

Letters to the Editor

Is There Unwarranted Risk in Cohorting AIDS Patients?

To the Editor:

Doctors Hospital is a voluntary community institution of 263 beds located in New York City. We are currently undergoing growing pains in the form of a multimillion dollar renovation and expansion project. Upon completion there will be completely modernized patient floors, new clinical/pathology laboratories, operating rooms, radiology department and an expanded emergency room. In the midst of this activity the hospital has remained open and continues to serve the surrounding Yorkville Community. Through repeated emphasis of basic sanitarian principles and infection control practices our nosocomial infection rate has remained relatively stable with no incidents traceable to construction activity (eg, Aspergillus in immunocompromised patients).

A situation arose which required some reflection on my part. To provide a properly functioning independent ventilation system for our isolation rooms required their being out of service for 3 to 4 days. Our isolation rooms are vertically aligned with one on each of seven patient floors. While ideally they are reserved for diseases which necessitate separation such as those under respiratory, AFB and contact isolation, they are more often used for individual AIDS patients. We acknowledge that these patients usually need be on Blood/Body Fluid Precautions only as per CDC Guidelines.^{1,2} However, the anxiety elicited by posting the obligatory sign is significant. The alarm felt by the roommate and his family/friends is such that it is often simpler to use the isolation rooms when available. It is understood however that should a patient be admitted with a more communicable disease (eg, tuberculosis, meningitis), the AIDS patient will be bumped to a

private room at the hospital's expense.

Having to keep our isolation rooms empty for 3 to 4 days raised the question of whether or not AIDS patients could be cohorted in two bedded, semi-private rooms. This would leave the private rooms available for those patients wishing to pay for such accommodations. As with many other New York Hospitals we have recently experienced a dramatic increase in the number of AIDS cases. In 1982 we saw perhaps one case every 3 months. Currently we average five cases in any given week which therefore ties up five of our seven isolation rooms.

When I was asked whether it was feasible to cohort our AIDS patients, my initial thought was why not, assuming of course, the patients were carefully selected. For example under no circumstances should an AIDS victim with *Pneumocystis carinii* pneumonia (PCP) be roomed with another who is free of this opportunistic infection. In essence I found myself attempting to pair AIDS patients based on specific opportunistic infections present and the degree of debilitation. For example, two patients with PCP and oral thrush might be considered excellent choices for roommates. On the other hand, with patients as vulnerable as AIDS victims, I was not comfortable with this idea. With the severely immunosuppressed we cannot anticipate all changes. Although when initially roomed together patients may have matching opportunistic infections we cannot predict when one of them may develop additional infections such as reactivated CMV or profuse diarrhea due to cryptosporidiosis. By the time such pathogens are detected it may be too late to protect the susceptible roommate. In spite of the fact that many opportunistic infections are transmissible only through direct contact there is still a high risk of cross-infection. How many health care workers wash their hands between patients *within* the same room?

The situation is not similar to

cohorting two or more patients with the same strain of bacterial or viral pneumonia. With AIDS we are dealing with a syndrome that makes the victim vulnerable to a wide variety of opportunistic infections often endogenous in origin. Therefore we cannot predict which opportunistic infection will surface in a patient nor when.

As one of the primary roles of an Infection Control Practitioner is prevention, it would appear to be prudent to avoid cohorting AIDS victims when possible.

Lastly, these are times of profuse litigation. It would be exceedingly difficult to explain to a lay jury our rationale of a policy which may easily lead to a life-threatening infection in an already debilitated patient.

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Group A Streptococcal Pharyngitis in Hospital Personnel

To the Editor:

It is with great interest that we read "Should routine throat cultures be done in hospital personnel complaining of a sore throat?"¹ since we have also been concerned about this problem in our hospital for the past several years.

We are a metropolitan teaching hospital with over 800 beds and approximately 4,300 employees from 1982 to 1985. During this period we have performed throat cultures on almost all

employees seen in our Employee Health Service with sore throat complaints. The results are summarized in Table 1. These values are significantly different ($P < 0.005$) from the reported value of 6.2% positive cultures.¹

Streptococcal pharyngitis is usually associated with tonsillar erythema, or exudate; fever; or enlarged anterior cervical nodes.² The American Heart Association (AHA) lists tender anterior cervical lymph nodes, pharyngeal exudate and scarlatiniform rash as clinical signs suggestive of streptococcal infection.³ However, we have found the following signs as summarized in Table 2 for data available from 1984. In no patient was a rash documented.

Three patients out of 49 had no objective findings. The most prevalent objective findings were erythema (85%) and enlarged anterior cervical nodes (55%). Fifty-one percent of those who were positive had both findings. Nine patients out of the 42 patients (21%) with erythematous tonsils had no other accompanying findings. In our study only 18% had exudative tonsils in contrast of 70% as reported by Pantell.⁴ Hence the most reliable findings for choosing candidates in a Hospital Employee Health setting for throat culture is erythematous tonsils. It is important that hospital employees who are in constant

contact with patients do not inadvertently transmit streptococcus infection to patient and co-workers.

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Dr. Chatrchai Watanakunakorn responds to Dr. Wu's comments.

The higher rate of positive throat cultures for group A streptococcus from hospital employees reported by Dr. Wu and her colleagues is of interest. There are obvious differences between our studies. For instance,

with only 3200 employees in our hospital, 323 throat cultures were done during a three month period in 1984, or 34 throat cultures per 1000 employees per month. In contrast, with 4300 employees in their hospital, only 457 throat cultures were done during a twelve-month period in 1984, or 9 throat cultures per 1000 employees per month. Obviously there were significantly less throat cultures done on employees at their hospital. Perhaps employees with a mild sore throat at their hospital did not seek treatment at the Employee Health Service. Or perhaps only employees with a severe sore throat were cultured.

I agree that it is important that hospital employees who are in constant contact with patients do not inadvertently transmit group A streptococcus from their throat to patients and co-workers. This did not happen in our hospital during the past six years that we have data. To my knowledge there have been no reports of its occurrence at others hospitals either.

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Influence of Multiple Isolates on Antimicrobial Susceptibility Patterns from Blood Cultures

To the Editor:

We recently reported that there was no practical differences between including multiple isolates versus only one isolate per patient when calculating the antibiotic susceptibility profiles of bacteria identified from the specimens submitted to a clinical microbiology laboratory.¹ We speculated, however, that the effect might be much greater if one considered only specimens, such as blood cultures, where repetitive cultures are especially common. Blood cultures are of special interest because of the clinical importance of empiric therapy.

We have now completed an analysis, using the same methodology as referenced above, of positive blood cultures. A total of 221 isolates from positive blood cultures obtained over

TABLE 1
CULTURE POSITIVE GROUP A STREPTOCOCCUS PHARYNGITIS

Year	No. of Positive/ No. of Cultures	% Positive
1982	99/732	13.5%
1983	64/650	12.9%
1984	56/457	12.3%
1/85-5/85	35/190	18.4%

TABLE 2
SIGNS ASSOCIATED WITH CULTURE POSITIVE GROUP A STREPTOCOCCUS (TOTAL CULTURES 49)

Signs	Number (total)	Percent of total
Temperature >99.5°F	10 (49)	20%
Erythema	42 (49)	85%
Edema of tonsils	8 (49)	16%
Exudate	18 (49)	37%
Enlargement of cervical nodes	27 (49)	55%