Correspondence

Vancomycin resistance among MRSA

Sir,

The study by Thati et al\(^1\) brings to limelight an alarming situation of vancomycin resistance in methicillin resistant Staphylococcus aureus (MRSA) in south India. There are certain points mentioned in the article which need clarification.

(i) The authors have not mentioned how they screened the isolates for MRSA. There is no point in testing oxacillin and methicillin together and they require a different temperature of incubation.

(ii) DNA extraction step in the PCR could have been elaborated.

(iii) How did the authors validate the PCR? There is no mention of running a positive control.

(iv) It is absurd to mention that MRSA isolates were also resistant to cefazidime. MRSA by definition are considered resistant to all beta-lactam antibiotics irrespective of the zones of inhibition.

(v) The authors mention that all vancomycin resistant S. aureus (VRSA) isolates were inducible for clindamycin resistance but the Table shows that two of the isolates (VRSA3 & VRSA6) were susceptible to erythromycin. How did authors determine inducible resistance to clindamycin when the isolates were susceptible to erythromycin?

(vi) How was the presence of mecA (PCR or latex agglutination) confirmed?

(vii) The authors have described an alarming situation but fail to suggest an alternative for treatment. They should have tested linezolid and quinupristin/dalfopristin and reported their sensitivity.

(viii) The authors have done MIC of vancomycin but failed to mention the MIC\(_{90}\) and MIC\(_{50}\) values.

(ix) The authors should have highlighted the presence or absence of MIC creep in their isolates.

(x) The authors should have determined the correlation between the diameters of vancomycin disc diffusion and MIC especially when they were in the intermediate range.

(xi) The authors have not mentioned about the VISA strains or their PCR results?

(xii) The authors should have mentioned the clinical source of at least the VISA and VRSA isolates.

V. Anil Kumar
Department of Microbiology
Amrita Institute of Medical Sciences
Ponekara, Kochi 682 041, Kerala, India
vanilkumar@aiims.amrita.edu

Reference

Authors’ response

Sir,

We thank the author to point out certain queries on our article\(^1\) and would like to present the following clarifications:

(i) MRSA were isolated and confirmed by both phenotypic and genotypic methods as per CLSI guidelines. Since, MRSA is not the main topic of our paper, we did not mention MRSA screening in detail. Oxacillin and methicillin have not been tested together.
The PCR work was done at Bio-serve Biotechnologies, Hyderabad. They have isolated DNA by using standard kit methods.

The primers used by us were of Biswajit *et al*.

They have validated the primers.

True, but we have tested the antibiogram of the isolates using different antibiotics and reported the same.

True, no new methods were followed for inducible clindamycin test for Ery resistance isolates.

*mecA* has been detected by PCR.

True, but we have not concentrated on the treatment aspects. We agree, suggestions could have been made.

We have not carried out MIC$^{90}$ and MIC$^{50}$.

True, we have not mentioned MIC$^{50}$ and MIC$^{90}$.

This is another aspect.

One VISA strain was isolated; however, it was not used for PCR. The same has been mentioned in the paper.

The clinical source of VRSA isolates has been mentioned in the Table.

**V. Thati, C.T. Shivannavar & S.M. Gaddad***

Department of P.G. Studies & Research in Microbiology, Gulbarga University, Gulbarga 585 106, Karnataka, India  
*For correspondence: smgaddad2009@gmail.com*

**References**
