

replacement and prosthetic joint infection diagnosis was 284 days (95% CI, 281-286 days) and the median time was 91 days (0-1,631 days). We found that SSI occurred during the first 30 days after the replacement in 30.3% of patients; 40.1% of patients were infected between 1 month and 1 year. Moreover, this hospital discharge cohort model allowed detecting SSI occurring >1 year after joint replacement (29.4%) (unpublished data).

The findings reported by Lower et al,<sup>1</sup> when compounded with our French results, demonstrate the potential use of passive postdischarge surveillance in SSI after arthroplasty. The hospital information systems covering the entire population allows data analysis and productions of indicators and then benchmarking,<sup>7,8</sup> and could be promoted as a cost-effective method for routine infection control surveillance.

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## Response to letter to the editor regarding: "Surgical site infections after hip arthroplasty in Norway, 2005-2011: Influence of duration and intensity of postdischarge surveillance"



To the Editor:

We would like to thank the authors for their comments on our article. We agree that postdischarge surveillance (PDS) is resource demanding, but it is also very important in correctly identifying the burden of surgical site infections. Our study<sup>1</sup> specifically addressed 1-year follow-up after hip arthroplasty. Our recommendation that active PDS may be replaced by passive PDS only applies to deep infections after hip arthroplasty, which manifest beyond 30 days of surgery.

We found that 79% of all infections up to 1 year after hip arthroplasty were detected after hospital discharge through active PDS, and that only about half of these could have been detected through readmissions. In a previous study,<sup>2</sup> which includes several types of surgery, we showed that 81% of all infections within 30 days of surgery were detected after discharge with active PDS. A recent study from The Netherlands<sup>3</sup> reported that the method and intensity of PDS are of high importance and that a large proportion of the infections would be missed by using inferior PDS methods.

In the 2010-2011 report from the European Centre for Disease Prevention and Control,<sup>4</sup> the incidence proportion of infections after hip arthroplasty, cholecystectomy, and colon surgery in The Netherlands and Norway is much higher than in France. Most of this difference may be attributed to the active PDS that is performed in both of these countries.

We would caution against promoting passive PDS, which solely relies on readmission data for the first 30 days after discharge. This may give an incomplete picture of the infection situation by missing infections detected by primary health care providers or other hospitals. Hopefully, legal and technical developments will enable primary health care and hospital data to be harnessed effectively for PDS in the near future.

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