

# STAPHYLOCOCCAL NASAL CARRIAGE V2.0

## Comments from the Expert Advisory Group

- *Staphylococcus aureus* nasal carriage is common - approximately 20% of individuals almost always carry one strain, with many more transiently colonised
- Treatment in all colonised patients is not required
- Nasal *Staphylococcus aureus* colonisation, may act as a reservoir in cases of recurrent staphylococcal infection
- In recurrent staphylococcal infection, nasal swabbing may be indicated, and suppression as per the table below initiated, depending on swab results
- Cases of recurrent or persistent infection, despite nasal staphylococcal decolonisation, may warrant consideration of alternative causes of infection, and referral to secondary care as appropriate
- Panton-Valentine Leukocidin (PVL) is a toxin produced by 2% of *Staphylococcus aureus* and is associated with persistent recurrent pustules and carbuncles or cellulitis. Send swabs for culture in these clinical scenarios as well as nasal swab for *Staphylococcus aureus* carriage. On rare occasions it causes more severe invasive infections, even in otherwise fit people. Risk factors include nursing homes, contact sports, sharing equipment, poor hygiene and eczema

## Treatment

STAPHYLOCOCCAL NASAL CARRIAGE			
Drug	Dose	Duration	Notes
<b>First choice option</b>			
Chlorhexidine 0.1% + Neomycin Sulphate 0.5% (Naseptin®)	Apply to the inside of each nostril every 6 hours	10 days	Apply by placing a small amount of the cream onto the little finger and applying to the inside of the nostril. Nostrils can be “squeezed”, by pressing the sides of the nose together after application to aid spread of ointment  A cotton bud may be used for application if needed
<b>MRSA Suppression</b>			
Mupirocin (Bactroban®)	Apply to the inside of each nostril every 8 hours	5 days	