Methods: In addition to the three carbapenemase-producing *E. coli,* three non-carbapenemase-producing *E. coli* were chosen to test if the media would select for strains with other mechanism of carbapenem resistance. The strains were spread onto the different media in duplicate and left overnight to incubate at 35°C. The following day, the colonies were counted and the lowest limit of detection (LLD) calculated.
Results: See the table.

Strain			LLD (CFU/ml)		
	Mechanism of carbapenem resistance	Meropenem MIC ($mg\,L^{-1}$)	ChromID™ CARBA	MIM	Modified MIM
DS1878/11	NDM	4	1.06×10^{1}	1.06×10^{5}	1.06×10^{3}
DB42339/12	OXA-48 type	2	$>1.26\times10^{7}$	$>1.26\times10^{7}$	$>1.26\times10^{7}$
DM6277/12	KPC	2	8.60×10^{1}	$>8.60\times10^{5}$	$>8.60\times10^{5}$
DR23975/10	CMY (pAmpC)	>32	9.10×10^{4}	9.10×10^{0}	$>9.10\times10^{6}$
DB16895/09	CTX-M-Group 1 (ESBL)	4	$>1.18\times10^{7}$	1.18×10^{4}	$>1.18\times10^{7}$
DM13596/10	CMY+ CTX-M-Group 1	16	5.40×10^{1}	5.40×10^{1}	5.40×10^{0}

Conclusion: ChromID™ CARBA was the most sensitive plate among the three we tested and was equivalent to modified MIM in specificity at picking out only the true carbapenemase-producers. Moreover, the cost of ChromID™ CARBA was approximately only 1.5× that of modified MIM which needs to be made in-house. ChromID™ CARBA is a viable alternative for a hospital looking to start a surveillance program looking for CRE in stool specimens.

P225
Efficiency of Uro-Vaxom as immunoprophylaxis in patients with urogenital tract infections

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Introduction: Urogenital tract infections (UTI) are widespread. Mostly they are caused by *E. coli* and about 60% have recurrent course. The results of a standard antibiotic therapy often are insufficient.
Methods: 127 patients with recurrent UTI were enrolled in study. 23 men had chronic bacterial prostatitis, 75 women had recurrent cystitis and 29 women – chronic pyelonephritis. Relapses of UTI were on average 3.4±0.8 per year. At the start of the trial, all patients were in acute recurrence, and were therefore treated with antibiotic. After confirming that their urine or prostate secretion was sterile, patients were treated for 1 month with 1 capsule daily of *Escherichia coli* extract Uro-Vaxom and observed for 2 years. Just after UTI episode occurring, the second course of Uro-Vaxom was prescribed with the same scheme. The degree of the disease was assessed with complex scale every two months as well as a quality of life (QoL).
Results: On base-line patients had 40.1 score, after aetiotropic therapy – 23.4 score and after first course of Uro-Vaxom – 12.1 score on average. After first course of Uro-Vaxom 86.7% of patients had "cold period" during more than 6 months. After second course of Uro-Vaxom 37 patients (29.2%) had a "cold period" for 6 months, 62 patients (48.8%) for 9 months and 28 patients (22.0%) had no recurrence during a year. UTI episode decreased from 3.4±0.8 to 0.4±0.2 per year, QoL increased from 4.7±1.0 up to 1.3±1.1 score. Alongside with high efficiency Uro-Vaxom showed a good tolerance – none side effect was registered.
Conclusion: The number of recurrence of cystitis, prostatitis and pyelonephritis was significantly lower after two consecutive courses of Uro-Vaxom. Immunoprophylaxis of relapses of UTI with Uro-Vaxom is high effective and good tolerant.

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Postoperative wound dealing and superficial surgical site infection in open radical prostatectomy

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Introduction: The therapeutic gold standard for locally limited prostate cancer (PCa) is radical prostatectomy (RP) and one of the most often performed open surgery in urological field in Japan. Even though recently robotic-assisted RP (RARP) have been admitted by medical insurance, postoperative dealing with surgical wound which is the major difference between RARP and RP has not been fully debated and investigated so far.
Objectives: The purpose of this study is to investigate postoperative wound dealing and superficial surgical site infection in open RP.
Methods: Two hundred and eighty-six antegrade RP cases which were performed in Department of Urology, Shinko hospital between January 2006 and December 2012 with data available for evaluation were included in this study. These cases were divided to 2 groups: 1) "no intervention" methods in which no any intervention undertook with covering the wound by KARAYAHESIVE and keeping until removal of surgical stapler (n = 206) and 2) "washing" methods in which wounds are washed by SECURA CL (Stomashop Co. Ltd, Tokyo, Japan) from 2nd post-operative day to the days of removal of stapler (n = 80). We investigated and compared these 2 groups regarding the superficial SSI. Diagnoses of SSI was referred to CDC guideline 1999.
Results: There was no significant difference between 2 groups in the kinds and duration of prophylactic antibiotic administration ($p > 0.05$). "no intervention" group had 4 (1.94 %) cases of superficial SSI (1 wound fascial infection and 3 wound subcutaneous infections) and bacterial data showed 1 fascial infection case was caused by Methicillin sensitive *Staphylococcus aureus* (MSSA). On the contrary, "washing" group had 10 (12.5%) cases of superficial SSI (9 wound subcutaneous infections and 1drain-related subcutaneous infections), and bacterial data showed 3cases caused by MSSA, 1 by Methicillin resistant *Staphylococcus aureus* (MRSA), and 1 by *Pseudomonas aeruginosa* in wound subcutaneous infections. "No intervention" group showed significantly lower ratio of superficial SSI ($p = 0.0002$).
Conclusion: This study suggests no intervention to wound after RC is recommended with the comparatively lower ratio of superficial SSI than washing methods to wound.

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Effect on infectious diseases practice and antimicrobial stewardship of one infectious diseases doctor at a community hospital

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Introduction: Issues on infectious diseases, such as infection caused by multi-drug resistant organisms, are a worldwide concern. Though they are a global challenge, each hospital should take measures to keep quality of infection control. In Japan, the universal healthcare system started to evaluate hospitals taking steps on infection control, of which the government began to think highly. However, most hospitals in Japan don't have their own doctor of infectious diseases.
Objectives: In order for hospitals to hire infectious diseases doctors, it is necessary to assess its importance and benefit. With such an aim, we examined the merit of hiring an infectious diseases doctor by comparing the data before with those after one infectious diseases doctor was hired, in terms of infectious clinical problems and appropriate antibiotic usage, at a community hospital located in the suburb of Tokyo.
Methods: We observed two periods; one was "no infection doctor period", from January 2009 to December 2010, and the other was "one