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**Inaccurate and Misleading Media Coverage of Methicillin Resistant Staphylococcus Aureus (MRSA) Infections**

*Absent from much of the recent discussions on MRSA infections has been the distinction between toxic and non-toxic strains or reference to the need for community testing for these bacteria. A simple yet sensitive and specific culture test for MRSA is available from the Progressive University.*

**/24-7PressRelease/** - BURBANK, CA, November 11, 2007 - Much of the recent news coverage relating to MRSA has failed to capture the essence of the enormous risk posed by the continuing evolution of these bacteria and the urgent need for a nationwide MRSA surveillance and eradication program. As summarized in a series of articles posted on [www.s3support.com](http://www.s3support.com) there are two distinct categories of MRSA. Individuals with preexisting illnesses have provided susceptible hosts for a form of MRSA that will generally be of little or no concern for a healthy individual. These MRSA have become progressively resistant to many antibiotics and have significantly added to the hospital mortality rate. Distinct from these MRSA is the growing presence of toxic strains that can inactivate much of the body's antibacterial defense mechanism. A leukocyte (a type of white blood cell) toxin or "Leukocidin" was named after its 1932 discovery by Drs. Panton and Valentine and is referred to as PVL. It is one of the distinguishing characteristic of toxic strains of MRSA. Some of these strains have acquired additional toxin producing genes rendering them capable of essentially eating away at the body and, if not controlled, causing death. Fortunately, these bacteria are still susceptible to many commonly available antibiotics. They are also generally incapable of penetrating through intact skin surfaces.

Toxic MRSA were initially described in Australia in 1992 but seemingly evoked little Public Health reaction. They were included within a broader category of community acquired MRSA infections that were occurring in non-hospitalized patients, including drug addicts and those with chronic illnesses. Yet the newly emerging toxic strains of MRSA were quite different in that severe infections were being seen amongst robust athletes, children in playground settings following simple cuts and scrapes and adults after what should have been an uncomplicated influenza infection. Even after successful therapy of the acute illness, many of these patients continued to harbor toxic MRSA on their skin and in their nose. Such patients were discharged from hospitals without regard to the risk they were posing to themselves or to other members of the community. Moreover, an increasing number of employees in hospitals and nursing homes became colonized with toxic MRSA and hospital authorities actively discouraged testing lest they be forced to accept responsibility of infecting others. Even newly admitted patients were not being tested so as to leave open the argument that any subsequent MRSA illness was self acquired rather than originating within the hospital.

The present day risk posed by toxic MRSA is not being adequately addressed by simple reminders of regularly washing ones hands or not sharing towels and razors in the locker rooms. Very few of the physicians recently quoted by the media or interviewed on television appeared to grasp the distinction between toxic and non-toxic strains of MRSA. Rather the focus of the coverage has mainly been on antibiotic resistance, which with the exception methicillin and related antibiotics, is not currently a problem with the highly toxic strains of MRSA. Predictably, however, this will become a major problem requiring no more than some genetic interchanges between non-toxic and toxic strains of MRSA.

To help delay such an event, it is important to start an MRSA eradication program aimed at lowering the prevalence of all MRSA within both the community and hospital settings. The key to eradication is surveillance. Inexpensive MRSA Testing Plates are available that can allow anyone to screen schools, workplaces, recreational facilities and other locations for MRSA contamination. Owners of such facilities can be notified of the results and decide whether to institute an infection control program. By doing so, the facilities will be at a decreased risk of legal liability and, more importantly, will help raise the community standard of MRSA infection control.

While physicians may still not want to jeopardize their right to practice medicine by identifying themselves as being MRSA infected, they owe it to their patients and non-licensed coworkers to ensure that their facilities are not contaminated. Again this practice will likely be triggered when patients bring MRSA Testing Plates into their hospital room, medical clinic or nursing homes to do their own testing.

Prisoners should also be allowed access to the MRSA Testing Plates, at least until the responsibility of MRSA surveillance is accepted by prison officials.

The Progressive University is providing limited numbers of MRSA Testing Plates for both home and institutional uses. It can also arrange for more formal surveys of contaminated public facilities if requested by those in charge of the facilities. For more information on the Test Plates and other infection control programs please send an e-mail to [s3support@mail.com](mailto:s3support@mail.com) or call 626-616-2868.

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#### About Inst. of Progressive Medicine

The Progressive University is a non-profit research and educational entity that provides an academic environment that is not driven by either political or economic incentives. The Institute of Progressive Medicine main focus is on the control of infectious diseases through an alternative cellular energy (ACE) pathway.