

- **High risk**
  - Prolonged (anticipated >7 days) and profound neutropenia (≤100 cells/mm³)
  - “comorbid medical problems”
    - Hypotension
    - Pneumonia
    - New abdominal pain or new GI symptoms
    - Neurologic changes
    - Line infection
    - Severe mucositis
  - Hepatic or renal insufficiency

**MASCC score: less is worse**

Multinational Association for Supportive Care in Cancer study

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burden of febrile neutropenia with no or mild symptoms⁸</td>
<td>5</td>
</tr>
<tr>
<td>No hypotension (systolic blood pressure ≥90 mmHg)</td>
<td>5</td>
</tr>
<tr>
<td>No chronic obstructive pulmonary disease⁹</td>
<td>4</td>
</tr>
<tr>
<td>Solid tumor or hematologic malignancy with no previous fungal infection⁹</td>
<td>4</td>
</tr>
<tr>
<td>No dehydration requiring parenteral fluids</td>
<td>3</td>
</tr>
<tr>
<td>Burden of febrile neutropenia with moderate symptoms⁸</td>
<td>3</td>
</tr>
<tr>
<td>Outpatient status</td>
<td>3</td>
</tr>
<tr>
<td>Age &lt;60 years</td>
<td>2</td>
</tr>
</tbody>
</table>

- 26 maximum score -> lowest risk
- <21 considered high risk

Freifeld et al. CID 2011;52:e56
Mortality risk by MASCC score

Risk determines initial treatment

Low risk patients...
- May be treated as outpatients
- May be considered for oral antibiotics
- Most commonly solid tumors

High risk patients...
- Require hospitalization
- Require initial IV antibiotics
- Most commonly HSCT preparation or acute leukemia induction chemotherapy
- CT chest +/- sinuses for fever $\geq 4$ days
Environmental precautions in febrile neutropenia, IDSA 2011

- General
  - Hand hygiene
  - Standard barrier precautions and infection specific precautions
  - HSCT recipients should be housed in private rooms. Allogeneic HSCT recipients should be housed in rooms with >12 air exchanges/h and HEPA filtration
  - Plants and dried or fresh flowers should be prohibited
  - Hospital work exclusion policies should be designed to encourage HCP to report their illnesses or exposures

- Neutropenic diet
  - Consists of well cooked foods
  - Prepared luncheon meats should be avoided
  - Well cleaned, uncooked raw fruits and vegetables are acceptable, as are cooked foods brought from home or restaurants, provided that the freshness of ingredients and means of preparation can be confirmed
Environmental precautions in febrile neutropenia, IDSA 2011

- Patient skin and oral care
  - Patients should take daily showers or baths
  - Skin should be inspected daily
  - Gentle but thorough perineal care after bowel movement
  - Avoid rectal thermometers, enemas, suppositories, and rectal exams
  - Menstruating females should avoid tampons
  - Patients with ongoing mucositis should perform oral rinses 4-6 times per day with sterile water, normal saline, or sodium bicarbonate
  - Patients with brush their teeth >2 times/day with a soft regular toothbrush
  - Avoid fixed orthodontic appliances and space maintainers

- Plants and animals
  - Avoid plants and dried or fresh flowers
  - Do not allow visitation by pets (including pet therapy)

- HCP personnel and visitors
  - Vaccination of HCP or visitors who are symptomatic with infections transmitted by air, droplet, and direct contact (e.g., VZV, infectious gastroenteritis, HSV lip lesions, URI) should not engage in patient care or visit patients unless appropriate barrier (e.g., mask and glove) protection is established

- Infection control surveillance
  - Do not routinely perform bacterial surveillance cultures of the environment, equipment, or devices
Engineering controls

- *Aspergillus* prevention
  - Filtered hospital air
  - Barrier protection during renovation or construction
  - Protective isolation (HEPA filtered) for hematopoietic stem cell transplants
  - Provide respiratory protection when patients must leave a protective environment

- *Legionella* prevention
  - Prohibit showers (use sponge baths)
  - Implement surveillance for *Legionella* cases
  - Monitor water supply: if *Legionella* present initiate decontamination (controversial)

Procedures during construction & renovation

- Seal hospital construction areas behind impervious barriers
- Clean construction area daily (i.e., remove dust with HEPA vacuum)
- Assure that ventilation system does not transport dust from inside construction area to other locations
- Move immunocompromised patients from adjacent areas
- Thoroughly clean construction area prior to patient use
- Conduct surveillance for airborne fungal infections
- Assess airborne fungal levels adjacent to construction
- Avoid transporting construction material through patient areas
- Assess compliance with infection control guidelines
Infection in burns

**6 of 10 are infectious complications!**

**Figure 17**

Infection in burns

Nosocomial infection in burns

Table 3. Risk factors for development of NI

<table>
<thead>
<tr>
<th></th>
<th>Univariate Analysis</th>
<th>Multiple Analysis Model</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Odds Ratio</td>
<td>95% CI</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1.02</td>
<td>0.69-1.49</td>
</tr>
<tr>
<td>Age</td>
<td>1.01</td>
<td>0.99-1.01</td>
</tr>
<tr>
<td>Underlying disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>1.61</td>
<td>0.96-2.69</td>
</tr>
<tr>
<td>Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scald</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Flame</td>
<td>3.48</td>
<td>2.32-5.22</td>
</tr>
<tr>
<td>Electrical</td>
<td>1.58</td>
<td>0.87-2.87</td>
</tr>
<tr>
<td>Contact</td>
<td>1.38</td>
<td>0.57-3.37</td>
</tr>
<tr>
<td>STBSA</td>
<td>1.05</td>
<td>1.04-1.06</td>
</tr>
<tr>
<td>ABRF*</td>
<td>1.44</td>
<td>1.33-1.56</td>
</tr>
<tr>
<td>Admission day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤24 hr</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>&gt;24 hr</td>
<td>0.11</td>
<td>0.04-0.20</td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>0.99</td>
<td>0.29-3.32</td>
</tr>
<tr>
<td>First excision day</td>
<td>1.14</td>
<td>1.10-1.18</td>
</tr>
<tr>
<td>Transfusion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5.01</td>
<td>3.29-7.63</td>
</tr>
</tbody>
</table>

Alp et al. Burn Care Res 2012;379
At UNC from 2008-2012, 32% of hospital-associated respiratory infections in the burn ICU were caused by MDR-GNB vs. 3% in all other ICUs


### MDR-bacterial outbreaks in burn units

<table>
<thead>
<tr>
<th>Study</th>
<th>Microorganism</th>
<th>Outbreak Duration</th>
<th>Patients Hospitalized, N</th>
<th>Cases, N (%)</th>
<th>Colonization</th>
<th>Infection</th>
<th>Total (Attack Rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babik et al 17</td>
<td>Acinetobacter baumanii</td>
<td>12 mo</td>
<td>73</td>
<td>—</td>
<td>7 (54)</td>
<td>6 (46)</td>
<td>13 (100%)</td>
</tr>
<tr>
<td>Bayat et al 18</td>
<td>A. baumanii</td>
<td>1 yr</td>
<td>72</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>21 (29%)</td>
</tr>
<tr>
<td>Herruzo et al 19</td>
<td>A. baumanii</td>
<td>13 mo</td>
<td>247</td>
<td>—</td>
<td>1 (7)</td>
<td>14 (93)</td>
<td>15 (12.55)</td>
</tr>
<tr>
<td>Lyttikinen et al 15</td>
<td>A. baumanii</td>
<td>3 mo</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>21 (29%)</td>
</tr>
<tr>
<td>Roberts et al 20</td>
<td>A. baumanii</td>
<td>16 mo</td>
<td>18 (42)</td>
<td>18 (58)</td>
<td>31 (12.55)</td>
<td>31 (12.55)</td>
<td>15 (12.55)</td>
</tr>
<tr>
<td>Sanoe et al 21</td>
<td>Acinetobacter baumanii</td>
<td>1 yo</td>
<td>—</td>
<td>—</td>
<td>2</td>
<td>2</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Fujitaka et al 20</td>
<td>Acinetobacter baumanii</td>
<td>1 yo</td>
<td>—</td>
<td>—</td>
<td>2</td>
<td>2</td>
<td>2 (100%)</td>
</tr>
<tr>
<td>Falk et al 22</td>
<td>Enterococcus faecalis</td>
<td>1 yr</td>
<td>17 (81)</td>
<td>4 (19)</td>
<td>21 (12.35)</td>
<td>21 (12.35)</td>
<td>21 (12.35)</td>
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<tr>
<td>Sanchez et al 23</td>
<td>Klebsiella pneumoniae</td>
<td>10 mo</td>
<td>18 (69)</td>
<td>8 (31)</td>
<td>26 (12.35)</td>
<td>26 (12.35)</td>
<td>26 (12.35)</td>
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<tr>
<td>Douglas et al 24</td>
<td>Pseudomonas aeruginosa</td>
<td>3 mo</td>
<td>30</td>
<td>—</td>
<td>4</td>
<td>4</td>
<td>4 (13.33)</td>
</tr>
<tr>
<td>Hooch et al 25</td>
<td>P. aeruginosa</td>
<td>2 yo</td>
<td>16</td>
<td>1 (25)</td>
<td>3 (75)</td>
<td>4 (25)</td>
<td>4 (25)</td>
</tr>
<tr>
<td>Treger et al 26</td>
<td>P. aeruginosa</td>
<td>2 yr</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Sidda et al 27</td>
<td>Providencia stuartii</td>
<td>5 mo</td>
<td>—</td>
<td>17</td>
<td>—</td>
<td>17</td>
<td>17 (100%)</td>
</tr>
<tr>
<td>Tsa et al 28</td>
<td>Serratia marcescens</td>
<td>9 yr</td>
<td>666</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>13 (1.95)</td>
</tr>
<tr>
<td>Edgar et al 18</td>
<td>Serratia marcescens</td>
<td>1 mo</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>3 (100%)</td>
</tr>
<tr>
<td>Boers et al 29</td>
<td>MRSA</td>
<td>2½ yr</td>
<td>12 (71)</td>
<td>5 (29)</td>
<td>17</td>
<td>—</td>
<td>21.9/1000 PD</td>
</tr>
<tr>
<td>Dansby et al 30</td>
<td>MRSA</td>
<td>7 yr</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>21.9/1000 PD</td>
</tr>
<tr>
<td>Embel et al 31</td>
<td>MRSA</td>
<td>2 yr</td>
<td>126</td>
<td>11 (92)</td>
<td>1 (8)</td>
<td>12 (9.52)</td>
<td>12 (9.52)</td>
</tr>
<tr>
<td>Espersen et al 30</td>
<td>MRSA</td>
<td>1 yr</td>
<td>23</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>10 (43.48)</td>
</tr>
<tr>
<td>Fuchs et al 30</td>
<td>MRSA</td>
<td>1 yr</td>
<td>43</td>
<td>18 (75)</td>
<td>2 (25)</td>
<td>8 (18.60)</td>
<td>8 (18.60)</td>
</tr>
<tr>
<td>Hunt et al 31</td>
<td>MRSA</td>
<td>8 yr</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>56 (100%)</td>
</tr>
<tr>
<td>Lilly et al 31</td>
<td>MRSA</td>
<td>2 yr</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>74 (100%)</td>
</tr>
<tr>
<td>Meier et al 30</td>
<td>MRSA</td>
<td>4 mo</td>
<td>—</td>
<td>6 (60)</td>
<td>4 (40)</td>
<td>10</td>
<td>10 (43.48)</td>
</tr>
<tr>
<td>Patel et al 30</td>
<td>MRSA</td>
<td>1 yr</td>
<td>—</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4 (100%)</td>
</tr>
<tr>
<td>Rashid et al 30</td>
<td>MRSA</td>
<td>5½ mo</td>
<td>176</td>
<td>15 (83)</td>
<td>2 (17)</td>
<td>18 (10.23)</td>
<td>18 (10.23)</td>
</tr>
<tr>
<td>Roberts et al 30</td>
<td>MRSA</td>
<td>18 mo</td>
<td>1896</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>109 (5.75)</td>
</tr>
<tr>
<td>Rautala et al 30</td>
<td>MRSA</td>
<td>5 mo</td>
<td>—</td>
<td>7</td>
<td>5</td>
<td>12 (723/1000 PD)</td>
<td>19 (12.35)</td>
</tr>
<tr>
<td>Saffar et al 30</td>
<td>MRSA</td>
<td>16 mo</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>19 (12.35)</td>
</tr>
</tbody>
</table>

Decline in the rate of BSI

van Duin et al. ICHE 2014;35:8;1066-68

Pathogens & infections in burn

Enterobacteriaceae
Pseudomonas aeruginosa
Staphylococcus aureus
Urinary tract infection
Bloodstream infection
Pneumonia
Skin and soft tissue infection
Antibacterial resistance

Prevention of infection in burns

- Topical agents
- Systemic antimicrobial prophylaxis
- Wound care
- Universal isolation precautions
- Frequency of line changes

Interventions to decrease CLABSI rate at UNC

<table>
<thead>
<tr>
<th>Year(s)</th>
<th>Intervention(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>Enhanced education of medical staff regarding central lines; addition of 2% chlorhexidine plus 70% isopropyl alcohol for skin preparation to central line kits</td>
</tr>
<tr>
<td>2001</td>
<td>Mandatory training for nurses on IV line site care and maintenance</td>
</tr>
<tr>
<td>2003</td>
<td>Central line changes over a guidewire every 3 days with use of a new site every 6 days becomes standard practicea use of full body drape for line insertion and changes</td>
</tr>
<tr>
<td>2003–2005</td>
<td>Introduction of antibiotic-impregnated central venous catheters for all patients</td>
</tr>
<tr>
<td>2004</td>
<td>Enhanced nursing education on central line insertion and maintenance</td>
</tr>
<tr>
<td>2005</td>
<td>Customized catheter-insertion kits</td>
</tr>
<tr>
<td>2006</td>
<td>Universal glove and gown use for all patient encountersa</td>
</tr>
<tr>
<td>2007</td>
<td>Implementation of the Institute for Healthcare Improvement bundle to prevent CLABSI</td>
</tr>
<tr>
<td>2009</td>
<td>Use of chlorhexidine patch at insertion site</td>
</tr>
</tbody>
</table>

Specific to burn ICU

van Duin et al. ICHE 2014;35:8;1066-68
Questions?
anne_lachiewicz@med.unc.edu