Medical News

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Correction: CDC's New HCV Exposure Guidelines

The July 1996 Medical News article on "New HCV Exposure Guidelines" listed an incorrect telephone number at the CDC to obtain a copy of the document "Issues and Answers: What Is the Risk of Acquiring Hepatitis C for Health Care Workers and What Are the Recommendations for Prophylaxis and Follow-Up After Occupational Exposure to Hepatitis C Virus?" (*Hepatitis Surveillance Report* No. 56; April 1996). The correct telephone number is 404-639-3048. We regret this error.

Hospital Infections Program Home Page

The CDC's Hospital Infections Program (HIP) has established a home page on the Internet. The HIP's home page can be reached via the National Center for Infectious Diseases and the CDC's home pages or directly at http://www.cdc.gov/ncidod/hip/hip.htm.

The HIP's home page brings together in one location all of the CDC information related to hospital infection control. Major areas include antimicrobial resistance, bloodborne pathogens, CDC guidelines and recommendations, occupational health, management of outbreaks, sterilization and disinfection strategies, and surveillance.

For more information about HIP's home page, contact J. Shaw at CDC, Hospital Infections Program, MS AO7, Atlanta, GA, 30333; telephone 404-639-6409 or e-mail JBS4@CIDHIP1.EM.CDC.GOV).

Spontaneous Combustion of Exam Gloves

In the spring and summer of 1995, the spontaneous combustion of powder-free, chlorinated latex patient examination gloves caused four warehouse fires in different states. All of the gloves were labeled "made in China," and manufacturers' serial numbers indicate that they were manufactured between 1992 and 1994.

Because of the concern about the potential for future fires, the Food and Drug Administration (FDA) issued a Public Health Advisory to hospital administrators, hospital risk managers, hospital procurement managers, latex glove manufacturers, and glove distributors and importers. The advisory notes that the FDA, in collaboration with the Bureau of Alcohol, Tobacco, and Firearms and local fire departments, has identified the fires as having started within gloves stored in stacks on pallets. Having ruled out arson, the investigators concluded that the cause of the fires was spontaneous combustion linked to high warehouse temperatures that apparently accelerated an exothermic chemical reaction on the chlorinated gloves to ignite the latex. This raises concern for gloves stored in warehouses in very hot summer weather. In addition, there is concern that heating of gloves just short of the igniting temperature may cause the latex glove to deteriorate and lose its effectiveness as a barrier. The labeling on the gloves instructs that the gloves be stored in a cool, dry place. The two greatest risk factors for fires are the storage temperature and mass of the gloves. It is recommended that large quantities of gloves not be stored in conditions of extreme heat. One or more pallets stored in a warm to hot location should be considered a risk.

The FDA recommends the following precautions: (1) avoid a large inventory of powder-free latex gloves; (2) remove shrink wrap from pallets of stacked cartons; (3) break the stacked cartons on each pallet apart and restack or reconfigure to facilitate cooling ventilation; (4) periodically check powder-free latex gloves for characteristics suggesting deterioration, such as brittleness, tackiness, or an acrid chemical odor or stench; and (5) rotate your powder-free latex glove stock using "first-in-first-out" practices. If any glove characteristics are noted that suggest deterioration, contact the FDA district office, or call the FDA Emergency Operations at 301-443-1240. The FDA also encourages the voluntary reporting of any observations regarding the quality of examination or surgeons' gloves by telephoning the FDA-MedWatch Program at 1-800-FDA 1088 or by faxing to 1-800 FDA-1078.

FROM: Food and Drug Administration. Risk of spontaneous combustion in large quantities of patient examination gloves. *FDA Public Health Advisory*; June 27, 1996.

CDC's NNIS System Evolves Into the 21st Century

The CDC's National Nosocomial Infections Surveillance (NNIS) System is a voluntary system of US acute-care hospitals that was initiated in 1970 to create a national database on nosocomial infections, in order to determine the quantitative and qualitative factors associated with nosocomial infections. Gradually, NNIS has become a worldwide gold standard.

Until 1986, the NNIS system offered only one method of surveillance of nosocomial infections: hospitalwide surveillance. Since 1986, three additional surveillance components that focus on specific groups of patients have been introduced, each of which allows for calculation of risk-adjusted infection rates: the intensive-care unit (ICU), high-risk nursery, and surgical patient components. To study changes in the use of NNIS surveillance components since 1986, the CDC analyzed 1986 to 1995 NNIS data from the 231 US hospitals that participated in the NNIS system during this period. The number of hospitals participating in the NNIS system increased sixfold from 1986 to 1995. A parallel increase was noticed in the amount of surveillance data for all NNIS components, except for the hospitalwide com-