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INFECTION CONTROL

LETTERS TO THE EDITOR

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 hospital 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.

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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.

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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