

MRSA

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IMPORTANT

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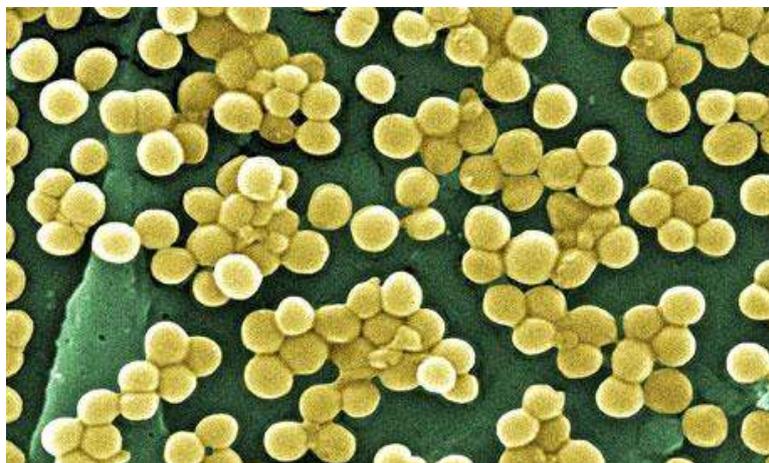
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Introduction

MRSA (Methicillin-resistant *Staphylococcus aureus*) is a bacterium responsible for several difficult-to-treat infections in humans. It is also called multidrug-resistant *Staphylococcus aureus* and oxacillin-resistant *Staphylococcus aureus* (ORSA).

MRSA is any strain of *Staphylococcus aureus* that has developed, through the process of evolution, resistance to beta-lactam antibiotics, which include the penicillins (methicillin, dicloxacillin, nafcillin, oxacillin, etc.) and the cephalosporins.

Staphylococcus aureus (also known as staph) is a common type of bacteria, which is often carried on the skin, inside the nostrils and the throat, and can cause mild infections of the skin, such as boils and impetigo.



MRSA bacteria magnified by a scanning electron micrograph.

*Deaths linked to the bacterium dropped by
25% between 2010 and 2011.*

S. aureus (Staphylococcus aureus) is the cause of skin infections such as boils, pimples, impetigo, and skin abscesses, and is a common cause of wound infections.

If staph bacteria get into a break in the skin, they can cause life-threatening infections, such as blood poisoning or an infection of the inner lining of the heart (endocarditis).

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MRSA infection

Infections with MRSA are usually associated with high fevers and signs of the infection. Most commonly these are infections of the skin and soft tissues (like boils and abscesses).

Less commonly, MRSA can cause pneumonia and urine infections.

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How serious is an MRSA infection?

MRSA strains of bacteria are no more aggressive or infectious than other strains of *S. aureus*. However, infections are much more difficult to treat because many antibiotics do not work against MRSA.

Infections with MRSA can sometimes become more severe than they may otherwise have been if the cause of the MRSA infection is not diagnosed early and an antibiotics is not effective was given at first.

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How is MRSA contracted?

MRSA infections are more common in people who are in hospital or nursing homes. Medical authorities often refer to this as healthcare-associated MRSA (or HA-MRSA).

Hospital patients are especially at risk because:

- They often have an entry point for the bacteria to get into their body, such as a surgical wound, burn or an intravenous drip.
- They are often older and weaker, and thus are more vulnerable to infection.
- They are surrounded by a large number of other sick people, which means bacteria can easily spread through direct contact with other patients, staff, or contaminated surfaces.

MRSA is also known to develop outside hospitals and nursing homes. This is known as community-associated MRSA (or CA-MRSA). This is more common in crowded environments where there is frequent skin-to-skin contact and poor hygiene, such as homeless shelters, hostels, and military bases.

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Complementary Treatment

IMPORTANT NOTE

**Any treatment should be selected in consultation
with a qualified health practitioner**

Tissue Salts (Acute - 4 tabs hourly - alternated; then 4 tabs, 4 x daily until condition is resolved:

- Ferr Phos
- Calc Sulph
- Silica

Homeopathy:

- belladonna

Supplements:

Activated charcoal caps/tabs - 4 x caps/tabs every hour for 4 hours; then 4 x caps/tabs, 4 x daily for 14 days (before or after meals).

Garlic Oil Caps (High Strength) - 1250 mg, 1-2 x cap, 4 x daily for 14 days

Acidophilus - 1 x cap of 1-2 billion CFU (Colony Forming Unit), 3 x daily

Vit C - 1,000 mg, 3 x daily

Vit B Complex - 100 mg daily

Zinc - 25 mg daily

Selenium - 75-100 ug daily

Omega 3 Fish Oil Cap - 1,000 mg daily

Omega 6 Oil of Evening Primrose Cap - 2,000 mg daily (Starflower Oil Caps may be substituted)

Echinacea Cap - 400 mg, 1 x cap, 2 x daily for 14 days

Swedish Bitters - 20 ml, 3-4 x daily

Aromatherapy oil

Tea Tree - applied topically and used with a steam inhaler

Lavender - applied topically and used with a steam inhaler

Sage - used with a steam inhaler

Other

Albas Oil - used with a steam inhaler

Hydrogen Peroxide therapy

When indicated, Hydrogen Peroxide therapy is strongly recommended.

3% for topical application; and as per therapist's direction when taken orally.

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Allopathic Treatment

Minor skin infections may not require any treatment other than the draining of any pus from the infection site.

More serious infections are treated with antibiotics that MRSA has not yet developed a resistance to.

The selected antibiotic will depend on the specific strain of MRSA involved.

Depending on the severity of the symptoms, the patient may need to have a much longer course of treatment compared to a normal staph infection.

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How do bacteria become resistant to antibiotics?

Antibiotic resistance can occur in several ways:

- Strains of bacteria can mutate and over time and become resistant to a specific antibiotic.
- If a patient has been treated with an antibiotic, it can destroy many of the harmless strains of bacteria that live in and on the body. Consequently, this allows resistant bacteria to quickly multiply and take their place.
- The overuse of antibiotics in recent years has played a major part in antibiotic resistance. This includes using antibiotics to treat minor conditions that would have got better anyway or not finishing a recommended course of antibiotics.

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MRSA Deaths

364 deaths in England and Wales were linked to methicillin-resistant *Staphylococcus aureus* (MRSA) in 2011, down from 485 the previous year.

The resistant strain accounted for 57% of all such cases where *S. aureus* was mentioned, up from 50% in 2010.

638 English and Welsh death certificates mentioned *S. aureus* in 2011, of which almost one in four named the bacterium as the underlying cause of death, according to data released by the Office for National Statistics.

Among deaths mentioning MRSA itself the proportion selected as the underlying cause was 17.86%.

Between 2001 and 2005 there were 6.7 fewer MRSA-related deaths per 100,000 people in the least deprived quintile of England's population than in the most deprived.

For 2006-2010 the gap widened to 8.0 deaths. These figures use age-standardised mortality rates, whereby the observed rates for different age groups are applied to the population in question under the assumption that the same age structure applies.

In the case of England the increase in inequality for death rates between the top and bottom quintiles was statistically significant, in that there was no overlap between the 95% confidence interval ranges for each five year period.

In Wales the gap widened from 7.5 more deaths per 100,000 to 8.7, but was not statistically significant, as the 95% confidence interval ranges for difference in death rate in 2001-05 and 2006-2010 overlapped.

The number of death certificates mentioning MRSA has fallen steadily over the last five years. 2011's total is less than a quarter of the corresponding figure for 2007.

The proportion of all deaths mentioning *S. aureus* in which the methicillin-resistant strain has been named has varied considerable over the same period. It rose to 82% in 2008, fell in 2009 and 2010 and then increased in the latest set of figures.

Where MRSA has been mentioned in a death certificate, the proportion of cases in which it was the underlying cause has fluctuated around 18% since 2008.

Similarly, identifications of *S. aureus* as the underlying cause of death have remained steady at around 24% of all mentions of the bacterium since 2009.

Mortality rates have been consistently higher among males than females for both *S. aureus* and MRSA since such figures were first recorded, but rates across both genders and bacteria fell in 2011.

The death rate for males where *S. aureus* was mentioned fell 30% year-on-year from 13.8 per million to 9.8, and by a fifth for MRSA from 6.8 to 5.4.

Among females the rate for *S. aureus* dropped by 41% from 8.2 per million to 4.8, and by a third from 3.7 to 2.4 for MRSA.

Between 2007 and 2011 mortality rates increased with age for both gender and both bacteria. For males, the mortality rate ranged between 2.3 (*S. aureus*) and 4.3 (MRSA) per million for under 45s, but rose to 411.2 (MRSA) and 524.5 (*S. aureus*) for those aged 85 and over.

For females the mortality rates for under 45s were 1.7 (*S. aureus*) and 0.5 (MRSA), rising to 197.5 (MRSA) and 256.6 (*S. aureus*).

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Summary

Age-standardised mortality rates for deaths mentioning <i>Staphylococcus aureus</i> and MRSA, England and Wales, 1993 to 2011 (rate per million population)				
Year	<i>Staphylococcus aureus</i> , Males	<i>Staphylococcus aureus</i> , Females	MRSA, Males	MRSA, Females
1993	8.8	5.1	1	0.4
1994	7.9	5.8	1.7	0.8
1995	12.5	6.4	4	1.7
1996	14.7	7.6	5.7	2.6
1997	14.7	8.4	7.3	3.6
1998	16	9.4	7.6	3.8
1999	18.5	9.5	9	4.1
2000	21.5	10.7	12.2	5.9
2001	21.8	11.8	12.7	6.5
2002	22.6	11	14.6	6.9
2003	24.2	13.9	16.6	8.8
2004	26.9	14.1	19.4	9
2005	32.6	19.4	25.8	14.4
2006	35.7	18	26.8	13.2
2007	33.8	16.7	26.3	11.8
2008	22.3	13.3	18.2	10.3
2009	19.2	10.9	11.7	5.9
2010	13.8	8.2	6.8	3.7
2011	9.8	4.8	5.4	2.4

Source: ONS - Adapted from <http://www.guardian.co.uk/news/datablog/2012/aug/22/mrsa-related-deaths-fall-but-poor-still-worst-affected>

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