Reference Group Choice and Antibiotic Resistance Outcomes

Citation
Kaye, Keith S., John J. Engemann, Essy Mozaffari, and Yehuda Carmeli. 2004. Reference group choice and antibiotic resistance outcomes. Emerging Infectious Diseases 10(6): 1125-1128.

Published Version
doi:10.3201/eid1006.020665

Permanent link
http://nrs.harvard.edu/urn-3:HUL.InstRepos:10347167

Terms of Use
This article was downloaded from Harvard University’s DASH repository, and is made available under the terms and conditions applicable to Other Posted Material, as set forth at http://nrs.harvard.edu/urn-3:HUL.InstRepos:dash.current.terms-of-use#LAA

Share Your Story
The Harvard community has made this article openly available. Please share how this access benefits you. Submit a story.

Accessibility
Reference Group Choice and Antibiotic Resistance Outcomes

Keith S. Kaye,* John J. Engemann,* Essy Mozaffari,† and Yehuda Carmeli‡

Two types of cohort studies examining patients infected with methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant enterococci (VRE) were contrasted, using different reference groups. Cases were compared to uninfected patients and patients infected with the corresponding, susceptible organism. VRE and MRSA were associated with adverse outcomes. The effect was greater when uninfected control patients were used.

Although several investigators have performed outcomes studies of patients infected or colonized with antimicrobial resistant bacteria, the design and interpretation of results with various methods has not been discussed (1). Typically, these outcomes studies use a cohort design and study patients infected with resistant bacteria (the exposure of interest for cases), who are compared either to patients without infection selected from a similar population (2–6) or to patients infected with corresponding, susceptible organism. VRE and MRSA were associated with adverse outcomes. The effect was greater when uninfected control patients were used.

Outcomes studies of antimicrobial drug resistance are notoriously hard to perform because of confounding variables related to underlying coexisting conditions (1). To control for confounding, we analyzed several variables, including individual coexisting conditions, the Charlson score, the American Society of Anesthesiologists-Physical Status (ASA) score, and duration of hospitalization before infection (Online Appendix). These variables were analyzed in multivariable analysis. Each of the outcomes was analyzed independently. The inverse log value was calculated for β coefficients of variables included in the predictor models, and these effect measures were described as the odds ratio (OR) for death rate and the multiplicative effects (ME) on length of stay and charges.

In the analysis comparing patients with SSI caused by MRSA to uninfected controls, the study cohort included 314 patients: 121 MRSA SSI cases and 193 uninfected surgical controls (Online Appendix). In multivariable analysis, MRSA SSI was significantly associated with death (OR = 11.4, p < 0.001). In the analysis comparing patients with MRSA SSI to patients with SSI caused by MSSA, the same 121 MRSA case-patients were compared to 165 control-patients with MSSA SSI. In multivariable analysis, MRSA SSI was significantly associated with death (OR = 3.4, p = 0.003). Additional covariates included in the adjusted models for death are listed in the footnotes of Table 1 and are discussed in the Online Appendix. The
shown that MRSA SSI was significantly associated with MRSA to uninfected controls, multivariable modeling controls than for analysis B using MSSA controls. The effect of MRSA on length of stay was approximately threefold greater (11 days) for the analysis using uninfected controls than for the analysis using controls with SSI due to MSSA.

Table 1. Outcomes and adjusted analyses for MRSA for study 1*

| Outcome                              | Cases  | Controls | OR (95% CI)* | Attributable to MRSA | p value |
|--------------------------------------|--------|----------|--------------|----------------------|---------|
| Three analyses comparing patients MRSA cases (n = 121) and uninfected controls (n = 193) |        |          |              |                      |         |
| Deaths                               | 20.7%  | 2.1%     | 11.4 (2.8 to 34.9) | –                    | < 0.001 |
| Hospital days after surgery, mean per case | 29.1   | 6.1      | 3.2 (2.7 to 3.7)  | 13.4                 | < 0.001 |
| Charges ($), mean/case               | 118,414| 34,395   | 2.2 (2.0 to 2.6)  | 41,274               | < 0.001 |
| Three analyses comparing MRSA cases (n = 121) and MSSA controls (n = 165) |        |          |              |                      |         |
| Deaths                               | 20.7%  | 6.7%     | 3.4          | –                    | 0.003   |
| Hospital days after infection, mean per case | 22.0   | 13.2     | 1.2          | 2.6                  | 0.11    |
| Charges ($), mean per case           | 118,414| 73,165   | 1.2          | 13,901               | 0.03    |

*OR, odds ratio; CI, confidence interval; MRSA, methicillin-resistant *Staphylococcus aureus*; MSSA, methicillin-susceptible *S. aureus*.

Three analyses comparing MRSA cases (n = 121) and uninfected controls (n = 193) showed that MRSA SSI was significantly associated with an increased length of stay (ME = 3.2, p < 0.001). Having an MRSA SSI was associated with an average adjusted attributable increase of 13.4 hospital days per case. In the analysis comparing patients with MRSA SSI to controls with SSI due to MSSA, a trend was seen toward an association between MRSA SSI and total hospital days (ME = 1.20, p = 0.11). Methicillin resistance was associated with an average adjusted attributable increase of 2.6 days per case, although this did not reach statistical significance. Additional covariates included in the adjusted models for length of stay are listed in the footnotes of Table 1 and are discussed in the Online Appendix. The effect of MRSA on cost was approximately twofold greater ($15,000) for the analysis using uninfected controls than for the analysis using controls with SSI due to MSSA.

In the analysis comparing patients with wound infection due to VRE to uninfected controls, 99 patients with VRE wound infection were compared to 280 matched controls who were not infected with enterococci (Online Appendix). In adjusted analysis, VRE wound infection was not an independent predictor of deaths (OR 2.0, p = 0.13). In the analysis comparing patients with wound infection due to VRE to control patients with wound infection due to VSE, the same 99 VRE wound infection cases were compared to 213 control patients with VSE wound infections. In multivariable analysis, VRE was significantly associated with mortality (OR 2.5, p = 0.04). Additional covariates included in the adjusted models for death rates are listed in the footnotes of Table 2 and are discussed in the Online Appendix. The magnitude of effect of VRE on deaths was similar for both analyses.

In the analysis comparing patients with wound infection due to VRE to uninfected controls, multivariable modeling showed a significantly longer duration of hospitalization after inclusion in the cohort for VRE cases than for controls not infected with enterococci (ME 1.8, p < 0.001, average adjusted attributable increase of 6.2 days in length of stay). In the analysis comparing patients with wound infection due to VRE to control patients with VSE wound infection, length of stay after isolation of enterococci was similar among VRE cases and VSE controls (mean of 15.2 vs. 13.6 days, p = 0.5) and the differences in length of stay remained non-significant in multivariate analysis (ME = 1.0, p = 0.5). Additional covariates included in the adjusted models for length of stay are listed in the
footnotes of Table 2 and are discussed in the Online Appendix. The effect of VRE on length of stay was approximately twofold greater (6 days) for the analysis using uninfected controls than for the analysis that used VSE controls.

In the analysis comparing patients with wound infection due to VRE to uninfected controls, multivariable modeling demonstrated that VRE cases generated significantly greater hospital charges than controls (adjusted ME = 1.5, p < 0.001, mean adjusted additional attributable charges of $13,884 per VRE wound infection and attributable cost of $9,719 per infection). In the analysis comparing patients with wound infection due to VRE to controls with VSE wound infection, VRE wound infection was associated with increased hospital charges (ME = 1.4, p < 0.001, average adjusted additional attributable charges of $12,766 per infection and attributable cost of $8,936 per infection). Additional covariates included in the adjusted models for cost are listed in the footnotes of Table 2 and are discussed in the Online Appendix. The effect of VRE on cost was similar in both analyses.

Conclusions

We examined how the criteria used to select a reference group (i.e., a comparison or control group for cases) influenced outcomes study results. Two types of control patients were studied, and in both types of analyses, VRE and MRSA were associated with significant, adverse clinical outcomes. In general, the effects (i.e., OR or ME) were of greater magnitude when controls not infected with the target organism (and thus representative of a random sample of the source population) were used. This is logical since analyses using uninfected controls assess the effect of acquiring a new infection and a resistant pathogen. When patients who are infected with a susceptible organism are used as controls, the analysis quantifies only the effect of acquiring a resistance trait.

The differences in results between the two analyses were much greater for the MRSA SSI study than for the VRE wound infection study. The impact on clinical outcomes was two- to threefold greater when patients with MRSA SSI were compared to an uninfected control group as opposed to comparison with control patients infected with MSSA SSI. In contrast, when patients with VRE wound infection were compared to uninfected patients, similar results were obtained as when patients with VSE wound infections were used as controls. We believe that the magnitude of differences in results for the two analyses is directly related to the virulence of the infecting organism (Online Appendix).

The studies were performed in two different geographic locales and by using slightly different analytic methods. While this is a limitation in that cost results are not directly comparable, we feel including these two studies improves the generalizability of our results and strengthens our findings.

For studies of antimicrobial resistance, a reference group must be chosen on the basis of the investigators’ objective. From a public health perspective, results from outcomes studies pertaining to antimicrobial resistance are frequently used to help allocate resources for interventions. If the objective of a study is to investigate the independent effects of a resistance trait or phenotype (e.g., methicillin resistance), then the most appropriate control group would consist of patients infected with a susceptible corresponding organism. If the goal is to assess the effect of a new infection caused by a particular pathogen, uninfected control patients would be the preferable comparison group. Alternatively, a complete analysis might include both types of control groups; this analysis would allow the
reader to assess the effect of acquiring a resistance phenotype alone and the impact of acquiring a new infection caused by a resistant bacteria.

Dr. Kaye is an assistant professor of medicine at Duke University Medical Center, where he is director of Hospital Epidemiology and Infection Control and chair of the Antibiotic Evaluation Committee. His research interests include antimicrobial resistance, antimicrobial utilization, selective antimicrobial pressure, surgical site infections, infections in the elderly, and hospital-acquired infections.

References

1. Cosgrove SE, Carmeli Y. The impact of antimicrobial resistance on health and economic outcomes. Clin Infect Dis. 2003;36:1433–7.
2. Chaix C, Durand-Zaleski I, Alberti C, Brun-Buisson C. Control of endemic meticillin-resistant *Staphylococcus aureus*: a cost-benefit analysis in an intensive care unit. JAMA. 1999;282:1745–51.
3. Edmond MB, Ober JF, Dawson JD, Weinbaum DL, Wenzel RP. Vancomycin-resistant enterococcal bacteremia: natural history and attributable mortality. Clin Infect Dis. 1996;23:1234–9.
4. Menon KV, Whiteley MS, Burden P, Galland RB. Surgical patients with meticillin resistant *Staphylococcus aureus* infection: an analysis of outcome using P-POSSUM. J R Coll Surg Edinb. 1999;44:161–3.
5. Montecalvo MA, Jarvis WR, Uman J, Shay DK, Petruolo C, Horowitz HW, et al. Costs and savings associated with infection control measures that reduced transmission of vancomycin-resistant enterococci in an endemic setting. Infect Control Hosp Epidemiol. 2001;22:437–42.
6. Newell KA, Millis JM, Arnow PM, Bruce DS, Woodle ES, Cronin DC, et al. Incidence and outcome of infection by vancomycin-resistant *Enterococcus* following orthotopic liver transplantation. Transplantation. 1998;65:439–42.
7. Abramson MA, Sexton DJ. Nosocomial meticillin-resistant and meticillin-susceptible *Staphylococcus aureus* primary bacteremia: at what costs? Infect Control Hosp Epidemiol. 1999;20:408–11.
8. Auburtin M, Porcher R, Bruneel F, Scavnic A, Trouillet JL, Bedos JP, et al. Pneumococcal meningitis in the intensive care unit: prognostic factors of clinical outcome in a series of 80 cases. Am J Respir Crit Care Med. 2002;165:713–7.
9. Carmeli Y, Eliopoulos G, Mozaffari E, Samore M. Health and economic outcomes of vancomycin-resistant enterococci. Arch Intern Med. 2002;162:2223–8.
10. Engemann JJ, Carmeli Y, Cosgrove SE, Fowler VG, Bronstein MZ, Trivette SL, et al. Adverse clinical and economic outcomes attributable to meticillin resistance among patients with *Staphylococcus aureus* surgical site infection. Clin Infect Dis. 2003;36:592–8.
11. Harbarth S, Rutschmann O, Sudre P, Pittet D. Impact of meticillin resistance on the outcome of patients with bacteremia caused by *Staphylococcus aureus*. Arch Intern Med. 1998;158:182–9.
12. Stosor V, Peterson LR, Postelnick M, Noskin GA. *Enterococcus faecium* bacteremia: does vancomycin resistance make a difference? Arch Intern Med. 1998;158:522–7.
13. Vergis EN, Hayden MK, Chow JW, Snydman DR, Zervos MJ, Lindén PK, et al. Determinants of vancomycin resistance and mortality rates in enterococcal bacteremia. A prospective multicenter study. Ann Intern Med. 2001;135:484–92.
14. Howard D, Cordell R, McGowan JE Jr, Packard RM, Scott RD, Solomon SL, et al. Measuring the economic costs of antimicrobial resistance in hospital settings: summary of the Centers for Disease Control and Prevention–Emory Workshop. Clin Infect Dis. 2001;33:1573–8.

Address for correspondence: Keith S. Kaye, Box 3152, Durham, NC 27710, USA; fax: 919-684-3137; email: kaye0001@mc.duke.edu

The opinions expressed by authors contributing to this journal do not necessarily reflect the opinions of the Centers for Disease Control and Prevention or the institutions with which the authors are affiliated.