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Infection Management

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Infections are common in many hospital departments, but no more so than on the intensive care unit (ICU) where, in a recent European study of more than 3000 ICU patients, 37% were infected at some point during their ICU stay (Vincent et al. 2005). While some patients will, of course, be admitted to the ICU with a community-acquired infection, perhaps of greater concern are the risks of nosocomial infection. Early and adequate diagnosis and treatment are essential to maximize outcomes, but hospital- or ICU-acquired infections are notoriously difficult to diagnose and treat, largely due to problems in identifying causative organisms in patients who have recently received or are still receiving antimicrobial agents and the increased incidence of antibiotic (multi)-resistant organisms. Nosocomial infections are responsible for considerable morbidity, mortality and costs.

Severe sepsis occurring as a result of ICU-acquired infection has been associated with a threefold increase in workload and costs (Adrie et al. 2005). The ‘best’ way of managing such infections is thus to avoid them in the first place and there are various strategies that have been shown to be effective in preventing the risk of nosocomial infection (Vincent 2003). Many hospitals and ICUs have now developed infection control programs, which, when adhered to, can reduce nosocomial infection rates, resulting in improved patient outcomes, shorter ICU/hospital stays, and reduced costs. An important consideration in the running of such programs is the inclusion of an infection surveillance system, whereby data related to the infections and to causative organism(s) and antimicrobial sensitivity patterns are systemically collected, so that infection control programs can be adapted such that all patients receive the most appropriate and effective prevention and treatment.

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