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Letter to the Editor

Four cases of aggressive MRSA wound infection following head and neck surgery

Dear Sir,

We read with interest the report of four cases of aggressive methicillin resistant *Staphylococcus aureus* (MRSA) infection following head and neck surgery by Parton *et al.* (*JLO* **111:** 874–876). We have recently treated two patients who, following major head and neck surgery, developed MRSA infection, causing significant skin loss adjacent to their tracheostomes. In addition to delaying their discharge from hospital, this delayed the use of a Blom-Singer valve for phonation.

The first patient was a 58-year-old man who developed local recurrence of a T4N1 squamous cell carcinoma of the right side of his tongue base, previously treated by radiotherapy. He underwent partial glossectomy, total laryngectomy with primary tracheo-oesophageal puncture, right modified radical neck dissection and left supra-omohyoid neck dissection with a radial forearm free flap reconstruction of the floor of mouth. Routine swabs showed his trachea to be colonized with MRSA and he was transferred to an isolation ward and barrier nursed. He made a slow but steady recovery until the 21st post-operative day when the inferior margin of his tracheostome began to break down exposing tracheal cartilage, which was partially excised. The skin graft donor site on this left thigh and grafted left forearm were slow to heal. Swabs from all three sites grew MRSA. On the advice of the microbiology department, he was treated with topical and systemic fucidic acid. His stoma and thigh have healed satisfactorily but his forearm has yet to heal completely.

The second patient was a 59-year-old man who underwent total laryngectomy with primary tracheo-oesophageal puncture following recurrence of a T1N0 squamous cell carcinoma of the left vocal fold, previously treated by radiotherapy. Routine swabs also showed his trachea to be colonized with MRSA and he was transferred to an isolation ward and barrier nursed. On the 11th post-operative day, he was noted to have an infection around the suture securing the feeding tube passing through the tracheo-oesophageal puncture. The infection rapidly spread to his tracheostome resulting in an area of skin loss of 3 cm x 3 cm at its inferior margin. Swabs grew MRSA and on the advice of the microbiology department, he was treated with topical fucidic acid and systemic vancomycin. The infection resolved rapidly. Although we expected that the area of skin loss would require a skin graft, it is healing well by secondary intention.

Both patients received prophylactic cefuroxime and metronidazole to reduce the risk of wound infection. This combination covers standard strains of *Staph. aureus* but not MRSA. Moreover, colonization with MRSA occurred post-operatively as MRSA was not cultured from routine pre-operative swabs taken from both patients. As with the cases described by Parton *et al.* MRSA infection in our patients appeared relatively late following surgery, after 11 and 21 days respectively. It is, therefore, unlikely that perioperative anti-MRSA antibiotic prophylaxis would have prevented these infections.

As a consequence of our recent experience and the cases reported by Parton *et al.* we have changed our policy with regard to MRSA in major head and neck cases. If routine pre- and post-operative swabs show evidence of colonization with MRSA, we intend to institute treatment with appropriate anti-MRSA antibiotics after consultation with our microbiology department. We believe that this is necessary in order to reduce the risk of the serious consequences of overt MRSA infection.

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Erratum

A Letter to the Editor was printed in *JLO* **110:** 1188–1190 in which the name and address of the author was inadvertently omitted. The letter commenting on the paper Analysis of CT scanning referrals for chronic rhinosinusitis was written by Rajesh S. Kakani, MD, Division of Otolaryngology, T19 Health Sciences Center, Stony Brook, NY 11749-8191, USA. We apologize for any inconvenience this may have caused.