Medical News

EDITED BY GINA PUGLIESE, RN, MS

CDC Revising Guidelines for Preventing Nosocomial Infections

The Hospitals Infection Control Practices Advisory Committee (HICPAC) has begun to revise the CDC's Guidelines for Preventing Nosocomial Infections, originally published in the early 1980s. The Guidelines for Preventing Nosocomial Pneumonia was selected as the first to be revised. The new guideline will be broadened to include viral, fungal, and Legionella pneumonias. The next five guidelines selected for revision or development are on Isolation Precautions in Hospitals, Prevention and Control of Intravascular Infections, Infection Control in Personnel Health, Appropriate Use of Antimicrobials, and Prevention of Surgical Wound Infection.

The 12-member HICPAC was established in 1991 by former Secretary of the Department of Health and Human Services, Dr. Louis Sullivan. HICPAC was charged to provide advice and guidance to the CDC regarding the practice of hospital infection control and strategies for surveillance, prevention, and control of nosocomial infections in U.S. hospitals. Dr. Walter Hierholzer of Yale New Haven Hospital currently chairs the committee, and Julia Garner of the CDC serves as executive secretary. Meetings are held twice yearly at the CDC, and notices of the meetings are published in the *Federal Register* prior to the meeting. The next meeting is scheduled for June 21-23, 1993.

Product Variance Reported with TB Skin Testing Materials

A cluster of tuberculin skin test (TST) conversions in an administrative nonpatient care department prompted an investigation by the Shands Hospital at the University of Florida. The 12% skin test conversion rate among employees of this department (16 TST positive of 134 tested) was higher than the overall hospital TST conversion rate of 8% (245 of 2,721 employees). The product used for TST was Aplisol (Parke Davis). After an unremarkable investigation to identify active cases and sources of possible exposures, an evaluation of the tuberculin skin test product was initiated.

Previously known positive individuals were retested with the product Tubersol (Connaught). Of the 159 known positive employees, 108 (68%) retested negative.

The results of this investigation were presented at the Annual meeting of the Society for Hospital Epidemiology of America in Chicago, April 18-20, 1993, by Loretta Fauerback et al from the Shands Hospital at the University of Florida. Several members of the audience shared similar discordant results between the two products, including Trisha Barrett from Alta Bates Medical Center in Berkeley, California. The results of these investigations have been reported to the FDA. Attendees expressed concern regarding the serious implications of the disparity in results from the two products.

New York City Adopts Rule Allowing Detention of TB Patients Unwilling to Take Medicine

New York City adopted a set of procedures that lay out the conditions under which the city health commission can order detention and other compulsory measures to address a public health threat posed by a confirmed or suspected case of tuberculosis. These procedures were adopted by New York City Board of Health on March 9, 1993 in-an amendment to Section 11.47 of the city Health Code. Under these rules, the city health commissioner is authorized to order physical examinations of people having or suspected of having active TB and completion of

treatment for those with active TB, including contagion precautions or a course of directly observed therapy. In addition, the rules allow the removal or detention for treatment of people who are infectious and cannot be separated from others sufficiently to prevent disease transmission, or people who have active disease but are unwilling or unable to participate in a prescribed course of treatment and/or to observe precautions to avoid infecting others.

Although the new rules drew praise from advocates for tuberculosis (TB) patients, there is a concern that as the caseload of TB cases rises, public fear may lead to more aggressive and inappropriate detention. The New York City Health Department was commended for convened working groups to discuss concerns raised by patient advocacy groups and adopting their suggestions in the rule.

The new rules were prompted by the rapid rise in TB cases in New York City and the core of noncompliant patients who cannot or will not take their prescribed medications through completion of necessary treatment. New York City had 3,673 TB cases in 1991, a 143% increase from 1980. With only 3% of the U.S. population, the city has 14% of the national total of TB cases. Many of the cases are from outbreaks in hospitals, prisons, and shelters. It has been estimated that a third of TB cases in New York City are resistant to at least one antituberculosis drug and possibly 15% of cases resistant to at least two drugs.

CDC Issues Guidelines for Counseling Persons Infected with HTLV-I and HTLV-II

The human Tlymphotrophic viruses type I (HTLV-I) and type II (HTLV-II) are closed related but distinct retroviruses that can infect humans. They differ from the human immunodeficiency virus that causes AIDS. Screening of the United States blood supply for HTLV-I/II, which began in 1988, identifies HTLV-I and HTLV-II-infected persons. However, the screening tests, and the investigational supplementary tests used to confirm seropositivity, do not reliably differentiate between antibodies to HTLV-I and HTLV-II. In addition, the licensed screening tests, which use HTLV-I antigens, vary in their sensitivity to detect antibodies to HTLV-II. Approximately 2,000 HTLV-I/II infected volunteer blood donors where identified in the first year of screening in the United States; testing, after amplification by the polymerase chain reaction (PCR), indicated that one half are infected with HTLV-I and one half with HTLV-II. These donors are counseled and permanently deferred from donating blood. Because the PCR test is not routinely available, many donors and other individuals who tested positive by serologic assays have been told they are infected with HTLV-I/II. The uncertainty regarding the identity of the infecting virus and the different epidemiologic and clinical correlates of these infections have made counseling these persons complicated and sometimes confusing.

The Centers for Disease Control and Prevention and the United States Public Health Service Working Group have summarized current information about the HTLV viruses and developed guidelines to be used by health care workers and public health officials for counseling HTLV-I, HTLV-II, and HTLV-I/II-infected persons. Persons found to be seropositive for HTLV-I or -11 should be given information regarding modes and efficiency of transmission, disease associations, and the probability of developing disease. In addition, they should be advised to share the information with their physician; not donate blood, semen, body organs, or other tissue; not share needles or syringes with anyone; and not breastfeed infants. Individuals found to be seropositive for HTLV-II also should be advised to consider the use of latex condoms to prevent sexual transmission. In addition, if the HTLV-I positive individual is in a mutually monogamous sexual relationship, testing of the sex partner is recommended to help formulate specific counseling advice. Medical follow-up is recommended for HTLV-I or HTLV-I/II-infected persons. Medical evaluation of confirmed HTLV-II-infected persons is considered optional.

FROM: Centers for Disease Control and Prevention and the USPHS Working Group. Guidelines for counseling persons infected with human T-lymphotrophic ***virus type I (HTLV-I) and type II (HTLV-II). Ann Intern*** *Med* 1993;118:448-454.

ASTM Releases Emergency Standards for Protective Clothing

The American Society for Testing Materials (ASTM) recently released two new emergency standard test methods to evaluate the barrier effectiveness of materials used for protective clothing.

The first of the two standards (ES 21) is a pass/fail test that evaluates a material for visible fluid penetration by using synthetic blood applied at a specific pressure and time interval. Materials passing this test would be considered a fluid barrier and then may be evaluated against a more rigorous standard, the ES 22 test. The ES 22 test uses the same pressure and time intervals as the ES 21. However, a high concentration of a surrogate virus is added to the synthetic blood. The surrogate virus, bacteriophage PhiX174, is similar to hepatitis B, although smaller