FOR IMMEDIATE RELEASE

CONTACT:
Mary McIntyre, M.D.
(334) 206-5325

The Alabama Department of Public Health and the Centers for Disease Control and Prevention have determined that the *Serratia marcescens* bacteremia in 12 hospitalized individuals who received TPN (total parenteral nutrition) has the same genetic fingerprint as the organism isolated from a container and stirrer used to mix the powdered amino acids, from the tap water spigot used for rinsing the container, and from the TPN.

A bag of compounded amino acids used in the production of TPN has also grown *Serratia marcescens*. Genetic fingerprint results are pending on the compounded amino acids.

The Alabama Department of Public Health is aware of 19 cases of *Serratia marcescens* in patients in six Alabama hospitals. Of these cases, 12 samples from individuals were matched with the bacterium found at Meds IV Pharmacy in Birmingham. Of the remaining seven cases in question, six have no samples available to test for a genetic match and one case is pending.

A failure in a step of the sterilization process in the compounding of TPN was most likely the cause of contamination. Use of these contaminated products led to a bacterial bloodstream infection in these 19 patients.

On March 16, ADPH was notified that an outbreak had occurred in two hospitals among patients receiving TPN. CDC's initial investigation identified TPN produced by Meds IV as a potential common source and determined that six hospitals received TPN from this pharmacy.

Illness with *Serratia marcescens* bacteremia occurred in approximately 35 percent of patients receiving TPN from Meds IV during March. Seventeen cases were reported in March, and two additional cases were retrospectively identified during the investigation, one in January and one in February.

The individuals affected are in the age range from 38 to 94 years; 8 males and 11 females were infected. The numbers of cases and deaths by hospital are as follows: Baptist Princeton, 7 cases, 4 deaths; Baptist Shelby, 5 cases, 2 deaths; Medical West, 3 cases, 1 death; Cooper Green Mercy, 1 case, no deaths; Baptist Medical Center Prattville, 1 case, 1 death; and Select Specialty Hospital of Birmingham, 2 cases, 1 death.

Meds IV was notified and informed its customers of the possibility of contamination. ADPH has been informed that impacted hospitals immediately stopped using TPN received from this
pharmacy and that the pharmacy discontinued all production. On March 24, Meds IV recalled all of its IV compounded products.

ADPH continues an ongoing investigation of the outbreak of *Serratia marcescens* bacteremia in collaboration with the CDC, the U.S. Food and Drug Administration, the Alabama Hospital Association, and the State Board of Pharmacy. At this time, there have been no reports of contaminated TPN, from any other pharmacy, sent to hospitals in Alabama or any other state.

As more information becomes available, ADPH will provide updates.

-30-

4/7/11