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**The changing face of MRSA in the diabetic foot clinic - an analysis of 5 years experience.**

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The isolation of methicillin resistant *Staphylococcus aureus* (MRSA) from diabetic foot ulcers has become a source of increasing concern amongst health care professionals and patients alike. We have previously published outcome data from two separate cohorts of diabetic foot patients in 2002 and 2004. We now present an analysis of the prevalence and risk factors for MRSA colonisation a cohort of patients with diabetic foot ulcers screened in a hospital-based specialist diabetic foot clinic five years after the initial cohort.

111 ulcers from 93 consecutive patients were screened in a 4-week period in November to December 2007. Vigorous surface sampling for MRSA was performed with a saline-moistened swab. MRSA was isolated from 15.3% ulcers and 16.1% patients. By comparison MRSA was isolated from 10% ulcers (n= 98) and 10.2% patients (n=150) in 2002 and 14.5% ulcers (n=85) and 16.7% patients (n=110) in 2004. The majority of patients in all three series were living in their own homes (94% 2002, 93% 2004 and 91% 2007) with more patients having been admitted to hospital in the previous 12 months in the 2007 (62%) than the 2002 (53%) or 2004 (49%) cohorts. The median length of preceding in-patient stay has however decreased from 20.5 days in 2002 to 12.5 days in 2007. In contrast to the 2002 cohort we found no association between previous admission to hospital and the isolation of MRSA (2002, Chi-square 6.25, p=0.017; 2007, Chi-square 0.43, p=0.53) the total number of days of antibiotic usage (2002, R=0.328 p=0.013; 2007, R=0.033 p=0.75) or the use of quinolone antibiotics (2002, Chi-square 6.7 p=0.02; 2007, Chi-square 0.13, p=0.50). Whilst the proportion of isolates of MRSA from diabetic foot ulcers has not increased over the last three years it is apparent that the risk factors for colonisation are different. It can no longer be assumed that patients are at low risk if they have not been admitted to hospital or had prolonged broad-spectrum antibiotics. Local infection control policy should reflect these changes.