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Nosocomial Bloodstream Infection in Critically Ill Patients Excess Length of Stay, Extra Costs, and Attributable Mortality

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JAMA. 1994;271(20):1598-1601.

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Abstract

Objective. —To determine the excess length of stay, extra costs, and mortality attributable to nosocomial bloodstream infection in critically ill patients.

Design. —Pairwise-matched (1:1) case-control study.

Setting. —Surgical intensive care unit (SICU) in a tertiary health care institution.

Patients. —All patients admitted in the SICU between July 1, 1988, and June 30, 1990, were eligible. Cases were defined as patients with nosocomial bloodstream infection; controls were selected according to matching variables in a stepwise fashion.

Methods. —Matching variables were primary diagnosis for admission, age, sex, length of stay before the day of infection in cases, and total number of discharge diagnoses. Matching was successful for

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89% of the cohort; 86 matched case-control pairs were studied.

Main Outcome Measures. —Crude and attributable mortality, excess length of hospital and SICU stay, and overall costs.

Results. —Nosocomial bloodstream infection complicated 2.67 per 100 admissions to the SICU during the study period. The crude mortality rates from cases and controls were 50% and 15%, respectively ($P<.01$); thus, the estimated attributable mortality rate was 35% (95% confidence interval, 25% to 45%). The median length of hospital stay significantly differed between cases and controls (40 vs 26 days, respectively; $P<.01$). When only matched pairs who survived bloodstream infection were considered ($n=41$), cases stayed in the hospital a median of 54 days vs 30 days for controls ($P<.01$), and cases stayed in the SICU a median of 15 days vs 7 days for controls ($P<.01$). Thus, extra hospital and SICU length of stay attributable to bloodstream infection was 24 and 8 days, respectively. Extra costs attributable to the infection averaged \$40 000 per survivor.

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Conclusions. –The attributable mortality from nosocomial bloodstream infection is high in critically ill patients. The infection is associated with a doubling of the SICU stay, an excess length of hospital stay of 24 days in survivors, and a significant economic burden. (*JAMA*. 1994;271:1598-1601)

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