

ever, specificity and PPVs of the latter combination were significantly higher than the former: 82% and 78.1% versus 59.7% ($P=.008$) and 61.9% ($P=.07$), respectively. The likelihood ratio of a positive test for the combined subcutaneous segment and hub culture was 4.68, and only 2.13 for the combined skin and hub culture.

The results indicate that the combined subcutaneous segment and hub culture constitute an easy, effective procedure for the conservative diagnosis of catheter colonization.

FROM: Fortun J, Perez-Molina JA, Asensio A, Calderon C, Casado JL, Mir N, et al. Semiquantitative culture of subcutaneous segment for conservative diagnosis of intravascular catheter-related infection. *J Parenter Enteral Nutr* 2000; 24:210-214.

Bacteremia After Transrectal Ultrasound-Guided Prostate Biopsy

Lindbert and coinvestigators, from the Department of Urology, Stanford University Medical Center, determined the incidence and predisposing factors of bacteremia and bacteriuria after prostate biopsy with specific emphasis on the value of a pre-biopsy enema. They randomized 50 men undergoing ultrasound and biopsy to rule out prostate cancer to receive a preoperative enema (25 men) or no enema (25 men). Preoperatively, urine was obtained for culture, and questionnaires regarding urological history and voiding symptoms were completed. Cultures were taken from the initial prostate biopsy, biopsy needle, and postoperative urine and blood specimens. The following day, a symptom questionnaire was completed.

Bacterial growth in post-procedure cultures did not correlate with the number of biopsies, prostate-specific antigen, obstructive voiding symptoms, prostate volume, cancer, or post-biopsy hematuria. Bacteriuria was noted in 44% of the cases, and bacteremia was present in 16% of the patients, of whom 87.5% did not receive an enema ($P=.0003$). One patient had chills and fever $>37.5^{\circ}\text{C}$, requiring additional antibiotics. On the follow-up questionnaire, 12% of patients described dysuria, including 84% with bacteriuria after biopsy.

The authors concluded that bacteremia and bacteriuria are common, but usually asymptomatic, after multiple biopsies. Bacteria apparently are introduced into the urine or blood from the rectum via the biopsy needle, which may be minimized by a pre-biopsy enema. Dysuria or a history of urinary tract infection did not predict problems after biopsy.

FROM: Lindert KA, Kabalin JN, Terris MK. Bacteremia and bacteriuria after transrectal ultrasound guided prostate biopsy. *J Urol* 2000;164:76-80.

Healthcare Worker-to-Patient Transmission of HCV in the UK

Several recent look-back investigations in the United Kingdom have demonstrated transmission of hepatitis C virus (HCV) from infected healthcare workers (HCWs) to patients during exposure-prone procedures. Since October

1999, investigations involving three HCV-infected HCWs and testing of more than 6,000 patients have identified 12 patients who likely contracted HCV from their healthcare providers, according to the UK Department of Health. The three HCWs were unaware they were infected with HCV until 1 of their patients presented with infection. In each instance, subsequent testing confirmed HCV infection in the HCW and led to a more extensive look-back investigation.

The Department of Health and the hospitals involved would not provide information on the specific occupations of the workers or what procedures led to the spread of infection. A BBC news report, however, identified one as a surgeon in obstetrics and gynecology. The BBC speculated that another HCW also is a surgeon.

HCV infection was identified by the presence of hepatitis C RNA in blood samples. Samples positive for hepatitis C RNA were then genotyped and underwent hepatitis C RNA sequence analysis. Samples from patients and HCWs were then compared.

An investigation associated with an HCW in Boston, Lincolnshire, involved contacting and testing 4,500 patients treated by the worker at 11 hospitals in England and Wales after 1978. The UK National Health Service (NHS) organized an initial investigation in October 1999 after it was discovered that an HCW at Pilgrim Hospital in Boston transmitted HCV to a patient. NHS patient records were searched at hospitals where the HCW was based after 1993. In March, the UK Advisory Panel for Health Care Workers Infected with Bloodborne Viruses advised extending the investigation to 1978. So far, 8 patients appear to have contracted HCV from the worker.

A second investigation of a London-based HCW involved contacting approximately 1,900 patients in March who were treated between 1994 and 1999 at three London hospitals. Data collected to date have identified 3 patients who likely contracted infection from the HCW.

A third investigation, which started on June 2, involves an HCW in Birmingham. Of 749 patients contacted, 1 patient has been found to be infected with HCV thus far.

Infected HCWs in the United Kingdom currently are advised not to perform exposure-prone procedures. Currently, no recommendations exist in the United States or elsewhere to restrict professional activities of HCWs with HCV infection. The CDC recommends that HCV-positive HCWs follow strict aseptic technique and Standard Precautions, including appropriate use of hand washing, protective barriers, and care in the use and disposal of sharp instruments.

In addition to the cases identified in this report, two incidents of transmission have been reported, one in Spain and one in London. In both, HCV transmission occurred during cardiothoracic surgery.

FROM: Adapted from news story in *icanPrevent News* (www.ican.prevent.com). Original source of information: UK Department of Health, June 7 press release: "Hepatitis C infected healthcare workers" and UK Department of Health, March 30 press release, with list of hospitals involved in the investigation: "4,500 patients notified of potential exposure to infection."