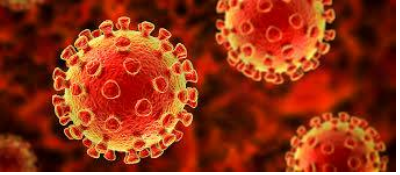

Strama Västra Götaland
Samverkan mot antibiotikaresistens

Initiativ för rationell antibiotikaanvändning under och efter pandemin

Gunnar Jacobsson Strama Västra Götaland
20201117

VÄSTRA GÖTALANDSREGIONEN

Antibiotikaronder VGR

SU
MAVA Sahlgrenska varje dag
Avd 34 (internmedicin) 2 ggr/v
MAVA Östra varje dag
Avd 351 (internmedicin) 2 ggr/v
Avd 357 (internmedicin) 2 ggr/v
Avd 234 (geriatrik) 1 ggn/v
Avd 235 (geriatrik) 1 ggn/v
Avd 236 (internmedicin) 1 ggn/v
Avd 237 (internmedicin) 1 ggn/v

SÄS	
MAVA	2 ggr/v
KAVA	2 ggr/v
Barn	2 ggr/v

NU	
MAVA	2ggr/v
MÄVA1	2ggr/v
MÄVA2	2 ggr/v
Urologavd	2 ggr/v
Lungavd	2 ggr/v

SkaS	
Urologavd	2ggr/v
Hematol.avd	1/v

KS	
Medavd7	1gg/varannanvecka
Medavd8	1gg/varannanvecka
Avd2	1gg/varannanvecka
Avd3	1 gg/varannanvecka

Eurosurveillance

EDITORIAL

Will coronavirus disease (COVID-19) have an impact on antimicrobial resistance?

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Factors that may influence levels of antimicrobial resistance during the COVID-19 pandemic

Type of factor	Factors that may favour an increase in AMR	Factors that may favour a decrease in AMR
Antibiotic use in hospitals	• About 70% of hospitalised COVID-19 patients receive antibiotics [33,34] • COVID-19 patients often receive empiric broad-spectrum antibiotic therapy [34-36] • 16% of hospitalised COVID-19 patients develop a secondary bacterial infection [34], which will necessitate antibiotic therapy • Possible increased use of azithromycin and teicoplanin (because of the initial absence of clear guidelines for the treatment of COVID-19 patients) [4,6,8] • Difficulties in accessing advice from experts before prescribing antimicrobial agents [4] • Antimicrobial stewardship efforts may be undermined because of high workloads and shifting priorities related to COVID-19 [37,38] • Possible aggravation of existing shortages of certain narrow-spectrum antimicrobial agents [39,40]	• Bacterial co-infection (estimated on presentation) in only 3.5% (95% CI: 1–7%) of COVID-19 patients [33] • Bacterial/fungal infection in only 8% of hospitalised COVID-19 patients vs 11% in non-COVID-19 patients [34]; the percentage for COVID-19 patients may be underestimated because many may have received empiric antimicrobial therapy [41] • Only 1.3% of COVID-19 patients in ICUs, and apparently no patients in other units, developed a healthcare-associated superinfection with antimicrobial-resistant bacteria [19] • Postponed planned surgical interventions result in fewer antibiotic courses for surgical prophylaxis [42] • Fewer emergency and planned hospital admissions [43,44], including chronically ill patients (e.g. oncology patients, diabetic patients, transplant patients), resulting in fewer antibiotic prescriptions

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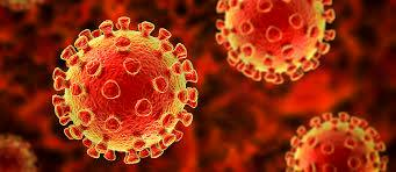
Infection prevention and control in hospitals	• Difficulties for HCWs in adhering to standard IPC precautions because of long shifts wearing the same PPE [45] and possible shortages of certain equipment [5] • Focus of HCWs on self-protection (e.g. universal gloving practices) rather than on preventing cross-transmission between patients • In COVID-19 cohort units and ICUs, sessional use of PPE, e.g. long-sleeved gowns that prevent effective hand hygiene [46] and gloves that may not be changed between patients [45] • Overcrowded facilities and possible staff shortages leading to low HCW-to-patient ratios [5] • Shortages of HCWs with appropriate IPC training [4] • Longer hospital stays for COVID-19 patients [5] • Traditional IPC efforts may be temporarily discontinued, including those targeting antibiotic-resistant bacteria, e.g. decreased frequency of screening for carriage of MDROs and difficulties in isolating or cohorting MDRO-positive patients [4,47] • Decreased laboratory capacity to detect AMR carriage, e.g. for processing rapid tests for MDROs, because resources are focused on SARS-CoV-2 diagnosis [4]	• Isolation of COVID-19 patients with enhanced standard precautions, e.g. increased hand hygiene and use of PPE, plus universal chlorhexidine bathing protocols for patients in ICUs [5] • Increased disinfection of the environment [4,5] • COVID-19 patients are often cohorted in one single unit and cared for by the same group of HCWs [5] • Fewer emergency and planned hospital admissions [43,44], including chronically ill patients (e.g. oncology patients, diabetic patients, transplant patients), resulting in lower colonisation pressure by fewer carriers of MDROs • Fewer transfers from long-term care facilities may lead to fewer cycles between long-term care facilities and hospitals [5] • Construction of new COVID-19 facilities without an established reservoir of MDROs [5]



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Samverkan mot antibiotikaresistens

Antibiotikaronder påverkar inte empirisk terapi …

vad göra då? Fråga Anders Lundqvist