

## **Restriction of Hospital Employees with Active HSV**

To the Editor:

In 1977, the American Academy of Pediatrics recommended that neonates be separated from all sources of herpetic infections, including employees and mothers.<sup>1</sup> Many centers have not followed these suggestions, presumably due to lack of data documenting transmission of Herpes simplex virus (HSV) in hospitals.<sup>2</sup> The recent review in *Infection Control of The Nursing Clinics of North America: Symposium on Infection Control* likewise questioned the validity of our statements concerning restriction of hospital employees with active HSV from nurseries, delivery rooms, or oncology units.<sup>3</sup> There is sufficient information now available concerning nosocomial transmission of HSV in nurseries to support our position.

Horizontal transmission of HSV in hospitalized newborns has been suggested by epidemiologic studies since the mid-1970s.<sup>4</sup> Until recently, definitive proof was hampered by an inability to distinguish between epidemiologically related and unrelated HSV isolates. Electrophoresis of virus-specific DNA cleaved by restriction endonucleases will separate and identify epidemic from nonepidemic strains of HSV-1 and HSV-2. Using

restriction endonuclease techniques, Linnemann and co-workers demonstrated horizontal transmission of HSV-1 from a father to a newborn in a neonatal nursery. A second neonate also harbored the epidemic strain, but the mode of transmission in that instance was not entirely clear.<sup>5</sup> Adams et al recently reported a series of acute herpetic infections occurring among nurses and patients in a pediatric intensive care unit. Restriction endonuclease analysis showed two clusters of infections were caused by different epidemic strains of HSV-1. There was clear epidemiologic and biologic evidence of cross-infection between employees and patients.<sup>6</sup> Similar evidence of hospital transmission of HSV in oncology units and delivery rooms has not yet been documented. Nevertheless, we consider these high risk areas for nosocomial transmission. We urge that infection control practitioners and committees carefully re-examine their current hospital guidelines for HSV.

### **REFERENCES**

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## **Cracked Infusion Bottles**

To the Editor:

As medical technology advances, physicians and nurses may be confronted with previously unrecognized infection control problems. Cracks in infusion bottles leading to microbial contamination of solutions contained within are a well-recognized potential source of hospital-associated bac-