

To the editor:

Following much concern, discussion and debate over the article by Favero et al., "Guidelines for the Care of Patients Hospitalized with Viral Hepatitis" in the December *Annals*, your recent editorial [Mayhall CG. Editorial: Isolation techniques for hospitalized patients with viral hepatitis: New guidelines premature. *Infect Control* 1980; 1(2):71-74.] was certainly appreciated. [Dr. Mayhall's] approach was well organized and concise, addressing the issues that caused most confusion.

I would like to ask your opinion on two situations we face with some frequency. First, what precautions would you recommend, if any, in handling the hospitalized patient who is chronically HBsAg-positive? Secondly, what precautions would you recommend for the patient with a recent (past year) history of non-A, non-B hepatitis? Since there is no serologic diagnosis available, infectivity is difficult to determine.

I will appreciate your consideration of my questions. Thank you again for your timely and enlightening editorial.

*Emily R. Smith, R.N.
Nurse Epidemiologist
Cleveland Clinic
Cleveland, Ohio*

This letter was referred to Dr. Mayhall, who wrote the following reply:

It is well known that chronic carriers of HBsAg may transmit hepatitis B virus to others. Many health care personnel who develop acute hepatitis B have no history of exposure to patients known to have HBsAg-positive blood. In most instances, they

probably acquire the disease after exposure to blood from asymptomatic patients who are unidentified carriers of HBsAg.

Thus, isolation precautions for chronic carriers of HBsAg should be the same as those used for patients with acute hepatitis B. Chronic carriers should be placed on blood and needle precautions, and body fluids should be handled with care. As with acute hepatitis B, formal enteric isolation is needed only when there is gross gastrointestinal bleeding.

The second question is more difficult to answer, because there are no serologic markers for the one or more viruses that cause non-A, non-B hepatitis and there is a resultant lack of information on the epidemiology of non-A, non-B hepatitis. It is well established that this type of hepatitis can be transmitted by blood and that infection with non-A, non-B hepatitis virus(es) can be followed by development of a chronic carrier state. However, what percent of patients with acute cases become chronic carriers is unknown. Also unknown is whether these viruses are excreted in feces and body fluids other than blood and, if so, for how long.

Fortunately, many patients who have recovered from acute non-A, non-B hepatitis never need to be hospitalized. For those admitted, there is no way to determine whether they are carriers of non-A, non-B hepatitis, because carriers may be asymptomatic and may have normal liver function tests. Therefore, any patient with a history of non-A, non-B hepatitis who is admitted to the hospital should be placed on blood and needle precautions. Although it is certainly appropriate to place patients with acute non-A, non-B hepatitis on formal enteric

isolation, it would be impractical to institute formal enteric isolation for a patient with a history of non-A, non-B hepatitis for the duration of each of multiple hospitalizations. However, health care personnel must be informed that feces and other body fluids from such a patient may be infectious and should be handled with care. It would be appropriate to place any patient with a history of non-A, non-B hepatitis and gross gastrointestinal bleeding on formal enteric isolation.

*C. Glen Mayhall, M.D.
Division of Infectious Diseases
Medical College of Virginia
Richmond, Virginia*

To the Editor:

[These are some] ideas I have after working 40 years in Boston Hospitals—most recently at the Lahey Clinic, from which I retired several years ago.

A number of things come to mind concerning infection control on a hospital-wide basis and I hope that your publication will direct vigorous attention to these:

(1) Hospitals lack housewifely cleanliness. This is a very complex problem and its solution should be the primary goal. Housekeeping, laundry, maintenance, dietary, pharmacy, doctors and nurses, the O.R., recovery room, intensive care, respiratory and I.V. therapy departments—all are in the picture. Your article on dirty fiberoptic scopes and cocaine used with them is an example.

(2) A tried and proven way to clean hospital floors should be advocated, for in this area we find the poorest paid workers, many with language barriers, who are poorly if at all indoctrinated in the proper way this most important aspect of hospital cleaning should be

done. Who trains these people, and for how long are they trained? What care and bacteriologic checks are made on their mops, buckets and vacuum cleaners?

(3) What bacteriologically proven method is there for the care of carpets in halls and patient's rooms?

(4) Are there time-tested methods for cleaning of patients' rooms? Are these effective when properly applied to adequately clean the entire room and bathrooms?

(5) What cleanliness standards apply to the plastic material issued to each new patient on admittance to hospitals? Should these items be re-sterilized—and if so, after how many days? Is it safe to allow patients to take these used items (cups, wash basins, urinals, etc.) home with them?

(6) How is the hospital laundry checked to make certain the workers are handling soiled material so as not to infect themselves, the area or the equipment? How often and by what

methods are the laundry trucks (which transport both dirty and clean laundry) checked and sanitized?

(7) Should the hospital bacteriologist visit and observe the areas from which cultures are received regularly, i.e., the OR, ICU, recovery room? Should the bacteriologist be responsible for prescribing the method of taking cultures and for delivering them?

(8) Who should be responsible for the safe bacteriologic operation of hospital air conditioning systems? Are there proven, effective methods in use that will allow an ongoing assurance that these potentially dangerous systems are clean?

(9) Who should be responsible for an ongoing evaluation of the dietary department and all of its equipment?

(10) With truckloads of disposable equipment coming into hospitals daily, what are the hazards? Who checks to be certain that items labeled sterile are really sterile? These plastic items are used in patients rooms, in

heart operations and after cataract surgery—and most hospitals assume they are sterile, but I'm not sure they verify that they are. Also, since more storage area is needed and used by hospitals for this constantly arriving material, who checks to make certain that the cartons as well as the storage area are not contaminated? How is the storage area checked and by whom?

(11) Is there a hazard to patients from interns, residents and staff doctors with beards and long, dirty hair to go along with their dirty clothes? I do not believe such people should be allowed in ORs or patients' rooms.

As far as I am concerned, the day-to-day management, investigation and constant checking of the above points has more to do with reducing hospital acquired infections than anything else we can do or have done.

Sincerely,

*Morris J. Nicholson
Sun City, Arizona*

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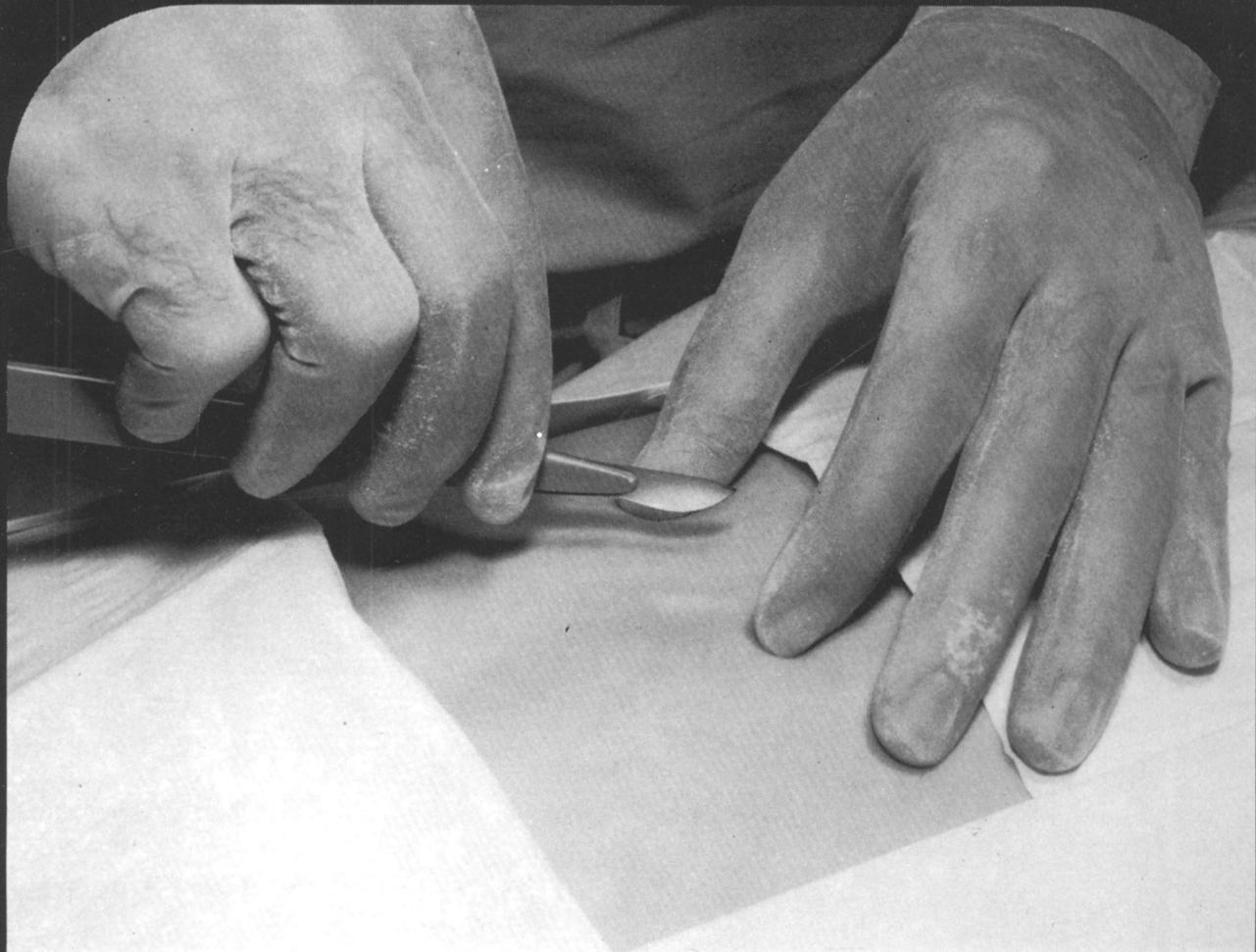
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