

MRSA FACT SHEET
August 2007

What are “staph” and MRSA?

Staphylococcus aureus (SA) is a bacterium commonly found living on the skin or in the nose of healthy individuals. Up to 50% of the overall population (not the incarcerated) have SA growing on their skin. This usually represents asymptomatic colonization, and does not lead to symptomatic disease.

Methicillin-resistant staphylococcus aureus (MRSA) is the name given to Staphylococcus aureus (SA) bacteria that have developed resistance to many of the common antibiotics that are used to treat this organism. MRSA can be treated with readily available medications.

By the 1970s, MRSA was increasingly recognized as an important pathogen in hospitals, nursing homes, and other long term care facilities in the United States. Currently, more than half of all health-care associated staph infections in hospitals in this country are due to MRSA. Over the past decade, infections due to MRSA have been increasingly recognized as a major problem in non-health care settings such as schools, and during athletic activities. Jails and prisons also have been increasingly recognized as locations where MRSA infections are found.

Overcrowded conditions and poor hygiene can contribute to the acquisition and spread of MRSA and other contagious illnesses. Examples in the California prison system include lack of sufficient hand washing facilities and delays in access to care.

Staph and MRSA are increased among some groups including injection drug users, health care workers, diabetics, the incarcerated, and those who have chronic skin conditions or indwelling urinary or vascular catheters.

Although MRSA and staph often colonizes humans without causing disease, they can be responsible for both minor skin infections and life-threatening infections of the skin, bone, joints, blood, heart valves, and lungs.

MRSA and staph can be spread from person to person by contact with the skin of someone who is infected or colonized with the bacteria. These bacteria can also be acquired by contact with contaminated environmental surface.

MRSA and staph bacteria are transmitted only by direct contact, and not through the air, coughing or breathing.

Risk factors identified in jail and prison MRSA outbreaks have included prolonged incarceration, the presence of skin lacerations and abrasions, previous antibiotic use, inadequate skin hygiene, draining one's own abscesses or performing one's own wound dressing changes, washing one's own clothing by hand, sharing razors, clothing, linen, or soap, restricted access to medical care, and requiring co-payments to see a clinician.

In both correctional and non-correctional settings, the misinterpretation of MRSA skin lesions as spider bites has led to delays in appropriate treatment and misguided vector control measures.

Myths and truths

MYTH: MRSA is a “flesh-eating” bacteria.

TRUTH: “Flesh eating” infections are associated with a different kind of bacteria called streptococcus, not staphylococcus.

MYTH: MRSA spreads through the air.

TRUTH: Staph and MRSA are spread only by direct contact with the organism.

MYTH: MRSA cannot be treated.

TRUTH: MRSA can usually be treated with drainage of abscesses and antibiotics, when appropriate.

MYTH: If MRSA is acquired on the skin, it always leads to disease.

TRUTH: MRSA usually does NOT lead to disease.

MYTH: People who have MRSA should always be isolated or placed in quarantine.

TRUTH: Only some patients with draining wounds should be placed in contact isolation.

MYTH: MRSA patients cannot be safely transported with other inmates.

TRUTH: Inmates who have MRSA can be safely transported, unless they have a wound that cannot be controlled with a dressing.

MYTH: Employees with MRSA must not work.

TRUTH: In most cases individuals can continue to work if their wound is properly treated and they are educated in prevention measures to avoid passing the bacteria to others.

Treatment

The first step in adequately treating infections due to MRSA is to ensure rapid access to health care for all persons who have skin and soft tissue infections (SSTIs). In many cases, drainage of the accumulated purulent material is all that is needed to resolve minor MRSA SSTI infections, and antibiotics are unnecessary. Antibiotics are useful in some MRSA and SA infections.

However, the indiscriminate use of antibiotics can lead to increased drug resistance and should be discouraged.

If treated properly, through wound care and hygiene measures, most MRSA infections clear up within a few days. In more severe cases, MRSA can cause pneumonia, meningitis and even death.

There is debate within the medical community about the most effective steps to take to identify and prevent MRSA. There is very little research or data about the prevention, diagnoses and treatment of this condition in correctional settings.

Education to prevent MRSA

- Wash hands regularly with soap and water. If hands are not visibly soiled, alcohol-based hand cleansers are a reasonable alternative.
- Maintain good hygiene by showering regularly.
- Do not share personal items that can transmit infectious agents, such as clothing, towels, bedding, razors, hair brushes and combs, and soap.
- Utilize the institutional laundry, and have clothes washed regularly especially if they have come into contact with wounds or wound drainage.
- Keep all wounds covered with a clean, dry bandage.
- Do not assist other inmates in the drainage or bandaging of wounds. Leave these activities to trained medical staff.

Sources:

Infectious Diseases in Corrections Report, March 2007, “Methicillin-resistant Staphylococcus aureus (MRSA) in the Correctional Setting,” **Joseph Bick, M.D.**, Chief Medical Officer, California Medical Facility, California Department of Corrections, Assistant Clinical Professor, Division of Infectious Diseases, University of California, Davis

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