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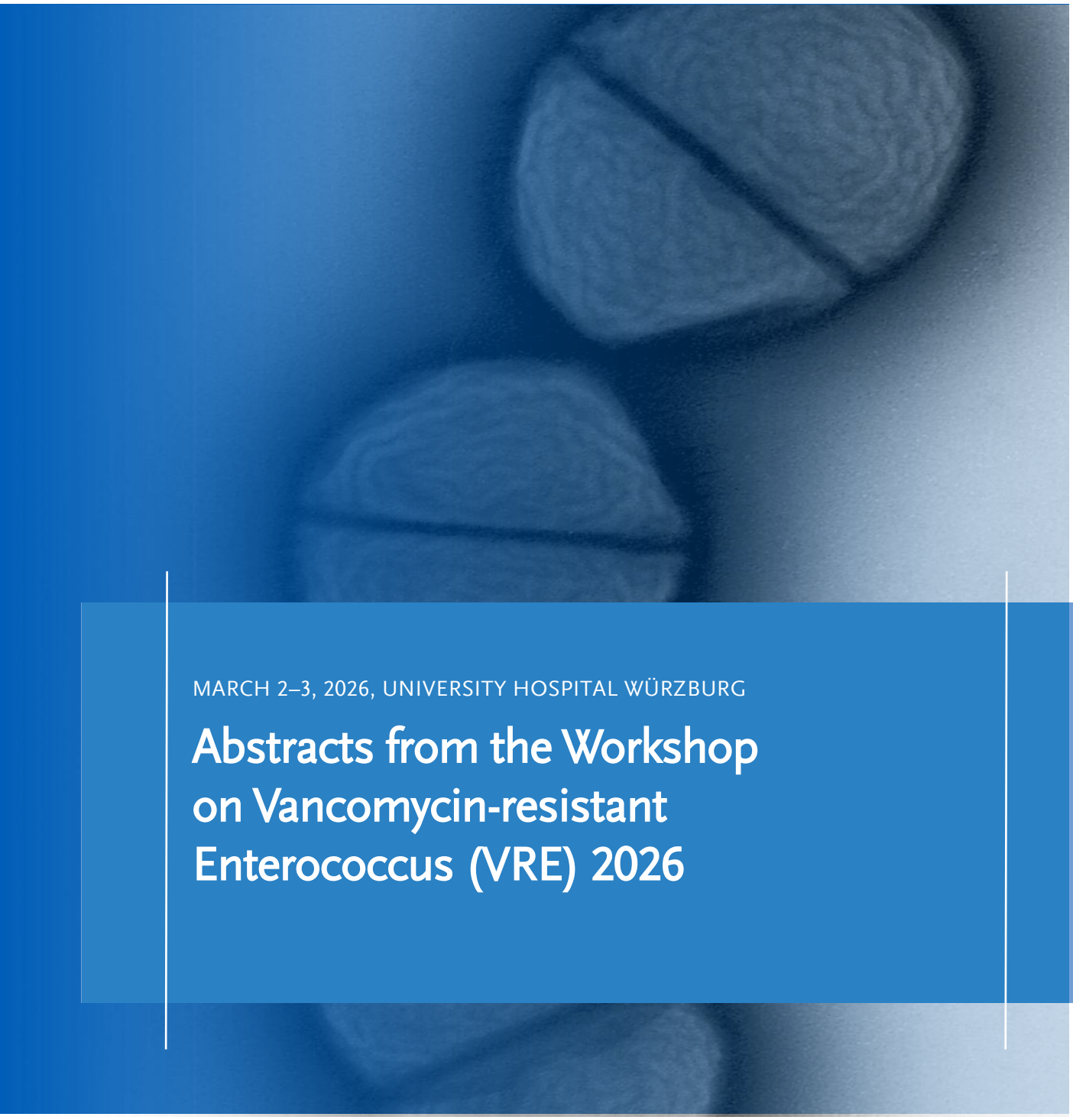

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Abstracts from the Workshop on Vancomycin-resistant Enterococcus (VRE) 2026

Contents

1 Discontinuation of isolation measures for VRE at a maximum care hospital in Northern Germany – First experiences

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Introduction

Over the past years, many German hospitals have reported increasing rates of vancomycin-resistant enterococci (VRE), with a partial decline since the COVID-19 pandemic. In 2018, the KRINKO emphasized prevention of nosocomial VRE infections.

Methods and Setting

In September 2024, general VRE isolation measures (single-room isolation and routine use of personal protective equipment) were discontinued at AGAPLESION Diakonieklinikum Rotenburg, a maximum care hospital with approximately 800 beds, except for the NICU. This change was accompanied by intensified standard IPC measures, including staff training, hand hygiene compliance monitoring, and prospective surveillance of nosocomial VRE bloodstream infections (BSI). VRE infection epidemiology from 2020 to 2025 was analyzed.

Results

Between January 2020 and September 2024, a median of three nosocomial VRE-BSI per year (range 0–4) was observed. From October 2024 to December 2025, one nosocomial VRE BSI occurred. The number of hospitalized VRE cases was stable at approximately 60 inpatient hospital stays per year. In addition, no increase in nosocomial VRE detection from urine or wound/intraoperative specimens was observed after discontinuation of isolation measures.

Discussion

During the first 15 months after discontinuation of general isolation measures, no increase in nosocomial VRE infections was observed. However, continued surveillance and cautious interpretation remain essential.

2 From sporadic VRE findings to a major outbreak in a tertiary care hospital in Austria

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Background

At the commencement of last year, the Infection Prevention and Control (IPC) team observed a notable increase in the number of cases of Vancomycin resistant enterococci (VRE) in two surgical wards.

Methods

Environmental swab samples from various locations in the patient's environment were taken. The IPC team started daily structured hand-hygiene observations according to WHO recommendations as well as staff monitoring for compliance with standard hygiene procedures. Antimicrobial susceptibility testing was performed according to EUCAST guidelines and all VRE-isolates were further genotyped using Next-Generation Sequencing.

Results

The environmental investigations did not yield any positive results of VRE. Compliance observations revealed that the application of the five moments of hand hygiene did not meet standards, which lead to intensified training. The vast majority of isolates were found in the same cluster group 1. A small proportion of isolates were found in clinical materials of multi-morbid patients and they subsequently developed clinical infections.

Conclusions

A retrospective analysis of the outbreak has shown that most Health care acquired Infections with cluster group 1 originally spread among the general patient population in the greater Vienna area. Factors, such as incorrect application of the five moments of hand hygiene, played a significant role in the course of the outbreak.

3 VRE clearance and the risk of recolonization in VRE-colonized patients

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Introduction

Vancomycin-resistant enterococci (VRE) are multidrug-resistant pathogen that can cause severe nosocomial infections. Therefore, extensive hygienic measures, including isolation, use of personal protective equipment (PPE) and thorough disinfection are frequently implemented in hospitals in order to prevent the transmission of VRE. These measures are usually discontinued after negative results of control swabs. Nevertheless, recolonization occurs regularly, meaning that the enhanced hygiene measures must be continued.

The aim of this study was to analyze the rate of VRE recolonization and risk factors for the recolonization of previously colonized hospitalized patients.

Methods

We analyzed data collected from routine anal VRE screenings from adult patients in the study period between January 2019 to June 2024. The study included patients with a documented history of VRE in whom no VRE was detected in a series of at least two consecutive anal swabs and in whom a further swab was performed (period of negativity). One period of negativity ended either with a VRE-positive anal swab (recolonization) or with the last anal swab in the patient's data set, which was hence negative (clearance). Patients with a VRE recolonization may therefore experience multiple periods of negativity. In patients with a VRE recolonization, we analysed clinical risk factors for their association with recolonization using uni- and multivariable cox-regression analyses.

Results

In total, 316 periods of negativity from 281 patients were included. Of all periods of negativity analyzed, 74% (n=233) remained VRE negative and therefore showed a persistent clearance of VRE colonization during the examined period. Recolonization with VRE occurred in 26% (n=83) of the periods. In the 83 periods in which a VRE recolonization was identified, 86% (n=71) of cases occurred within the first six months following the initial negative VRE swab. In 93% (n=77) of the periods, a recolonization was found within the first twelve months after the first negative VRE swab. A duration of hospital stay ≥ 12 days prior to the VRE recolonisation was significantly associated with the VRE recolonization in the multivariable analysis ($p < 0.001$), but no significance was found for antibiotic use prior to the VRE recolonization.

Conclusion

In the majority of cases, patients remained VRE- negative after two consecutive negative anal swabs. Recolonization was only observed in a small proportion of patients, with the majority of these cases occurring within the first twelve months after the first negative swab.

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