



Summary Report on Carbapenemase Producing Enterobacterales (CPE)

August 2022

This is a summary report on CPE in Ireland for the period
August 1st 2022 to September 2nd 2022

1. THE REPORT IS BASED LARGELY ON DATA RELATED TO THE HSE ACUTE HOSPITAL OPERATIONS BUT ALSO INCLUDES DATA RELATED TO ISOLATES FROM OTHER ACUTE HOSPITALS AND THE COMMUNITY.



Antimicrobial Resistance &
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Key points.

- There were **109** new CPE patients identified in August 2022.
- This is the highest level of new detections in one month since the reference laboratory was established (see figure 3)
- 24,765 CPE surveillance samples were reported tested in HSE laboratories in July 2022.
- The provisional total of new patients for the first 36 weeks of 2022 is 588. The total for the corresponding period in 2021 was 418.
- This represents a 41% increase in detection in 2022 compared to the corresponding period in 2021
- The increase is not likely to be explained by an increase in sampling.

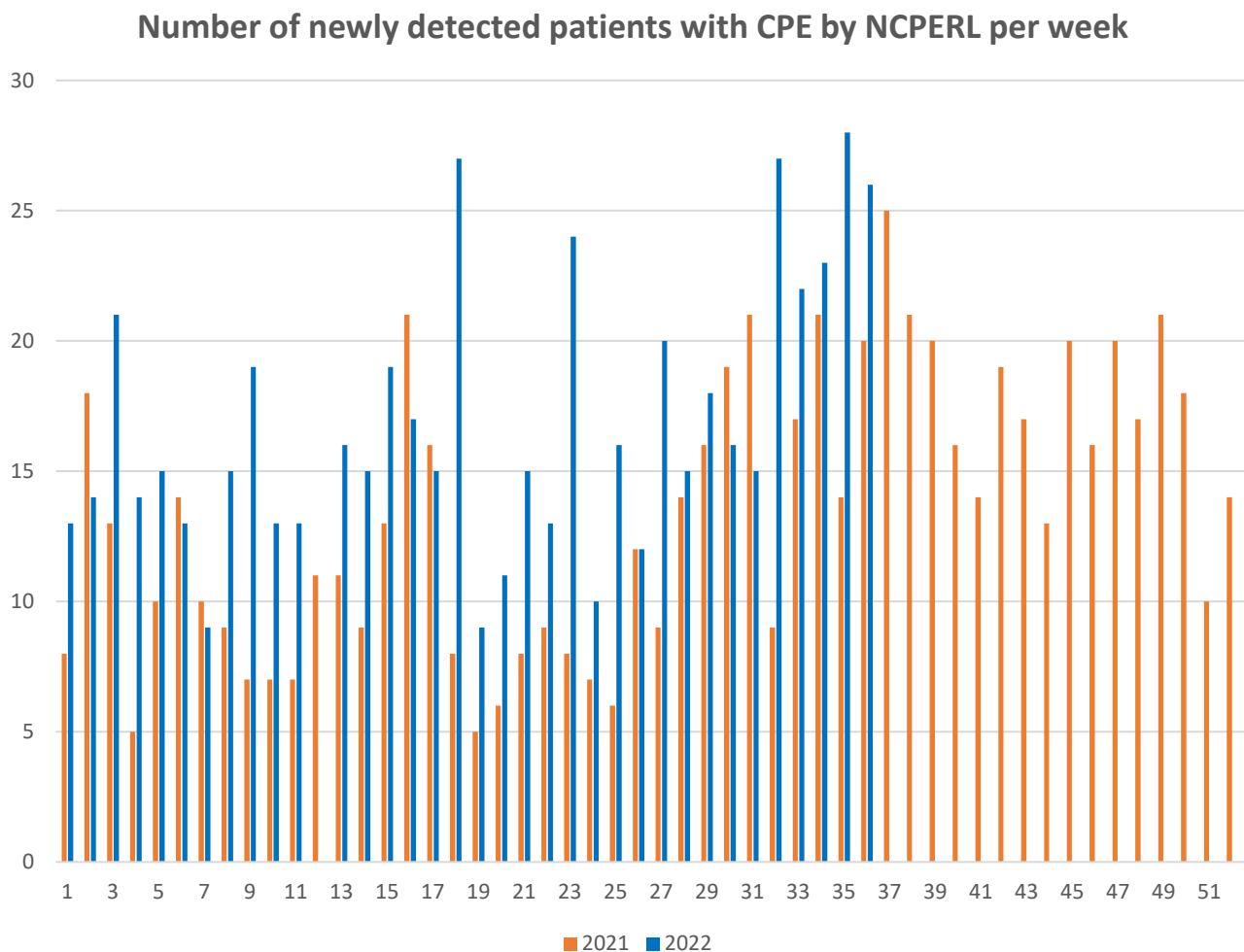
Additional details

Week 32-Week 36 (1st August 2022- 2nd September 2022)

- Total of **177** CPE isolates were received, **126** were newly identified CPE patients in this period.
- 3 Environmental isolates were received.

Figure 1 – Number of newly detected patients with CPE by the National CPE Reference Laboratory Service per week.

This figure is based on data from the National CPE Reference Laboratory Service. It is intended that it be updated monthly.



This figure illustrates the total number of people newly detected with CPE each week in 2021 (orange) and 2022 (blue).

Table 1 - Hospitals with current outbreaks (as per July 2022 return for Business Information Unit (BIU), HSE)

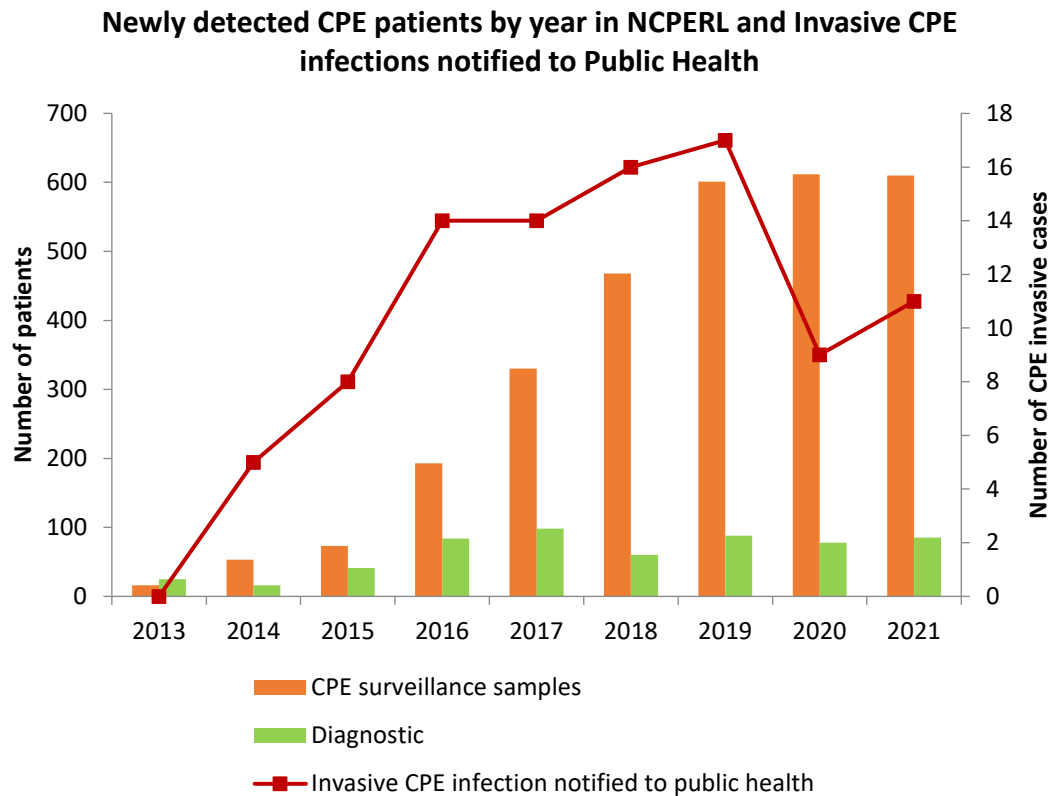
This figure is based on data collated by the HSE Business Information Unit (BIU). It is intended that it be updated monthly.

HOSPITAL GROUP	HOSPITALS REPORTING CPE OUTBREAKS
Children's Hospital Group	No outbreaks reported
Dublin Midlands Hospital Group	No outbreaks reported
Ireland East Hospital Group	St. Luke's Hospital Kilkenny St. Vincent's University Hospital
RCSI Hospital Group	No outbreaks reported
Saolta Hospital Group	Galway University Hospital
South / South West Hospital Group	Mercy University Hospital University Hospital Kerry University Hospital Waterford
University Limerick Hospitals Group	Croom Orthopaedic Hospital University Hospital Limerick

(NOTE: **47 of 50 hospitals** have provided data returns to the question "Do you have an active/current CPE outbreak in your hospital during this month?")

Figure 2 – Number of CPE patients by year by sample site (& Number of invasive CPE cases notified to Public Health)

This figure is based on data from the National CPE Reference Laboratory Service. It is intended that it be updated annually.



Comment: The total number of CPE detected from blood stream infections in 2021 was 11. The total number of CPE detected from blood stream infections in 2020 was 9. However healthcare provision in 2020 was very atypical in the context of the Covid-19 pandemic therefore this change should be interpreted with caution particularly as the number of positive surveillance and diagnostic samples does not show a corresponding decline.

Overall the data to the end of 2019 support a conclusion that measures to control the spread of CPE have been generally effective. The number of invasive CPE (provisional) has fallen and the number of CPE from diagnostic samples is at or close to a plateau level.

This figure illustrates the number of newly detected people with CPE from surveillance samples (orange) and diagnostic samples (green) each year since 2013. The red line illustrates the number of CPE invasive infections (mainly blood stream infections) based on notifications to CIDR. The total number of CPE detected from blood stream infections in 2020 (provisional) was 10 compared with 17 in 2019.

The number of people with CPE first detected from surveillance samples increased each year from 2013 to 2019. The number of people with CPE first detected from diagnostic samples peaked in 2017. Some year to year fluctuation is expected.

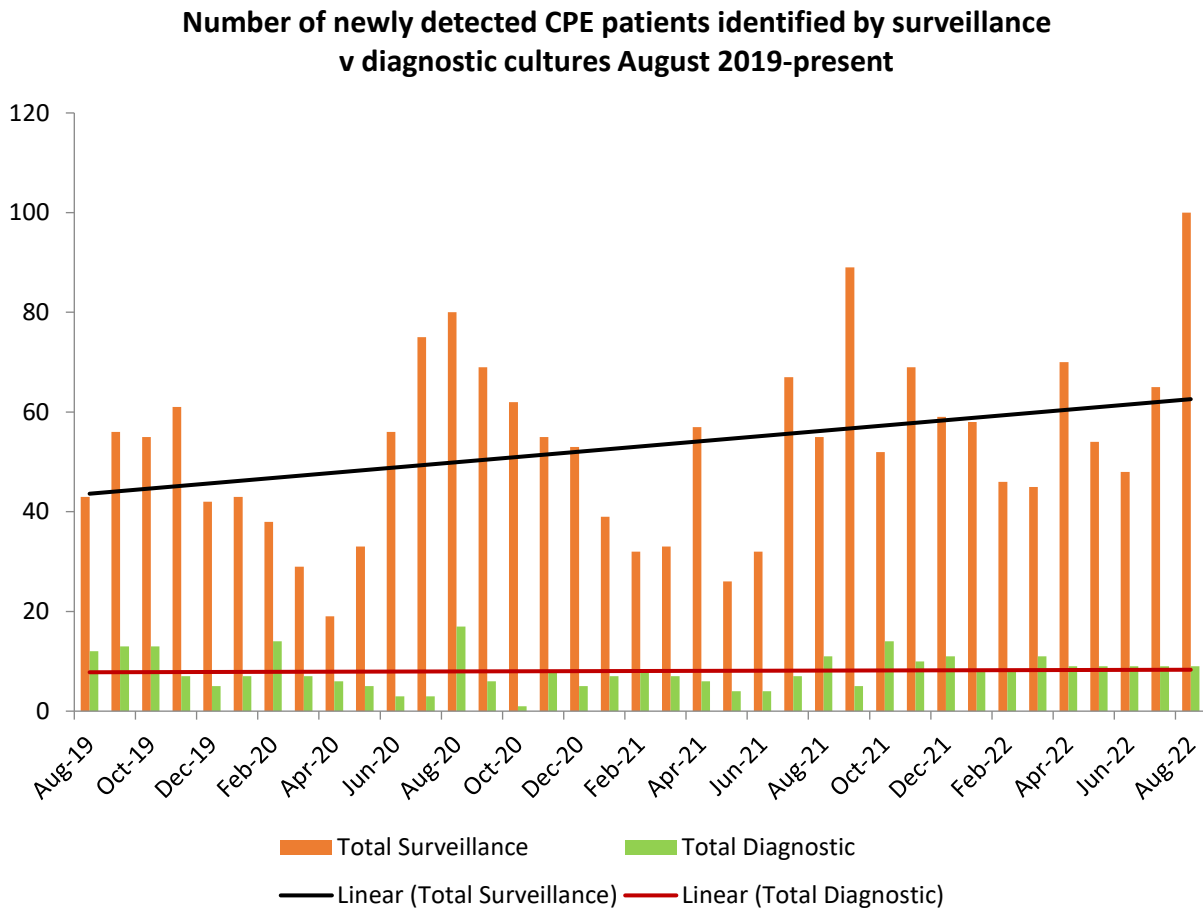
In general isolates from diagnostic samples are likely to reflect clinical infection. Isolates from surveillance samples reflect detection of CPE gut colonisation in the absence of clinical CPE infection.

If most cases of CPE are detected from diagnostic samples this reflects a system in which relatively late detection of people with CPE in the context of clinical infection is the norm because the preceding asymptomatic colonisation is not detected. This would suggest that interventions to control spread are being applied late in most cases.

Detection of most cases of CPE in surveillance samples, as is currently the case, reflects a system in which most people with CPE are detected relatively early in their contact with the healthcare system allowing early application of measures to control spread.

Figure 3 – Total numbers of CPE patients identified by Surveillance and Diagnostic samples for the 3 most recent years.

This figure is based on data from the National CPE Reference Laboratory Service. It is intended that it be updated monthly.



Comment: This figure illustrates the number of newly detected people with CPE from surveillance samples (orange) and diagnostic samples (green) each month since August 2019. The red line illustrates the trend for number of people with newly detected CPE from diagnostic samples. The black line illustrates the trend for number of people with newly detected CPE from surveillance samples.

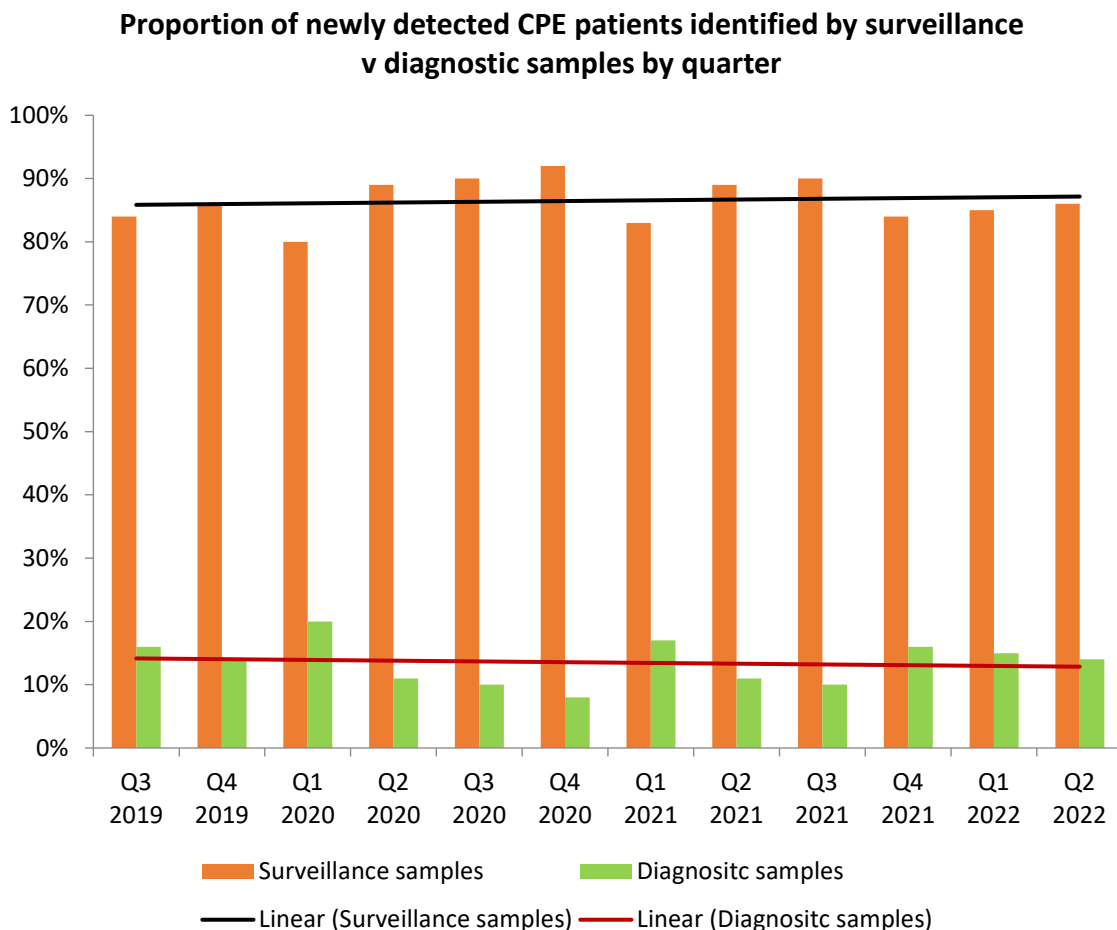
The trend line for people with CPE first detected from surveillance samples shows an upward trend although note that in Figure 4 with data presented by quarter rather than by month the trend line is essentially flat. The number of people with CPE first detected from diagnostic samples is essentially stable. In general isolates from diagnostic samples are likely to reflect clinical infection. Isolates from surveillance samples reflect detection of CPE gut colonisation in the absence of clinical CPE infection.

If most cases of CPE are detected from diagnostic samples this reflects a system in which relatively late detection of people with CPE in the context of clinical infection is the norm because the preceding asymptomatic colonisation is not detected.

Detection of most cases of CPE in surveillance samples reflects a system in which most people with CPE are detected relatively early in their contact with the healthcare system allowing early application of measures to control spread.

Figure 4 – Proportion of CPE isolated from people identified by Surveillance and Diagnostic samples for the 3 most recent years.

This figure is based on data from the National CPE Reference Laboratory Service. It is intended that it be updated quarterly.



Comment: This figure illustrates the percentage of newly detected people with CPE from surveillance samples (orange) and diagnostic samples (green) each quarter for the last 3 years. The red line illustrates the trend for percent of new detections of CPE from diagnostic samples. The black line illustrates the trend for percent of new detections of CPE from surveillance samples.

In general isolates from diagnostic samples are likely to reflect clinical infection. Isolates from surveillance samples reflect detection of CPE gut colonisation in the absence of clinical CPE infection.

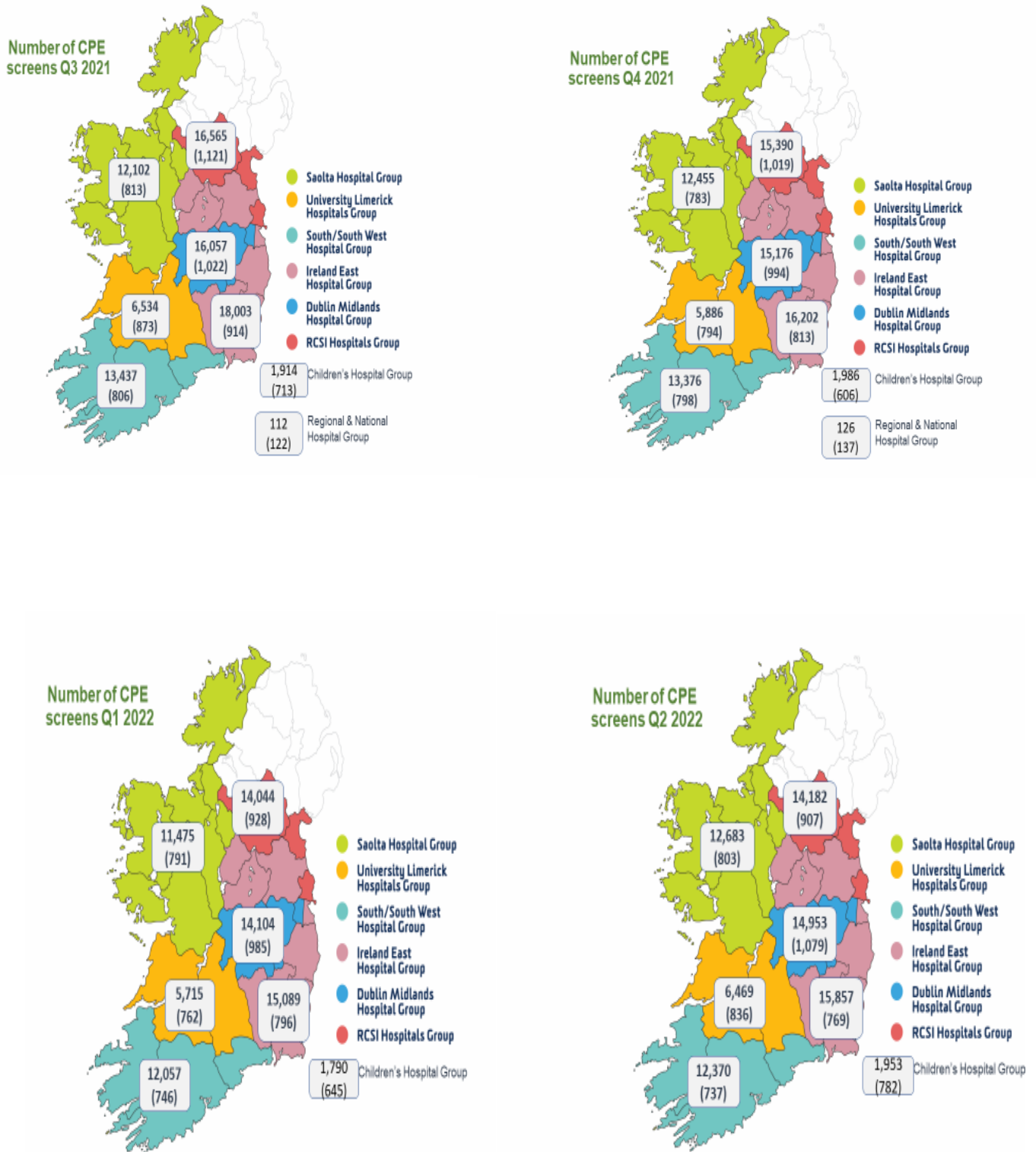
If most cases of CPE are detected from diagnostic samples this reflects a system in which relatively late detection of people with CPE in the context of clinical infection is the norm because the preceding asymptomatic colonisation is not detected.

Detection of most cases of CPE in surveillance samples reflects a system in which most people with CPE are detected relatively early in their contact with the healthcare system allowing early application of measures to control spread.

The proportion of first isolates from diagnostic samples declined with increased surveillance consistent with improved control of CPE. This now appears to be stabilising around 10 to 15% of isolates from diagnostic samples with some quarter to quarter fluctuation.

Figure 5 - Number of CPE surveillance samples per hospital group & (Rate per 10,000 Bed Days Used)

This figure is based on data collated by the HSE Business Information Unit (BIU). It is intended that it be updated quarterly.



Figures 6 & 7: Number of Environmental isolates of CPE by location and by type of variant (2018-2022 January-August)

This figure is based on data from the National CPE Reference Laboratory Service.

Comment: The transmission and spread of CPE in the acute hospital setting remains the key driver of new CPE detections however there have now also been a number of significant outbreaks in Nursing Homes. Since late 2018, there has been an increasing recognition that, in addition to direct and indirect person-to-person spread, environmental reservoirs of these organisms in acute hospitals represents a significant source. Increasing numbers of hospitals are undertaking environmental testing in wards that are deemed potential high risk areas. Moist areas for example showers, sinks and toilets are the most common locations from which CPE have been detected. This figure provides a summary of CPE from acute hospital environments by site. The increase in 2019 was likely to be largely related to increased awareness and testing. The low number of isolates 2020 is likely to be related to reduced sampling activity in the context of COVID-19.

Figure 6

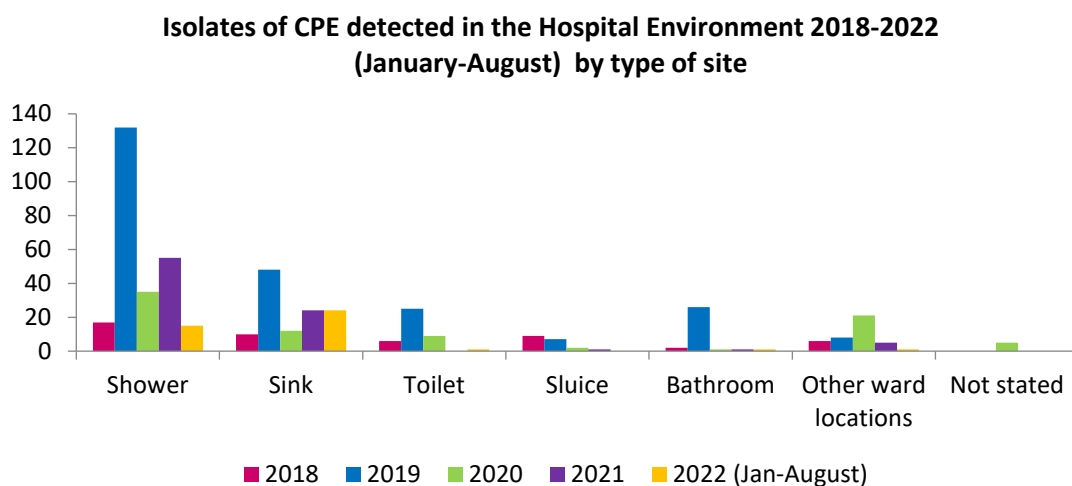
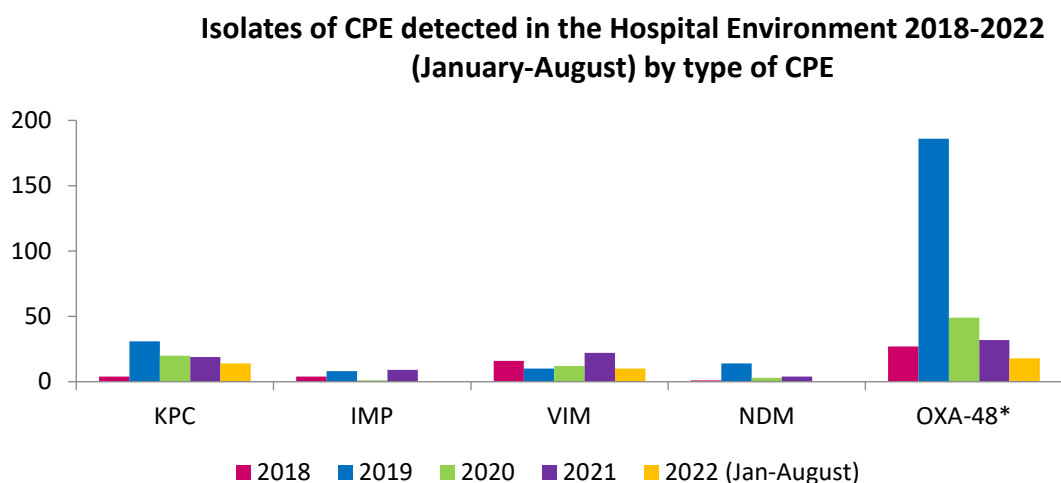


Figure 7



* 13 isolates are dual producers (6=OXA-48+VIM-1, 1=OXA-48+GES-5, 4= OXA-48+NDM-1, 1 =OXA-48+KPC-2 & 1 OXA-48+IMP-4).

(Figures 6 & 7 excludes carbapenemase producing organisms other than Enterobacterales and excludes CPE detected from sewage sampling)
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