found that *Staphylococcus aureus* was the pathogen responsible for bronchopneumonia in approximately 50% of cases in both the placebo and SDD groups. These percentages appear higher than expected for the incidence of pneumonia and for the proportion due to *S aureus*. Would Quinio and colleagues consider the possibility of pneumonia in the placebo groups being contributed to by cross-infection of *S aureus* from the SDD-treated group?22

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REFERENCES


To the Editor:

The incidence of nosocomial pneumonia during mechanical ventilation reported in the literature varies widely, ranging between 18 and 60%.5 In our study,6 we found a global incidence of 51% in the placebo group. It is well known that the risk of nosocomial pneumonia is greater in postoperative patients7 and consequently, surgical and medico-surgical ICUs, such as ours, have a greater incidence. Thus, our patients do not have an incidence which is higher than expected. In multiple-trauma patients, alterations in the physiologic and anatomic defenses predispose to development of pneumonia.8,9 Additionally, treatment with mechanical ventilation increases a patient’s risk of developing pneumonia.10 In these trauma patients there is a considerable influence of the level of consciousness, and the incidence of nosocomial pneumonia is significantly increased among comatose patients (Glasgow coma score ≤9) from 13.3 to 42.2%.11

Multiple trauma is often associated with altered swallowing and depressed gag reflexes associated with altered consciousness. Such patients may aspirate oropharyngeal contents during the process of injury, resuscitation, and early in the emergency department. Furthermore, intubation impairs bronchial clearance mechanisms and increases the risk of aspiration. These mechanisms probably were the most important factors in developing respiratory tract infections in our patients. The most common etiologic agent of nosocomial pneumonia in our study was *Staphylococcus aureus* (approximately 50%), and this is probably explained by oropharyngeal and nasal carriage resulting in colonization of lower airways and later to nosocomial pneumonia. Such a high incidence of *S aureus* was found in another study in multiple-trauma patients.12 *S aureus* was responsible for 45.6%, and in comatose patients the incidence was even higher (55.8 percent). These data agree with previous authors who reported a high incidence of *S aureus* pneumonia in neurosurgical10 and in head trauma patients requiring mechanical ventilation.12 Rello et al13 have recently reported that antecedent of trauma and coma were significantly associated with *S aureus* nosocomial pneumonia. As discussed in the above studies and as shown by our data, a substantial proportion of respiratory tract infections in multiple-trauma patients are caused by *S aureus* and this has nothing to do with the use of selective digestive decontamination (SDD). The data from our control group reflect what is expected in such multiple trauma patients and cross-infection from the SDD-treated group does not seem to be a likely explanation for the high incidence of *S aureus*.

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REFERENCES


Danny’s Liberation on Independence Day

An 18-year-old male was ventilator-dependent for 2 weeks due to traumatic brain damage and gastric aspiration complicated by acute lung injury and bacterial pneumonia. He underwent left-sided craniotomy for acute subdural hematomata, and then right-sided craniotomy for subacute subdural hematoma during this period. His pulmonary status was managed with assist-control ventilation, antibiotics, sedation, hypothermia, and gradual titration of the fractional inspired oxygen concentration. Tracheostomy was performed and brief successful periods of intermittent mandatory ventilation followed by T-piece trials prompted the decision to disconnect the patient from the ventilator. He was switched to a 40% tracheostomy oxygenation collar where he maintained an acceptable pulse oxim-