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LETTER TO THE EDITOR

Definitions and resistance rate difference

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Dear Editor,

We read the study by Stapleton and colleagues [1] on the antibiotic consumption data and relation between antibiotic resistance patterns of *Escherichia coli* urinary isolates with great interest. However, we have some comments regarding this study.

Authors retrieved their data from the microbiology laboratory information system and classified as being of community or hospital origin. They classified the samples originating from general practitioners in the surrounding catchment area, from hospital outpatients and long-term care facilities as community; and samples from the emergency department and hospital wards as hospital. However, this classification can lead to the misrepresentation of community origins to hospital based or hospital origins as community based. According to Centers for Disease Control and Prevention (CDC) 1988 guidelines; infections identified from samples taken more than 48 h after admission and before discharge should be categorized as hospital acquired, and those taken before or within 48 h of admission should be categorized as community acquired [2]. Moreover, CDC changed the definitions in 2008 and started to use the generic term "health care-associated infection" instead of nosocomial. According to new definitions, extensions of infections already present on admission should not be accepted as health care-associated or nosocomial infection [3]. So, samples originating from the emergency department and hospital words on the first two day of admission could not be classified as hospital origin. If the researchers did the correct classification, the rate of resistance in hospital-derived isolates could be detected higher than they reported.

References

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