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OPINION REVIEW

- 6759 Semaglutide might be a key for breaking the vicious cycle of metabolically associated fatty liver disease spectrum?

Cigrovski Berkovic M, Rezić T, Bilic-Curcic I, Mrzljak A

MINIREVIEWS

- 6769 Drainage of pancreatic fluid collections in acute pancreatitis: A comprehensive overview
Bansal A, Gupta P, Singh AK, Shah J, Samanta J, Mandavdhare HS, Sharma V, Sinha SK, Dutta U, Sandhu MS, Kochhar R

- 6784 Frontiers of COVID-19-related myocarditis as assessed by cardiovascular magnetic resonance

Luo Y, Liu BT, Yuan WF, Zhao CX

ORIGINAL ARTICLE

Case Control Study

- 6794 Urinary and sexual function changes in benign prostatic hyperplasia patients before and after transurethral columnar balloon dilatation of the prostate

Zhang DP, Pan ZB, Zhang HT

- 6803 Effects of the information-knowledge-attitude-practice nursing model combined with predictability intervention on patients with cerebrovascular disease

Huo HL, Gui YY, Xu CM, Zhang Y, Li Q

Retrospective Cohort Study

- 6811 Effects of Kampo medicine hangebyakujutsutemmato on persistent postural-perceptual dizziness: A retrospective pilot study

Miwa T, Kanemaru SI

Retrospective Study

- 6825 Longitudinal changes in personalized platelet count metrics are good indicators of initial 3-year outcome in colorectal cancer

Herold Z, Herold M, Lohinszky J, Szasz AM, Dank M, Somogyi A

- 6845 Efficacy of Kegel exercises in preventing incontinence after partial division of internal anal sphincter during anal fistula surgery

Garg P, Yagnik VD, Kaur B, Menon GR, Dawka S

Observational Study

- 6855 Influence of the water jet system vs cavitron ultrasonic surgical aspirator for liver resection on the remnant liver

Hanaki T, Tsuda A, Sunaguchi T, Goto K, Morimoto M, Murakami Y, Kihara K, Matsunaga T, Yamamoto M, Tokuyasu N, Sakamoto T, Hasegawa T, Fujiwara Y

- 6865** Critical values of monitoring indexes for perioperative major adverse cardiac events in elderly patients with biliary diseases

Zhang ZM, Xie XY, Zhao Y, Zhang C, Liu Z, Liu LM, Zhu MW, Wan BJ, Deng H, Tian K, Guo ZT, Zhao XZ

- 6876** Comparative study of surface electromyography of masticatory muscles in patients with different types of bruxism

Lan KW, Jiang LL, Yan Y

Randomized Controlled Trial

- 6890** Dural puncture epidural technique provides better anesthesia quality in repeat cesarean delivery than epidural technique: Randomized controlled study

Wang SY, He Y, Zhu HJ, Han B

SYSTEMATIC REVIEWS

- 6900** Network pharmacology-based strategy for predicting therapy targets of Sanqi and Huangjing in diabetes mellitus

Cui XY, Wu X, Lu D, Wang D

META-ANALYSIS

- 6915** Endoscopic submucosal dissection for early signet ring cell gastric cancer: A systematic review and meta-analysis

Weng CY, Sun SP, Cai C, Xu JL, Lv B

- 6927** Prognostic value of computed tomography derived skeletal muscle mass index in lung cancer: A meta-analysis

Pan XL, Li HJ, Li Z, Li ZL

CASE REPORT

- 6936** Autosomal dominant osteopetrosis type II resulting from a *de novo* mutation in the *CLCN7* gene: A case report

Song XL, Peng LY, Wang DW, Wang H

- 6944** Clinical expression and mitochondrial deoxyribonucleic acid study in twins with 14484 Leber's hereditary optic neuropathy: A case report

Chuenkongkaew WL, Chinkulkitnivat B, Lertrit P, Chirapapaisan N, Kaewsutthi S, Suktitipat B, Mitrpant C

- 6954** Management of the enteroatmospheric fistula: A case report

Cho J, Sung K, Lee D

- 6960** Lower lip recurrent keratoacanthoma: A case report

Liu XG, Liu XG, Wang CJ, Wang HX, Wang XX

- 6966** Optic disc coloboma associated with macular retinoschisis: A case report

Zhang W, Peng XY

- 6974** A 7-year-old boy with recurrent cyanosis and tachypnea: A case report
Li S, Chen LN, Zhong L
- 6981** Schwannomatosis patient who was followed up for fifteen years: A case report
Li K, Liu SJ, Wang HB, Yin CY, Huang YS, Guo WT
- 6991** Intentional replantation combined root resection therapy for the treatment of type III radicular groove with two roots: A case report
Tan D, Li ST, Feng H, Wang ZC, Wen C, Nie MH
- 6999** Clinical features and genetic variations of severe neonatal hyperbilirubinemia: Five case reports
Lin F, Xu JX, Wu YH, Ma YB, Yang LY
- 7006** Percutaneous transhepatic access for catheter ablation of a patient with heterotaxy syndrome complicated with atrial fibrillation: A case report
Wang HX, Li N, An J, Han XB
- 7013** Secondary positioning of rotationally asymmetric refractive multifocal intraocular lens in a patient with glaucoma: A case report
Fan C, Zhou Y, Jiang J
- 7020** Laparoscopic repair of diaphragmatic hernia associating with radiofrequency ablation for hepatocellular carcinoma: A case report
Tsunoda J, Nishi T, Ito T, Inaguma G, Matsuzaki T, Seki H, Yasui N, Sakata M, Shimada A, Matsumoto H
- 7029** Hypopituitary syndrome with pituitary crisis in a patient with traumatic shock: A case report
Zhang XC, Sun Y
- 7037** Solitary plasmacytoma of the left rib misdiagnosed as angina pectoris: A case report
Yao J, He X, Wang CY, Hao L, Tan LL, Shen CJ, Hou MX
- 7045** Secondary coronary artery ostial lesions: Three case reports
Liu XP, Wang HJ, Gao JL, Ma GL, Xu XY, Ji LN, He RX, Qi BYE, Wang LC, Li CQ, Zhang YJ, Feng YB
- 7054** Bladder perforation injury after percutaneous peritoneal dialysis catheterization: A case report
Shi CX, Li ZX, Sun HT, Sun WQ, Ji Y, Jia SJ
- 7060** Myotonic dystrophy type 1 presenting with dyspnea: A case report
Jia YX, Dong CL, Xue JW, Duan XQ, Xu MY, Su XM, Li P
- 7068** Novel mutation in the *SALL1* gene in a four-generation Chinese family with uraemia: A case report
Fang JX, Zhang JS, Wang MM, Liu L
- 7076** Malignant transformation of primary mature teratoma of colon: A case report
Liu J

- 7082** Treatment of pyogenic liver abscess by surgical incision and drainage combined with platelet-rich plasma: A case report
Wang JH, Gao ZH, Qian HL, Li JS, Ji HM, Da MX
- 7090** Left bundle branch pacing in a ventricular pacing dependent patient with heart failure: A case report
Song BX, Wang XX, An Y, Zhang YY
- 7097** Solitary fibrous tumor of the liver: A case report and review of the literature
Xie GY, Zhu HB, Jin Y, Li BZ, Yu YQ, Li JT
- 7105** MutL homolog 1 germline mutation c.(453+1_454-1)_(545+1_546-1)del identified in lynch syndrome: A case report and review of literature
Zhang XW, Jia ZH, Zhao LP, Wu YS, Cui MH, Jia Y, Xu TM
- 7116** Malignant histiocytosis associated with mediastinal germ cell tumor: A case report
Yang PY, Ma XL, Zhao W, Fu LB, Zhang R, Zeng Q, Qin H, Yu T, Su Y
- 7124** Immunoglobulin G4 associated autoimmune cholangitis and pancreatitis following the administration of nivolumab: A case report
Agrawal R, Guzman G, Karimi S, Giulianotti PC, Lora AJM, Jain S, Khan M, Boulay BR, Chen Y
- 7130** Portal vein thrombosis in a noncirrhotic patient after hemihepatectomy: A case report and review of literature
Zhang SB, Hu ZX, Xing ZQ, Li A, Zhou XB, Liu JH
- 7138** Microvascular decompression for a patient with oculomotor palsy caused by posterior cerebral artery compression: A case report and literature review
Zhang J, Wei ZJ, Wang H, Yu YB, Sun HT
- 7147** Topical halometasone cream combined with fire needle pre-treatment for treatment of primary cutaneous amyloidosis: Two case reports
Su YQ, Liu ZY, Wei G, Zhang CM
- 7153** Simultaneous robot-assisted approach in a super-elderly patient with urothelial carcinoma and synchronous contralateral renal cell carcinoma: A case report
Yun JK, Kim SH, Kim WB, Kim HK, Lee SW
- 7163** Nursing a patient with latent autoimmune diabetes in adults with insulin-related lipodystrophy, allergy, and exogenous insulin autoimmune syndrome: A case report
He F, Xu LL, Li YX, Dong YX
- 7171** Incidental diagnosis of medullary thyroid carcinoma due to persistently elevated procalcitonin in a patient with COVID-19 pneumonia: A case report
Saha A, Mukhopadhyay M, Paul S, Bera A, Bandyopadhyay T
- 7178** Macular hole following phakic intraocular lens implantation: A case report
Li XJ, Duan JL, Ma JX, Shang QL

LETTER TO THE EDITOR

- 7184** Is every microorganism detected in the intensive care unit a nosocomial infection? Isn't prevention more important than detection?

Yildirim F, Karaman I, Yildirim M

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Is every microorganism detected in the intensive care unit a nosocomial infection? Isn't prevention more important than detection?

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Abstract

The present letter to the editor is related to the study entitled "Multidrug-resistant organisms in intensive care units and logistic analysis of risk factors." Not every microorganism grown in samples taken from critically ill patients can be considered as an infectious agent. Accurate and adequate information about nosocomial infections is essential in introducing effective prevention programs in hospitals. Therefore, the development and implementation of care bundles for frequently used medical devices and invasive treatment devices (*e.g.*, intravenous catheters and invasive ventilation), adequate staffing not only for physicians, nurses, and other medical staff but also for housekeeping staff, and infection surveillance and motivational feedback are key points of infection prevention in the intensive care unit.

Key Words: Critical care; Prevention; Intensive care unit; Nosocomial infection; Detection

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Core Tip: Microorganisms grown from every sample taken from critically ill patients cannot be considered as an infectious agent. Development and implementation of care bundles for frequently used medical devices and invasive treatment devices (*e.g.*, intravenous catheters and invasive ventilation), adequate staffing not only for physicians, nurses and other medical staff but also for housekeeping staff, and infection surveillance and motivational feedback are key points of infection prevention in the intensive care unit. Providing accurate and adequate information about nosocomial infections is essential in introducing effective prevention programs in hospitals.

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TO THE EDITOR

We recently read with great interest the manuscript by Han *et al*[1] entitled "Multidrug-resistant organisms in intensive care units and logistic analysis of risk factors," which was published in the last issue of *World J Clin Cases*. We would like to state that the article is very detailed, and we have benefited from it in many points. However, we would like to humbly highlight some parts of their paper. They analyzed 2070 samples from critically ill patients in the intensive care unit (ICU). They found that 55.1% of the samples were sputum, 25.2% blood, and 5.7% other drainage fluids. Most commonly detected pathogens were *Acinetobacter baumannii* (*A. baumannii*), *Escherichia coli*, *Pseudomonas aeruginosa*, *Klebsiella pneumoniae*, and *Staphylococcus aureus* with a detection rate of 35.97% (378/1051). In addition, detection rate of *Klebsiella pneumoniae* was 9.42% (99/1051), which was generally resistant to multiple antimicrobial drugs. This study pointed out some critical issues; however, there are some practical questions to be answered for a proper clinical extrapolation.

First of all, when we look at the study from the perspective of intensivists, the most important limitation of this study is the lack of definition of infections. In order to distinguish between contamination and colonization, it is necessary to define ventilator-associated pneumonia, blood-catheter-associated infection, and urinary tract infection according to the Centers of Disease Control criteria[2]. Not every microorganism grown in samples taken from critically ill patients can be considered an infectious agent.

Secondly, accurate and adequate information about nosocomial infections is essential in introducing effective prevention programs in hospitals. Therefore, the development and implementation of care bundles for frequently used medical devices and invasive treatment devices (*e.g.*, intravenous catheters and invasive ventilation), adequate staffing not only for physicians, nurses, and other medical staff but also for housekeeping staff, and infection surveillance and motivational feedback are key points of infection prevention in the ICU. It is recommended to use infection prevention packages for the prevention of nosocomial ventilator-associated pneumonia, blood-catheter infection, urinary tract infection, and other infections in the ICU and to check compliance with these packages, particularly by the infection control committee[3,4]. In the study of Han *et al*[1], although one of the authors was affiliated with an infection control committee, the control precautionary packages and the rates of compliance with the precautionary packages in the ICU were not mentioned in the study. If one of the aims of the study was to examine the risk factors for the development of nosocomial infection in the ICU, the rates of compliance with these infection prevention packages should be included in the study.

In the study of Han *et al*[1] where the rate of intubated patients was 98.1%, resistance rates of *A. baumannii* to minocycline in 2017 and 2019 were found as 28.41% and 32.42%, respectively; whereas meropenem resistance was 74.6%, and the imipenem resistance rate was 75.66%. Carbapenem resistance of *A. baumannii* has increased from 2005 to 2018 all over the world, which is an important issue. A study conducted by Talan *et al*[5] in our country detected *A. baumannii* in 25.6% of patients between February 2013 and January 2014 in intubated patients, and while all of them were resistant to carbapenems, colistin resistance was found in 27.2%. *A. baumannii* resistance in Turkey is much higher. The reason for this is the widespread use of antibiotics in the community before admission to the hospital in our country. The discussion of Han *et al*[1] of this high carbapenem and polymyxin resistance in their study will add strength to their study.

FOOTNOTES

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