Module I

EPIDEMIOLOGICAL SURVEILLANCE OF HEALTHCARE-ASSOCIATED INFECTIONS
Acknowledgements

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Table of Contents

I. INTRODUCTION AND RATIONALE page 7

1 Evaluation of programs for the prevention and control of healthcare-associated infections in Latin America page 7

2 Core components of programs for the prevention and control of healthcare-associated infections page 8

3 Burden of disease and proposal page 10

II. SURVEILLANCE METHODOLOGY page 13

1 Minimum capacity of participating hospitals page 14

2 Device-associated hospital infection 16

III. INFECTIONS SUBJECT TO SURVEILLANCE page 19

1 Pneumonia (PNEU) page 19

2 Urinary Tract Infection (UTI) page 29

3 Bloodstream Infection (BSI) page 33

IV. INDICATORS page 39

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAC</td>
<td>laboratory-confirmed bloodstream infection</td>
</tr>
<tr>
<td>BAL</td>
<td>bronchoalveolar lavage</td>
</tr>
<tr>
<td>BSI</td>
<td>blood stream infection</td>
</tr>
<tr>
<td>CPAP</td>
<td>continuous positive airway pressure</td>
</tr>
<tr>
<td>PSB</td>
<td>protected-specimen brushing</td>
</tr>
<tr>
<td>IUC</td>
<td>indwelling urinary catheter</td>
</tr>
<tr>
<td>CVC</td>
<td>central venous catheter or central line</td>
</tr>
<tr>
<td>FIO2</td>
<td>fraction of inspired oxygen</td>
</tr>
<tr>
<td>ET-CPAP</td>
<td>endotracheal continuous positive airway pressure</td>
</tr>
<tr>
<td>IPPB</td>
<td>intermittent positive pressure breathing</td>
</tr>
<tr>
<td>MINI BAL</td>
<td>synonym for NB-BAL</td>
</tr>
<tr>
<td>NB-BAL</td>
<td>nonbronchoscopic bronchoalveolar lavage</td>
</tr>
<tr>
<td>ml</td>
<td>milliliter</td>
</tr>
<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
</tr>
<tr>
<td>PaO2</td>
<td>partial pressure of oxygen in arterial blood</td>
</tr>
<tr>
<td>P-BAL</td>
<td>protected bronchoalveolar lavage</td>
</tr>
<tr>
<td>PMN</td>
<td>polymorphonuclear leukocyte</td>
</tr>
<tr>
<td>ICU</td>
<td>intensive care unit</td>
</tr>
<tr>
<td>CFU/ml</td>
<td>colony forming units per milliliter</td>
</tr>
<tr>
<td>MV</td>
<td>mechanical ventilation</td>
</tr>
<tr>
<td>* PEEP</td>
<td>positive end-expiratory pressure</td>
</tr>
<tr>
<td>RSV</td>
<td>respiratory syncytial virus</td>
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</table>
Introduction and Rationale

1 / Evaluation of programs for the prevention and control of healthcare-associated infections in Latin America

In order to improve country capacity to detect and respond effectively and quickly to infectious disease, the Pan American Health Organization (PAHO) has worked in the Region of the Americas to strengthen epidemiological surveillance systems for both health-facilities and laboratories.

Between 2006 and 2007, PAHO, in partnership with national experts, conducted an assessment of the status of programs for the prevention and control of healthcare-associated infections in 67 hospitals in seven countries in the Region (1). As a result of that evaluation, the countries adopted measures to improve their programs. PAHO is addressing the issue at the Regional level.

Epidemiological surveillance and the diagnosis of healthcare-associated infections (HAIs) were among the areas found to require additional attention. Issues with diagnosis were affecting intervention measures, which were implemented based on flawed data. An analysis of surveillance indicator data obtained through the evaluations revealed that these intervention measures needed improvement in over half of participating institutions.

Epidemiological surveillance in hospitals generates data on the principal problems of infectious etiology present at each facility, and on invasive procedures primarily associated with these
In 2008, the World Health Organization convened a meeting of experts on the control of healthcare-associated infections in order to identify core components of national and healthcare facility-based programs for the prevention and control of healthcare-associated infections (2). The group concluded that the core components of such a program are: organization, technical guidelines, trained human resources, surveillance of healthcare-associated infections, assessment of compliance with international recommendations, support from microbiology laboratories, the environment, program evaluation, and collaboration with public health or other services. Following the meeting, the issue of healthcare-associated infection surveillance regained international visibility.

With regard to surveillance, the group of experts recommended that national health authorities should collect and document data available on healthcare-associated infections; define national objectives for surveillance efforts; establish priorities for surveillance of healthcare-associated infections and pathogens; determine what data should be provided to the health authority and in what form; and comply with reporting requirements of stakeholders regarding the national state of healthcare-associated infection and during special disease events. National health authorities would also be responsible for standardizing case definitions and surveillance methods, and promoting the assessment of infection prevention practices and other relevant processes.

In addition, the principal duties of each healthcare facility are to document the state of healthcare-associated infections and processes related to their prevention and control; define institutional objectives for surveillance that align with national objectives; establish priorities for surveillance according to the scope of care provided by the facility; determine what data must be collected; apply existing national definitions and methods; detect outbreaks and coordinate an appropriate response; promote practices for the prevention and control of healthcare-associated infections and related aspects of organizational culture without retaliation; and produce and disseminate information on healthcare-associated infections and other related events to local stakeholders and health authorities.

2 / Core components of programs for the prevention and control of healthcare-associated infections*

* Any further mention of infection in this document refers to healthcare-associated infection (HAI).
It is recommended that, with modifications appropriate to the Region, the definitions and criteria of the United States Centers for Disease Control and Prevention (CDC)* be used, given that they are widely known and have a long history of use.

Several experts in the prevention and control of healthcare-associated infections in the Region of the Americas collaborated with PAHO during the development of this proposal in order to guarantee its applicability and usefulness.

3 / Burden of disease and proposal

In the Americas, the burden of disease from healthcare-associated infections is unknown. The data available are from targeted studies that reflect specific situations in healthcare facilities or, at best, in some countries. The availability of data in the Region varies dramatically. Some countries have very good surveillance of healthcare-associated infections in healthcare facilities, but do not have national data; others have data from healthcare facilities and national data; and others have neither structured surveillance in healthcare facilities nor data at the national level. As a result of this wide range of situations, the impact of actions in the Region cannot be adequately evaluated.

Because of this, and with the aim of strengthening the capacity of healthcare facilities and local and national governments to identify outbreaks and to understand the burden of disease caused by healthcare-associated infections, a surveillance system for these infections and methods for its implementation are proposed. The system will be flexible enough that each country can determine its priorities with regard to the infections and pathogens to monitor, and will provide case definitions and instruments for the active surveillance of infections. Instruments will be offered for systematic evaluation of efforts to prevent and control healthcare-associated infections, with the aim of detecting and promptly responding to outbreaks.

* Available at http://www.cdc.gov/ncidod/dhqp/pdf/nnis/NosInfDefinitions.pdf

Surveillance Methodology

Place: All information reported through this surveillance system will come from intensive care units.

Country capacity: In order to participate, countries must have the capacity to collect and analyze data. To this end, it is essential that they have professionals who are devoted to collecting and analyzing data provided by hospitals, and who can make decisions about the problems detected. Countries that already have their own surveillance system with definitions and information systems are requested to provide those national definitions to PAHO.

Healthcare-associated infections: A healthcare-associated infection is an infection that is not present or incubating at the time of admission to a healthcare setting, but which is observed during the patient’s hospital stay or after the patient’s time of discharge.

Healthcare-associated infections in the intensive care unit (ICU): A healthcare-associated infection that was not present or incubating at the time of admission to the ICU that might be associated with a patient’s stay in the ICU, and might be detected after discharge from the ICU.

Healthcare-associated infection in the ICU and associated with an invasive procedure: A healthcare-associated infection that was not present or incubating at the time of admission to the ICU and that might be associated with a patient’s stay in that unit and with invasive procedures undergone during the patient’s stay.
Microbiological data should be analyzed by unit of care where the infection was identified.

1 / Minimum capacity of participating hospitals

Intensive care unit: In order to be included in reporting systems, a hospital must have at least one intensive care unit. For this purpose, an intensive care unit is defined as the hospital unit in which beds are reserved for the care of critically ill patients who require specialized medical and nursing care 24 hours a day, in addition to specialized life-support equipment (3). This excludes intermediate therapies (without mechanical respiratory assistance).

Program for the prevention of healthcare-associated infections: Hospitals should also have a program for the prevention and control of healthcare-associated infections that is responsible for setting policy, objectives, strategies, and legal and scientific bases for the prevention and control of hospital infections. The program will also be responsible for the surveillance of those infections. The hospital program should have qualified, dedicated staff with defined responsibilities and duties, and have a budget sufficient to meet the tasks programmed in their work plans (2).

Trained local staff: The responsibilities of these staff members are to detect cases (numerators) and identify the exposed population (denominators), keep records, and consolidate and analyze collected data. In general, these duties are carried out by nursing personnel dedicated to infection control, although other clinicians familiar with the topic may participate depending on the organization of the facility or hospital and of the surveillance system. The following is a more detailed list of the responsibilities of staff dedicated to the monitoring and control of healthcare-associated infections:

1. Review the charts of patients with exposure factors in order to detect infections.
2. In the event that an infection is suspected, use case definition criteria to classify it as such, if appropriate.
3. Record infection information for all confirmed cases (numerators): pneumonia, urinary tract infection, or bloodstream infection (dates and etiologic agents).
4. For patients with confirmed HAI record epidemiological information in order to establish numerators: patient identification, name, hospital identification, bed, primary underlying disease (ICD-9 or ICD-10) (optional), sex, age, date of ICU admission, date of ICU discharge, reason for discharge, and length of exposure to mechanical ventilation, indwelling urinary catheter, or central venous catheter. Keep information for later consolidation.

The professional in charge of surveillance should have the time necessary to perform tasks and receive training. The time that surveillance activities require depends on the number of patients and the quality of records kept by the facility or hospital, as well as on the frequency of surveillance rounds in the intensive care units. There is no universal, precise ratio of minutes per patient. This decision is generally made locally. However, experience has shown that 15 to 20 minutes per inpatient per week, with at least two weekly rounds, may be required. In other words, a 10-bed ICU could require between 150 and 200 dedicated minutes per week.
2 / Device-associated hospital infection

Methodology: Surveillance of device-associated infections in intensive care units should be active, selective, prospective, and patient-based.

Case-finding: A properly trained infection prevention and control professional will identify patients suspected of having a device-associated infection and collect the corresponding denominator data.

Numerator: The infection prevention and control professional will find infections incurred during the patient’s stay using different sources, including: temperature charts, antibiotic use, cultures performed, physician’ instructions, and the suspicion of attending clinicians.

Monitoring of any HAI is no longer required after the patient is discharged from the ICU.

Case confirmation: In patients suspected of having a device-associated infection, the infection prevention and control professional will confirm the infection based on case definition criteria using: records from the laboratory, pharmacy, patient admission, discharge, and transfer, and radiology (imaging); pathological anatomy databases and patient charts, including interviews, physical exam notes, and notes taken by physicians and nurses (4). Laboratory surveillance data should not be used in isolation, unless all possible criteria for diagnosing an infection are determined by laboratory evidence alone.

The collection of data on the infection should be completed for all confirmed cases (numerators) — pneumonia, urinary tract infection, or bloodstream infection (dates and etiologic agents) — on the form in Appendix 1 and titled, FORM FOR

Devices inserted outside the unit under surveillance:
Infections that develop within 48 hours of a patient’s arrival and that are related to devices inserted outside the intensive care unit will NOT be counted in the numerator.

Retrospective chart reviews should be used only when patients have been discharged before all necessary information can be obtained. Use the attached form (Appendix 1) to record the data.

Frequency of surveillance: It is recommended that surveillance be carried out in intensive care units at least twice a week. Data should be consolidated monthly for the hospital’s use, and forwarded to the Ministry of Health following its analysis. The Ministry of Health should ensure that all hospitals providing data do so in a standardized way and according to a regular timetable.
Infections Subject to Surveillance

1 / Pneumonía (PNEU)

Pneumonia is diagnosed through a combination of radiologic, clinical, and laboratory criteria. The following paragraphs describe the various assessment criteria that may be used for meeting the surveillance definition of nosocomial pneumonia. For cases of ventilator-associated pneumonia, a patient has to be intubated and ventilated at the time of onset of symptoms, or have been ventilated up to 48 hours prior to the onset of infection.

**NOTE:** There is no minimum length of time the mechanical ventilator has to be in place for the pneumonia to be associated with mechanical ventilation. Cases of infection should be analyzed on a case by case basis. Mechanical ventilation can be associated with infection even if it was in place over 48 hours before the onset of infection.

**Setting:** Pneumonia surveillance will be conducted in the ICU. Monitoring of ventilation-associated pneumonia is no longer required after the patient is discharged from the ICU.

**Requirements:** Surveillance of ventilator-associated pneumonia should be conducted in at least one ICU in the healthcare facility. Ideally, monitoring should be conducted year-round. However, if surveillance is scheduled to occur only during specific periods, monitoring should take place during at least one calendar month.
Criteria for defining nosocomial pneumonia

General comments

1. Physician’s diagnosis of pneumonia alone is **not** an acceptable criterion for nosocomial pneumonia.

2. Although there are specific criteria for infants and children, pediatric patients are included and may meet any of the other pneumonia-specific criteria.

3. Ventilator-associated pneumonia should be so designated when reporting data.

4. When assessing a patient for the presence of pneumonia, it is important to distinguish between changes in clinical status due to other conditions, such as myocardial infarction, pulmonary embolism, respiratory distress syndrome, atelectasis, malignancy, chronic obstructive pulmonary disease, hyaline membrane disease, bronchopulmonary dysplasia, etc. Also, care must be taken when assessing intubated patients to distinguish between tracheal colonization, upper respiratory tract infections (e.g. tracheobronchitis), and early-onset pneumonia. Finally, it should be recognized that it may be difficult to determine nosocomial pneumonia in the elderly, infants, and immunosuppressed patients since such conditions may mask typical signs and symptoms associated with pneumonia.

5. Nosocomial pneumonia can be characterized by its onset: early or late. Early onset pneumonia occurs during the first four days of hospitalization, and is often caused by strains of *Moraxella catarrhalis, Haemophilus influenzae, and Streptococcus pneumoniae*. Causative agents of late-onset pneumonia are frequently gram-negative bacilli or Staphylococcus aureus, including methicillin-resistant S. aureus. Viruses (e.g. Influenza A and B or Respiratory...
Syncytial Virus) can cause early and late onset nosocomial pneumonia, whereas yeasts, fungi, legionellae, and *P. jirovecii* are usually pathogens of late-onset pneumonia.

6. Positive Gram stain for bacteria and positive potassium hydroxide (KOH) mount for elastin fibers and/or fungal hyphae from appropriately collected sputum specimens are important clues that point toward the etiology of the infection. However, sputum samples are frequently contaminated with airway colonizers and therefore must be interpreted cautiously. In particular, *Candida* is commonly seen on stain, but infrequently causes nosocomial pneumonia.

7. Pneumonia due to gross aspiration is considered nosocomial if it meets the aforementioned criteria, and was not clearly present or incubating at the time of admission to the hospital.

8. Multiple episodes of nosocomial pneumonia may occur in critically ill patients with lengthy hospital stays. When determining whether to report multiple episodes of nosocomial pneumonia in a single patient, look for resolution of the initial infection. The addition of or change in pathogen alone is not indicative of a new episode of pneumonia. The combination of new signs and symptoms and radiographic evidence, or other diagnostic testing is required.

### Pneumonia case definition for surveillance

<table>
<thead>
<tr>
<th>Criterion 1:</th>
</tr>
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<tbody>
<tr>
<td>a) Radiological data: Two or more serial chest x-rays with at least one of the following (1, 2):</td>
</tr>
<tr>
<td>- New or progressive and persistent infiltrate</td>
</tr>
<tr>
<td>- Consolidation</td>
</tr>
<tr>
<td>- Cavitary</td>
</tr>
<tr>
<td>b) At least one of the following signs or symptoms:</td>
</tr>
<tr>
<td>- Fever (&gt;38°C with no other recognized cause)</td>
</tr>
<tr>
<td>- Leukopenia (&lt;4000 WBC/mm$^3$)</td>
</tr>
<tr>
<td>- Leukocytosis (&gt;12,000 WBC/mm$^3$)</td>
</tr>
<tr>
<td>- For adults &gt;70 years, altered mental status with no other recognized cause, and</td>
</tr>
<tr>
<td>- At least two of the following:</td>
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<tr>
<td>- New onset or worsening cough, or dyspnea, or tachypnea (5)</td>
</tr>
<tr>
<td>- Worsening gas exchange (e.g. $O_2$ desaturations (e.g. PaO$_2$/FiO$_2$ &lt; 240)) (7), increased oxygen requirements, or increased mechanical ventilator demand</td>
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</tbody>
</table>

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22. **Epidemiological Surveillance**

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**MODULE I**

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23.
**Criterion 2:**

**a)** Radiological data: Two or more serial chest radiographs with at least one of the following (1,2):
- New or progressive and persistent infiltrate
- Consolidation
- Cavitation

*(NOTE: In patients without underlying pulmonary or cardiac disease (e.g. respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable (1)).*

**b)** At least one of the following signs or symptoms:
- Fever (>38 °C) with no other known cause
- Leukopenia (<4000 WBC/mm$^3$) or leukocytosis (>12,000 WBC/mm$^3$)
- For adults >70 years old, altered mental status with no other recognized cause, and

**c)** At least one of the following:
- New onset of purulent sputum (3), or change in character of sputum (4), or increased respiratory secretions, or increased suctioning requirements
- New onset or worsening cough, or dyspnea, or tachypnea (5)
- Rales (6) or bronchial breath sounds
- Worsening gas exchange [e.g. $O_2$ desaturations (e.g. $PaO_2/FiO_2 <240$)] (7), increased oxygen requirements, or increased mechanical ventilator demand, and

**d)** At least one of the following laboratory findings:
- Positive growth in blood culture (8) not related to another source of infection
- Positive growth in culture of pleural fluid
- Positive quantitative culture (9) from minimally contaminated lower respiratory tract specimen (e.g. bronchoalveolar lavage or protected specimen brushing)
- ≥5% bronchoalveolar lavage-obtained cells contain intracellular bacteria on direct microscopic exam (e.g. Gram stain)
- Histopathologic exam shows at least one of the following evidences of pneumonia:
  - Abscess formation or foci of consolidation with intense polymorphonuclear leukocyte (PMN) accumulation in bronchioles and alveoli
  - Positive quantitative culture (9) of lung parenchyma
  - Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae
NOTES:

1. Occasionally, in nonventilated patients, the diagnosis of nosocomial pneumonia may be quite clear on the basis of symptoms, signs, and a single definitive chest radiograph. However, in patients with pulmonary or cardiac disease (e.g., interstitial lung disease or congestive heart failure), the diagnosis of pneumonia may be particularly difficult. Other noninfectious conditions (e.g., pulmonary edema from decompensated congestive heart failure) may simulate the presentation of pneumonia. In these more difficult cases, serial chest radiographs must be examined to help separate infectious from noninfectious pulmonary processes. To help confirm difficult cases, it may be useful to review radiographs on the day of diagnosis, three days prior to the diagnosis, and on days two and seven after the diagnosis. Pneumonia may have rapid onset and progression, but does not resolve quickly. Radiographic changes of pneumonia persist for several weeks. As a result, rapid radiographic resolution suggests that the patient does not have pneumonia, but rather a noninfectious process, such as atelectasis or congestive heart failure.

2. Note that there are many ways of describing the radiographic appearance of pneumonia. Examples include, but are not limited to, “air-space disease”, focal opacification, and patchy areas of increased density. Although perhaps not specifically delineated as pneumonia by the radiologist, in the appropriate clinical setting, these alternative descriptive wordings should be seriously considered as potentially positive findings.

3. An adequate sample for culture in an immunocompromised patient is one with a Gram stain of ≥25 neutrophils and ≤10 squamous epithelial cells per low power field (x100).

4. A single notation of either purulent sputum or change in character of the sputum is not meaningful; repeated notations over a 24-hour period would be more indicative of the onset of an infectious process. Change in character of the sputum refers to color, consistency, odor, and quantity.

5. In adults, tachypnea is defined as respiration rate >25 breaths per minute. Tachypnea is defined as >75 breaths per minute in premature infants born at <37 weeks gestation and until the 40th week; >60 breaths/minute in patients <2 months old; >50 breaths/minute in patients 2-12 months old; and >30 breaths/minute in children >1 year old.

6. Rales may be described as “crackles”.

7. This measure of arterial oxygenation is defined as the ratio of the arterial tension (PaO₂) to the inspiratory fraction of oxygen (FiO₂).

8. Care must be taken to determine the etiology of pneumonia in a patient with positive blood cultures and radiographic evidence of pneumonia, especially if the patient has invasive devices in place such as intravascular lines or a urinary catheter. In general, in an immunocompromised patient, blood cultures positive for coagulase-negative staphylococci, common skin contaminants, and yeasts will not be the etiologic agent of the pneumonia.

9. Once laboratory-confirmed cases of pneumonia due to respiratory syncytial virus (RSV), adenovirus, or influenza virus have been identified in a hospital, a clinician’s presumptive diagnosis of these pathogens in subsequent cases with similar clinical signs and symptoms is an acceptable criterion for presence of hospital infection.

10. Scant or watery sputum is commonly seen in adults with pneumonia due to viruses and Mycoplasma although sometimes the sputum may be mucopurulent. In infants, pneumonia due to RSV or influenza yields copious sputum. Patients, except premature infants, with viral or mycoplasmal pneumonia may exhibit few signs or symptoms even when significant infiltrates are present on radiographic exam.

11. Few bacteria may be seen on stains of respiratory secretions from patients with pneumonia due to Legionella spp., mycoplasma, or viruses.

12. Immunocompromised patients include those with neutropenia (absolute neutrophil count <500/mm³), leukemia, lymphoma, HIV with CD4 count <200, or splenectomy; those who have had a recent transplant; and those who are on cytotoxic chemotherapy or on daily doses of steroids for >2 weeks (e.g. >20mg prednisone or its equivalent).

13. Blood and sputum specimens must be collected within 48 hours of each other.

14. Semiquantitative or nonquantitative cultures of sputum obtained by deep cough, induction, aspiration, or lavage are acceptable. If quantitative culture results are available, refer to algorithms that include such specific laboratory findings.
Data analysis: The rate of ventilator-associated pneumonia per 1,000 mechanical ventilator-days is calculated by dividing the number of cases of ventilator associated pneumonia by the number of mechanical ventilator-days and multiplying the result by 1,000. These calculations are performed separately for each ICU.

2 / Urinary Tract Infection (UTI)

Urinary tract infections are diagnosed through a combination of clinical and laboratory criteria. UTIs will be counted only for patients with an indwelling urinary catheter or an infection related to its use; in other words, the patient had a urinary catheter inserted at the time of, or within seven days before, the onset of infection.

NOTE: There is no a minimum length of time that the catheter has to be in place for a UTI to be considered catheter-associated.

For the purposes of hospital infection surveillance systems, case definitions for urinary tract infections are divided into symptomatic and asymptomatic infections. In this proposal, only data on symptomatic urinary tract infections will be compiled.

Setting: Surveillance will take place in the intensive care units. Monitoring of patients following their discharge from the ICU is not required.

Requirements: Surveillance for urinary tract infection is performed in at least one ICU in the healthcare facility for at least one calendar month. Ideally, monitoring should be conducted year-round. However, if surveillance is scheduled to occur only during specific periods, monitoring should take place during at least one calendar month.

### Collection of culture specimens* used in the diagnosis of pneumonia, and threshold values

<table>
<thead>
<tr>
<th>Specimen type</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung parenchyma (open lung biopsy specimens and immediate post-mortem specimens obtained by transthoracic or transbronchial biopsy)</td>
<td>≥10⁴ CFU/g tissue</td>
</tr>
<tr>
<td>Endotracheal aspirate</td>
<td>10⁴ o 10⁵ CFU</td>
</tr>
<tr>
<td>Bronchoscopically (B) obtained specimens</td>
<td></td>
</tr>
<tr>
<td>- Bronchoalveolar lavage (B-BAL)</td>
<td>≥10⁴ UFC/ml</td>
</tr>
<tr>
<td>- Protected bronchoalveolar lavage (BP-BAL)</td>
<td>≥10⁴ UFC/ml</td>
</tr>
<tr>
<td>- Protected specimen brushing (B-PSB)</td>
<td>≥10⁴ UFC/ml</td>
</tr>
<tr>
<td>Non-bronchoscopically (NB) obtained (blind) specimens</td>
<td></td>
</tr>
<tr>
<td>- NB-BAL or MINI BAL</td>
<td>≥10⁴ UFC/ml</td>
</tr>
<tr>
<td>- NB-PSB</td>
<td>≥10⁴ UFC/ml</td>
</tr>
</tbody>
</table>

* For specimen collection techniques, see Appendix 7.

Numerator data: The form included in Appendix 1 is used to collect and report on every case of ventilator-associated pneumonia that is identified during the month selected for surveillance. The form includes patient demographic information and information regarding the use of mechanical ventilation. Additional data include whether the patient died, the what microorganisms were isolated from cultures and their antimicrobial susceptibilities. (See Section II on surveillance methodology.)

Denominator data: The number of patients managed with a ventilation device is collected on the Appendix 2. The patient count is obtained daily. The sum of these daily counts is reported monthly. The data are compiled separately for each intensive care unit identified. (See Section II on surveillance methodology.)
Definitions

Indwelling urinary catheter (IUC): A drainage tube that is inserted into the urinary bladder through the urethra, is left in place, and is connected to a closed collection system; also called a Foley catheter. Does not include straight in-and-out catheters.

Closed urine collection system: A closed system that does not allow any type of disconnection (bag-tube) no matter how brief. Systems remain connected even during urine removal or specimen collection.

Urinary Tract Infection Case Definition

A symptomatic urinary tract infection must meet at least one of the following criteria:

Criterion 1:

a) Clinical data: at least one of the following signs or symptoms with no other recognized cause:
   - fever (>38 °C)
   - urgency (urinary)
   - increased urinary frequency
   - dysuria or suprapubic tenderness, and

b) The following laboratory criterion:
   - positive urine culture (i.e., >10^5 microorganisms/cm^3 of urine with no more than two species of microorganisms).
   -
**Numerator data:** The form included in Appendix 1 is used to collect the information and report each urinary tract infection that is identified during the month selected for surveillance. The UTI form includes patient demographic information and information on whether or not a urinary catheter was present. Additional data include whether the patient died, what microorganisms were isolated from cultures and their antimicrobial susceptibilities. (See Section II on surveillance methodology.)

**Denominator data:** The number of patients managed with an indwelling urinary catheter is collected on Appendix 2. The patient count is obtained daily. The sum of these daily counts is reported monthly. The data are compiled separately for each intensive care unit identified. (See Section II on surveillance methodology.)

**Data analysis:** The urinary tract infection rate per 1,000 catheter-days is calculated by dividing the number of infections by the number of catheter-days and multiplying the result by 1,000. This calculation is performed separately for each intensive care unit.

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**3 / Bloodstream Infection (BSI)**

Bloodstream infections are classified according to clinical and laboratory criteria, either as laboratory-confirmed bacteremia (BAC) or clinical sepsis (CSEP). A bloodstream infection is considered either primary or secondary depending on whether it is caused by an infection at another site. For surveillance, only laboratory-confirmed, primary, intravascular catheter-associated bacteremia will be recorded.
Setting: Surveillance will occur in intensive care units. Monitoring of bloodstream infections after the patient is discharged from the ICU is not required.

Requirements: Surveillance for bloodstream infection in at least one ICU in the healthcare institution for at least one calendar month. Ideally, monitoring should be conducted year-round. However, if surveillance is scheduled to occur only during specific periods, monitoring should take place during at least one calendar month. Only bloodstream infections associated to central catheter are reported.

Definitions

Primary BSI: BSI not related to an infection at another site.

Central line-associated BSI: Primary BSI in a patient with a central line or catheter in place at the time of detection or no more than 48 hours before the onset of infection.

NOTE: There is no required minimum length of time the central line must be in place for the infection to be considered central line-associated.

Central line (CVC): An intravascular catheter that terminates at or close to the heart or in one of the great vessels that is used for infusion, withdrawal of blood, or hemodynamic monitoring. The following are considered great vessels for the purpose of reporting central-line infections and counting central-line days: aorta, pulmonary artery, superior vena cava, inferior vena cava, brachiocephalic veins, internal jugular veins, subclavian veins, external iliac veins, and common femoral veins.

Temporary central line: A non-tunneled catheter.

Permanent central line: Includes tunneled catheters, including dialysis catheters, and implanted catheters, including port-a-cath.

NOTES:
1. An introducer is not considered an intravascular catheter.
2. Neither the location of the insertion site nor the type of device may be used to determine if a line qualifies as a central line. The device must terminate in one of the great vessels or in or near the heart to qualify as a central line.
3. Pacemaker wires and other nonlumened devices inserted into central blood vessels or the heart are not considered central lines, because fluids are not infused, pushed, or withdrawn through such devices.

Infusion: The introduction of a solution through a blood vessel via a catheter lumen. This may include drip phleboclysis, as in the case of nutritional fluids or medications, or intermittent infusions such as flushes or intravenous antimicrobial administration, or blood, in the case of transfusion or hemodialysis.
**Numerator data:** The form included in Appendix 1 includes patient demographic information and information on the patient's stay in the ICU. The form is also used to record whether the patient died, what microorganisms were isolated from blood cultures and their antimicrobial susceptibilities. (See Section II on surveillance methodology.)

**Denominator data:** Denominator data are collected using the form included in Appendix 2. Since the patient may have more than one bloodstream infection (BSI) during their stay, data need to be recorded for all blood lines during the patient's entire stay in the ICU. (See Section II on surveillance methodology.)

---

### Bacterrmia* Definition Criteria

Laboratory-confirmed bacteremia must meet at least one of the following criteria:

**Criterion 1:**

a) A pathogen was identified in one or more blood cultures of the patient, except for common skin contaminants (see Criterion 2 below), and

b) The microorganism cultured from the blood is not related to infections at other sites.

**Criterion 2:**

a) Clinical data: patient has at least one of the following signs or symptoms with no other recognized cause:
   - fever (>38 °C)
   - chills
   - hypotension, and

b) Positive laboratory results are not related to an infection at another site, and

c) The following laboratory criterion: common skin contaminant (e.g., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group Streptococci, Aerococcus spp., Micrococcus spp.) cultured from **two or more** blood samples drawn on separate occasions. (See Appendix 7 for specimen collection technique.)
## Indicators for Calculating ICU Healthcare Associated Infection Rates

<table>
<thead>
<tr>
<th>Infection and Indicator</th>
<th>Description</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator-associated pneumonia</td>
<td>Incidence of ventilator-associated pneumonia</td>
<td>Number of cases of pneumonia in patients with mechanical ventilation/ Number of mechanical ventilator-days x 1000</td>
</tr>
<tr>
<td>Indwelling urinary catheter associated urinary tract infection</td>
<td>Incidence of indwelling urinary catheter-associated urinary tract infections</td>
<td>Number of urinary tract infections in patients with indwelling urinary catheters/ Number of IUC-days x 1000</td>
</tr>
<tr>
<td>Central venous catheter-associated bloodstream infection</td>
<td>Incidence of central venous catheter-associated bloodstream infection</td>
<td>Number of bloodstream infections in patients with central venous catheter/ Number of central venous catheter-days x 1000</td>
</tr>
</tbody>
</table>
Infections subject to surveillance:
1. Mechanical ventilator-associated pneumonia
2. Indwelling urinary catheter-associated symptomatic urinary tract infection
3. Central venous catheter-associated, laboratory-confirmed bloodstream infection.

Data: Data will only be collected from intensive care units during the patient’s stay; infections occurring after the patient’s discharge from the ICU will not be counted, even if they are related to the patient’s stay in the intensive care unit. Microbiology data are compiled separately for each intensive care unit identified.

Numerator: Numerators will be collected in the intensive care unit at least twice per week through active surveillance under the responsibility of the infection prevention and control team. The following information should be recorded for all confirmed cases (numerators): pneumonia (date and etiologic agent), urinary tract infection (date and etiologic agent), bloodstream infection (date and etiologic agent). These data will be recorded on the form in Appendix 1.

Denominator: Denominator data to be used for calculating rates will be: mechanical ventilation days; indwelling urinary
catheter days; central venous catheter days; and total patient days per month and per intensive care unit.

**Information system:** The information system has three levels: first, the local level, or healthcare facility; second, the national health authority; and third, the Pan American Health Organization.

**Hospital:** The hospital is responsible for compiling the data (numerator and denominator), for its analysis, and for calculating indicators. Analysis should be conducted by the surveillance unit or the intensive care unit, preferably monthly. The hospital should send aggregate data for mechanical ventilation-associated pneumonia, indwelling urinary catheter-associated urinary tract infection, and central venous catheter-associated bloodstream infection to the health authority on a monthly basis. The hospital will fill out the form in Appendix 1.

The patient should be monitored until departure from the intensive care unit. Data from the form will be entered into the computer program to produce the necessary reports (Appendix 3).

The hospital will send data from the Table for Submission of Data to Health Authorities (Appendix 3) to the health authority, preferably monthly.

**Health authority:** The health authority will receive the aggregated information from each hospital, on the form in Appendix 3. The information will be the sum of the data collected from all of the intensive care units in the hospital within a given time period. The health authority should determine the frequency with which data should be sent from each hospital. We recommend, at a maximum, quarterly reports.

The health authority will receive the hospital’s identification and demographic data and:

- Incidence density for indwelling urinary catheter-associated urinary infections
- Incidence density for central venous catheter-associated bloodstream infections
- Incidence density for mechanical ventilation-associated pneumonias

With this information, the health authority can calculate the 10th, 25th, 50th, 75th, and 90th percentiles for each of the rates of infection under surveillance Appendix 4. It is recommended that this analysis be done monthly in addition to an annual report.

**Pan American Health Organization:** PAHO requests that the national health authority send the annual data on the form included in Appendix 5 (Form for Submission of Data to the Pan American Health Organization). Together with the data, health authorities should provide the hospital infection definitions being used in the country and the demographic information requested in Appendix 4.


## Appendix 1. Form for Device-Associated Infection Monitoring

### Numerator and Denominator Collection Form

<table>
<thead>
<tr>
<th>Infection</th>
<th>Date of EICU start: (dd/mm/yyyy)</th>
<th>Date of EICU ends: (dd/mm/yyyy)</th>
</tr>
</thead>
</table>

#### Patient identification:
- Name:
- Gender: (F) or (M)

#### Date of ICU start:
- (dd/mm/yyyy)

#### Date of ICU ends:
- (dd/mm/yyyy)

#### IUC days:

#### Symptomatic Urinary tract infection?
- YES(1)/NO(0)

#### UTI date:

#### Etiological agent:

#### Bloodstream infection (BSI):
- Central venous catheter? YES(1)/NO(0)

#### Date of CVC start: (dd/mm/yyyy)

#### Date of CVC ends: (dd/mm/yyyy)

#### CVC days:

#### Bloodstream infection? YES(1)/NO(0)

#### Date of BSI:

#### Date of BSI ends: (dd/mm/yyyy)

#### BSI days:

#### Bloodstream infection?
- YES(1)/NO(0)

#### BSI date:

#### Etiological agent:

### Pneumonia (PNEU): Mechanical Ventilation

#### Date of MV start: (dd/mm/yyyy)

#### Date of MV ends: (dd/mm/yyyy)

#### MV days:

#### Pneumonia? YES(1)/NO(0)

#### Pneumonia date:

#### Etiological agent:

### Urtinary tract infection (UTI): Indwelling urinary catheter

#### Date of IUC start: (dd/mm/yyyy)

#### Date of IUC ends: (dd/mm/yyyy)

#### IUC days:

#### Symptomatic Urinary tract infection?
- YES(1)/NO(0)

#### UTI date:

#### Etiological agent:

### Bloodstream infection (BSI):
## Appendix 2. Denominators

<table>
<thead>
<tr>
<th>Month/Day</th>
<th># paciente w/ CVC</th>
<th># paciente w/ IUC</th>
<th># paciente w/ MV</th>
<th># Patient</th>
</tr>
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<tbody>
<tr>
<td>15</td>
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<td>16</td>
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<td>31</td>
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<td>Total</td>
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</table>
### Appendix 3. Healthcare-Associated Infections Data Collection Table-Hospital

<table>
<thead>
<tr>
<th>Year</th>
<th>Intensive care unit</th>
<th>Number of mechanical ventilation associated pneumonia</th>
<th>Number of indwelling urinary catheter associated urinary tract</th>
<th>Number of central venous catheter associated bloodstream infection</th>
<th>Ventilation-days</th>
<th>CVC-days</th>
<th>IUC-days</th>
<th>Total patient-days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Incidence</th>
<th>PNEU/MV</th>
<th>BAC/CVC</th>
<th>UTI/IUC</th>
<th>% USE MV</th>
<th>% USE CVC</th>
<th>% USE IUC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Hospital</td>
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</tbody>
</table>
## Appendix 4. Healthcare-Associated Infections Data Collection Table—Ministry of Health

<table>
<thead>
<tr>
<th>Year/Month</th>
<th>Hospital name</th>
<th>Number of mechanical ventilation associated pneumonia</th>
<th>Number of indwelling urinary catheter associated urinary tract infections</th>
<th>Number of central venous catheter associated bloodstream infection</th>
<th>ventilation-days</th>
<th>CVC-days</th>
<th>IUC-days</th>
<th>Total patient-days</th>
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<td>Total Country</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Incidence</th>
<th>PNEU/MV</th>
<th>BAC/CVC</th>
<th>UTI/IUC</th>
<th>% USE MV</th>
<th>% USE CVC</th>
<th>% USE IUC</th>
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<thead>
<tr>
<th>Total Country</th>
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</tbody>
</table>
### Annual Country Report

<table>
<thead>
<tr>
<th>Country:</th>
<th>Total population:</th>
<th>Year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of hospitals reporting:</td>
<td>Number of ICUs:</td>
<td></td>
</tr>
</tbody>
</table>

**Administrative category:**
- Number of public hospitals:
- Number of private hospitals:
- Number of university hospitals:
- Number of other:

<table>
<thead>
<tr>
<th>Total number of beds:</th>
<th>Laboratory:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of intensive care unit (ICU) beds:</td>
<td>Number of isolates/year:</td>
</tr>
<tr>
<td>Number ICU/adults:</td>
<td>Number of antibiograms/year:</td>
</tr>
<tr>
<td>Number ICU/pediatrics:</td>
<td></td>
</tr>
<tr>
<td>Number ICU/neonatology:</td>
<td></td>
</tr>
</tbody>
</table>

### Healthcare-associated infections in ICU

<table>
<thead>
<tr>
<th>Infectious Category</th>
<th>Year</th>
<th>10</th>
<th>25</th>
<th>50</th>
<th>75</th>
<th>90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical ventilation-associated pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indwelling urinary catheter-associated urinary tract infection</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Central venous catheter-associated bloodstream infection</td>
<td></td>
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</tr>
</tbody>
</table>
### Appendix 6. Etiologic Agents of Health-Associated Infections and Antibiotic Susceptibility Profile of Microorganisms

<table>
<thead>
<tr>
<th>Microorganism Code</th>
<th>Microorganism and resistance profile</th>
<th>Number of isolates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Pneumonia</td>
</tr>
<tr>
<td>1</td>
<td>Acinetobacter baumanii imipenem-resistant</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Candida albicans</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Candida non albicans</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Candida sp (fill only when no species is identified by the laboratory)</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Escherichia coli resistant to third generation cephalosporins</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Enterococcus sp vancomycin-resistant</td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Klebsiella pneumoniae resistant to third generation cephalosporins</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Pseudomonas spimipenem-resistant</td>
<td></td>
</tr>
<tr>
<td>64</td>
<td>Staphylococcus aureus oxacillin-resistant</td>
<td></td>
</tr>
<tr>
<td>65/66</td>
<td>S. epidermidis and other oxacillin-resistant coagulase-negative staphylococcus</td>
<td></td>
</tr>
</tbody>
</table>
With an endotracheal aspirate, the sample is taken by aspiration of respiratory secretions through the endotracheal tube using a DeLee trap. The trap, which holds the sample, is sent to the laboratory. No saline solution should be instilled, since its introduction would dilute the secretions and alter the bacterial count. A sample can also be taken through a tracheostomy. In the absence of a DeLee trap, a suction catheter can be used, and the sample obtained sent to the laboratory in a sterile container. The suction tube should not be sent to the laboratory.

Label the sample, indicating the suspected diagnosis and the antimicrobial drugs the patient is receiving. Do not refrigerate the sample, and transport it immediately to the laboratory.

All endotracheal aspirates should be processed for bacterial count, which should be included in the laboratory report.

**Bronchoalveolar Lavage (BAL)**

Bronchoalveolar lavage is an invasive procedure for obtaining a sample, which means that an exhaustive search for microorganisms is justified regardless of the quality of the sample (1). This sample is obtained by a specialist. The method is used to wash cells in airways that cannot be accessed through the use of a bronchoscope. The goal is to wash the affected lobe, although bilateral washing increases the likelihood of recovery of certain pathogens. In addition to being particularly useful for diagnosing ventilator-associated pneumonia in patients with mechanically assisted ventilation, it is also useful in HIV or AIDS cases and, to a lesser extent, for patients with pneumonia (2,3,4). A BAL procedure requires the following:

1. A double-lumen bronchoscope with a telescoping double catheter and a distal polyethylene glycol plug for collecting the wash. The involved area of the lung should be accessible.
2. Lidocaine (2%) for anesthesia, delivered locally through the lumen of the fibroscope.
3. Ringer's lactate or saline solution for washing.
4. A Lukens trap in which to place the sample.
5. An intravenous sedative to improve the patient’s tolerance of the procedure.
The advantage of this technique is that it does not require the use of a fibrobronchoscope. It is offered as an alternative to other techniques for the diagnosis of ventilator-associated pneumonia. According to a study by Rouby (5), the usefulness of mini-BAL for diagnosing ventilator-associated pneumonia was found to be low. The procedure has an LR+ of 2.2 and an LR- of 0.43 and lacks the reliability of endotracheal aspirates, bronchoalveolar lavage, and protected bronchial brushing.

**Protected Bronchial Brushing (PBB):**

This procedure is similar to the bronchoalveolar lavage, with the exception that the bronchoscope is advanced through a double-sheathed, balloon-tipped, plugged catheter. The previously inflated balloon tip is used to protect the sample from possible contamination by flora in the upper respiratory tract (6,7).

- Insert the cytology brush into the channel opening of the bronchoscope and advance the brush through it.
- Remove the plug at its tip and insert the catheter into the infected area. Collect the sample and remove the catheter.
- Place the entire brushing unit in a transport medium, which can be lactated Ringer’s solution or saline (1ml).
- Send to the laboratory.
- For pediatric patients, proceed as with adults.

**Lung Biopsy:**

Histopathological studies of the lung have been considered the gold standard by a majority of studies that have evaluated the success of diverse diagnostic methods for ventilator-associated pneumonia (2). Notwithstanding, the reproducibility of this method has been drawn into question given the lack of agreement in the histopathological results produced by the same operator or those of three different technicians (8). The method can be performed through a needle biopsy or an open biopsy. In the former, either a computerized tomography or thoracic cavity x-ray can be used to identify the exact location of the biopsy. The latter takes place in an operating room under general anesthesia.
Appendix 7. Specimen Collection (Continued)

**Needle Biopsy:**
If the biopsy is conducted using computerized tomography, the patient must remain horizontal during the exam. A lung biopsy can also be conducted by pricking the patient during a bronchoscopy or mediastinoscopy.

The skin is cleansed and local anesthesia injected. The patient is asked to remain still and without coughing for the duration of the biopsy. A small incision of approximately 3 mm is made in the skin. The biopsy needle is inserted into the pulmonary tissue.

A small tissue sample is collected with the needle and sent to a laboratory for analysis. Send one pulmonary tissue fragment in formaldehyde (10%) for histopathological study and another in saline solution for microbiological study.

Pressure is applied to the site and, once the bleeding has stopped, a bandage is applied. An x-ray of the thoracic cavity is taken immediately after the biopsy.

The procedure normally takes between 30 and 60 minutes. The laboratory analysis can take a few days.

**Open Biopsy:**
A catheter is inserted through the patient’s oral cavity to the airways. After cleaning the patient’s skin, the surgeon makes an incision in the thorax, removes a small amount of lung tissue, and sutures the incision. Chest tubes may remain in place for one or two days in order to prevent the lungs from collapsing. There is both a risk of infection, and a risk that air may leak into the thorax through a puncture, which depends on whether the patient does or does not already have pulmonary disease.

**Transport and Conservation of Respiratory Samples:**
Endotracheal aspirate samples should be sent to the laboratory in a DelEe trap; BAL samples should be sent in Lukens traps; mini-BAL samples should be sent in a sterilized container; and bronchial brushing samples sent protected in 1 ml saline solution or lactated Ringer's solution. If no traps are available, samples may be sent in sterilized, well-sealed, screw-top containers within two hours of having been collected. Biopsy tissue samples should be divided into two; one fraction should be sent to the laboratory in 10% formaldehyde for histopathological study, and the other, in saline solution for microbiological study (9).

**URINARY TRACT INFECTION**

**Patients with bladder catheter:**
In patients with an indwelling catheter, urine will be taken with a sterile needle and syringe. The catheter and the closed system are emptied and then clamped for 5 minutes, subsequently disinfecting with alcohol an appropriate area to puncture. The area is punctured with the needle and syringe, and approximately 10 ml of urine are extracted. Urine should be taken by aspiration with a needle from a disinfected point in the connection, but not from the collection bag, or by disconnecting the catheter from the collection tube. If no place for puncturing exists on the extension, the catheter is punctured at its softest spot with a needle and syringe. Approximately 10 ml of urine are extracted. If a catheter is used, do not send the tip of the Foley catheter for culture (10).

It is preferable to obtain the sample from the first urine voided in the morning (1). At this time the bacterial count will be higher, since bacteria can multiply as they incubate overnight (every 20 minutes). Otherwise, wait 4 hours after the patient’s last voiding before collecting the sample. Urination should not be forced with liquids, but if it is, it should be stated on the order sheet. Urine collected
Appendix 7. Specimen Collection (Continued)

Caterización:

Urethral catheterization is recommended as a routine sampling method for urine culture.

1. Personnel taking the sample must wash their hands.
2. External genitalia are washed gently using a wet, soapy compress or gauze.
3. After washing, genitalia are rinsed with water and dried with sterile gauze.
4. The catheter is inserted using aseptic technique.

Sample Transport:

Once the urine sample is collected it should be processed immediately. If this is not possible, the sample may be stored in a refrigerator at 4°C for a maximum of 24 hours. Refrigeration prevents bacterial growth. Collection containers that include preservatives in tablet form are commercially available. If this commercial method is not available, the sample can be preserved in boric acid. Any of these methods can be used if it is inevitable that the sample remain at room temperature for several hours prior to or during transport to the laboratory. Thus, the organism can be preserved without facilitating the growth of contaminants that might have been introduced into the sample.
1. Whenever possible, inform the patient about the procedure.
2. Wash and dry hands properly.
3. Thoroughly cleanse the selected site on the skin with 70% isopropyl or ethyl alcohol.
4. Spread an antiseptic on the site (1-2% iodine tincture, or povidone iodine, or 2% chlorhexidine). Cleansing is done in a circular motion, starting towards the center and moving outward. It is important to allow time for the antiseptic to dry for it to work; do not wipe the area while still wet.
5. Disinfect the rubber stopper on the bottle with alcohol or another antiseptic before puncturing the bottle. Wait for it to dry.
6. Put on sterile gloves.
7. Do not palpate the venipuncture site with fingers, and do not speak or cough while drawing blood. Sometimes palpating the vein cannot be avoided; if is the case, the collector's finger must undergo the same cleansing and disinfection procedure, or sterile gloves must be worn to perform the procedure.
8. Insert the needle into the selected vein to extract the required volume of blood.
9. Once the blood is withdrawn, inoculate the bottle immediately by perforating it vertically with the needle in order to avoid coagulation of the blood in the syringe. Inoculate slowly to prevent hemolysis. If a vacuum extraction system is being used, the blood can directly inoculate the bottles of the automated system. The vacuum in this type of bottle rapidly extracts the contents of the syringe; once the patient has stopped bleeding, withdraw the needle.
10. It is not necessary to replace the needle before inoculating the blood in the bottle (11).
11. Place the cotton ball on the puncture site, maintain pressure for a few minutes, and then apply an adhesive bandage.

The blood sample should be sent to the microbiology laboratory immediately. If this is not possible, it should be incubated at 35°C-37°C. If no stove is available for incubation, it should be left at room temperature (do not refrigerate) until transferred to the laboratory. Samples are transported at room temperature.
The quantity of blood is currently regarded as one of the most critical variables in the increase in positivity of blood cultures (13, 14, 15). Because the majority of bacteremias are of low magnitude (<1 - 10 CFU/ml), higher sample volume leads to greater sensitivity of the blood culture. For each additional ml of sample that is inoculated in the bottle, positivity increases 2%-5%. Mermel and Maki (16) demonstrated a significant reduction (p < 0.001) in blood culture positivity when an average of 2.7 ml (89%) were obtained in comparison with 8.7 ml (92%). The importance of the volume of blood holds even when using automated equipment (15, 17, 18).

The generally accepted volume of culture blood is 10 ml per extraction for adults. In newborns and premature babies, 1 ml; in infants, between 2 and 3 ml; in preschool children and schoolchildren, 3 to 5 ml; and in adolescents, 10 ml (12).

If the patient is taking antimicrobial drugs, blood culture bottles containing resins (automated systems) should be used in order to neutralize the drugs administered to the patient.

The recommendation is for growing two blood cultures in 24 hours with a 30-90 minute interval between them (19, 20). In cases of meningitis or septic shock, a set of two blood cultures with an interval of 30 minutes or less can be taken. If the patient is going to require immediate antimicrobial treatment, two blood cultures can be obtained at the same time, but from different puncture sites.
Bibliography


