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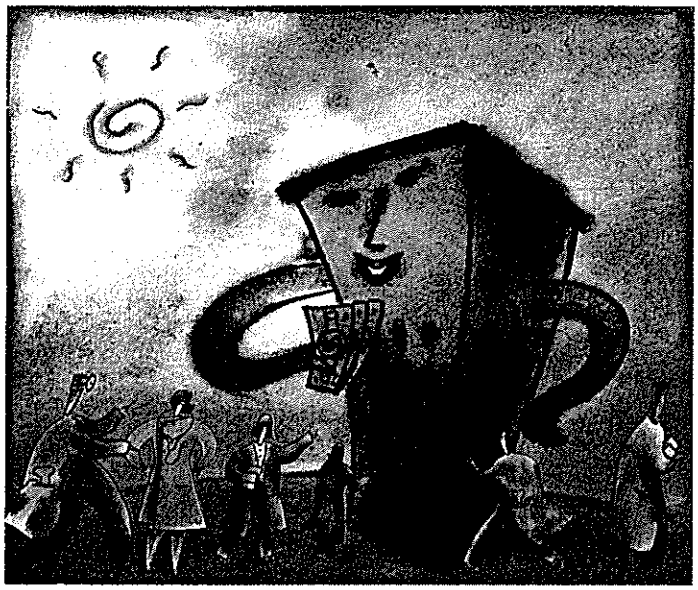

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From the **Editor's Desk**

CONFRONTING CONFLICT OF INTEREST

Recently, a French medical organisation initiated legal action against nine doctors for failing to disclose their relationships with drug and other medical industries. At the same time, federal legislators in the United States are moving to enforce mandatory disclosure of industry gifts and payments to doctors on a public website. Indeed, Senator Chuck Grassley of the Senate Committee on Finance is in open conflict with US medical schools over their non-disclosure of drug-firm gifts and payments to faculty members, and is threatening to withhold federal funds. Such developments are testament to an accelerating campaign to confront conflict of interest.

Earlier this year, the US Institute of Medicine (IOM) released a comprehensive report on conflict of interest, covering medical research, education and practice, as well as individual and institutional circumstances. The report advanced wide-ranging recommendations for the handling of conflict of interest in order to "protect the integrity of professional judgment and to preserve public trust". Closer to home, the National Health and Medical Research Council (NHMRC) is currently reviewing its policy on conflict of interest.

It is perhaps surprising that a profession which prides itself on ethical performance should continue to be plagued by lack of transparency in this one area.

But history repeatedly attests to the lure of financial advantage. The IOM has thus recommended that Congress enact legislation requiring companies and their foundations to publicly report payments and gifts made to both individuals and institutions, whether they be physicians or non-physicians prescribing drugs or using medical devices, biomedical researchers, professional societies, continuing medical education providers, or specific patient advocacy groups.

Sadly, our approach to conflict of interest is hopelessly fragmented. The time has come for rhetoric to give way to binding recommendations based on the US model. To make this happen, we need committed leadership and a national organisation with clout.

Martin B Van Der Weyden

LETTERS

SNAPSHOT

CORRECTIONS

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seasonal influenza of 5%–10%,[5] the likelihood of contracting infection while crammed into under-resourced train networks is significant. In the context of an influenza pandemic, with higher attack rates, the risk is even greater.

Substantial community resources have appropriately been invested in pandemic planning and mitigation strategies. Perhaps we should devote some of these resources to public transport services to reduce overcrowding. Our national pandemic plan advises that

> A very simple way of reducing the chances of being infected or passing on infection is to stand or sit back from other people in public or in the workplace. Where possible, you should try to maintain a distance of at least a metre, which is about a large step.[4]

Such advice is impossible to follow on peak-period train services, certainly in Melbourne.

Investment in train services to reduce the spread of infections would not only help delay the onset of the next influenza pandemic, but would also reduce seasonal influenza and other respiratory virus transmission. Furthermore, it could avert injuries and illness due to crushing and overheating/dehydration, and could conceivably reduce the road toll by taking cars off roads during peak hours. Few pandemic influenza planning investments could deliver such diverse public health dividends while we ride out the latest influenza pandemic and await the inevitable next one.

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First clinical case of a locally acquired carbapenem-resistant VIM-1 metallo-β-lactamase in *Pseudomonas aeruginosa* in Australia

John Merlino, Harold W Stokes, Elaine Y-L Cheong and Thomas Gottlieb

To the Editor: Nosocomial infections caused by *Pseudomonas aeruginosa* often prove difficult to treat because of their resistance to multiple drugs. Carbapenems play a pivotal role in the management of severe multidrug-resistant gram-negative Enterobacteriaceae and *P. aeruginosa* infections. However, reports in Australia of carbapenem resistance due to production of a variety of carbapenemases, including metallo-β-lactamases (MBLs), have been increasing alarmingly.[1,2] We wish to report the first clinical case of a VIM-1-producing MBL in Sydney. To our knowledge, this is the first reported locally acquired case of a *P. aeruginosa* strain producing acquired VIM-1 MBL in Australia.

The patient was an 81-year-old man with chronic rheumatoid arthritis, managed with prednisone. He had a prosthetic knee infection that was first diagnosed in 1997 and, because of multiple recurrences, had been managed with oral moxifloxacin since 2003. The patient had not travelled outside the Sydney area since before his knee surgery. He was hospitalised in November 2005, when he underwent repair of a colovesical fistula. Carbapenem-resistant *P. aeruginosa* was isolated repeatedly from both urine and sputum cultures from December 2005 until February 2008, when further testing was performed using newly available molecular real-time polymerase chain reaction (PCR) technology with VIM generic and specific primers and DNA sequencing. This testing detected a VIM-1 gene.

The *P. aeruginosa* isolates were routinely screened for antibiotic susceptibility. Multiresistance to numerous antibiotic classes was detected, with high minimum inhibitory concentrations for meropenem, gentamicin, ciprofloxacin, ceftazidime, cefepime, piperacillin–tazobactam, and ticarcillin–clavulanic acid. The isolates were susceptible to polymyxin B and aztreonam, and had intermediate resistance to amikacin.

Multiresistant *P. aeruginosa* is a therapeutic challenge when managing patients with such infections.[3] In the context of facilities such as large burns units or intensive care units, the presence of plasmid-transmissible carbapenem resistance within the gram-negative bacterial population has serious infection control implications. Until novel molecular real-time PCR methods became available, the underlying mechanism of carbapenem resistance in these organisms could not be adequately delineated. The increasing availability of such molecular technology and its routine application in the diagnostic laboratory will support appropriate antibiotic prescribing practices and enhance infection control measures in the hospital setting.

Identification of a plasmid-mediated carbapenem-resistant strain is a concern in our hospital and throughout Australia, as outbreaks of VIM-1 resistance have been reported in Europe and the United States.[4] As demonstrated by our isolates, such strains have a broad spectrum of hydrolytic activity against amino-, carboxyl- and ureido-penicillins, cephalosporins, cephamycins and carbapenems, but not monobactams. Our isolate was susceptible only to polymyxin and aztreonam.

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