studies done at CDC showed that, with flash sterilization, the "margin of safety" may be relatively small. In point of fact, a recent outbreak of meningitis on a neurosurgical service was traced to inadequate flash sterilization of central-nervous-system tubing.[2]

Although following the CDC recommendation mentioned by Dr. Weinstein may result in increased costs for some hospitals, we believe that the costs are reasonably small and acceptable for most hospitals, considering the potentially enormous costs of an undetected sterilization failure involving an implanted device. However, CDC and its working group realize that: **1)** *the proper period of time to withhold implantables from use pending spore test results is not known, although it is probably at least 24 hours;* **2)** *even with the best planning, not all implantable devices necessary for an operation will have been sterilized 48 hours in advance; and* **3)** *strict compliance with the recommendation as written may be very expensive and impractical for a few hospitals with a large volume of implant surgery and limited storage space. Thus, the recommendation in the Environmental Control Guidelines has now been changed, with the agreement of panel members, to the following:*

1. Every load (sterilized) should be monitored with a spore test if it contains implantable objects. These objects should not be used until the spore test is found to be negative (at 48 hours). Category II
2. Implantable objects should not be sterilized by "flash" steam sterilization. Category I

We will soon incorporate this change into our next revision of the Guidelines and bring this change to the attention of hospital personnel. We appreciate the comments and criticism presented by Dr. Weinstein; such comments give us the opportunity to improve our guidelines. As we said in our preface to these guidelines, we welcome all comments, suggestions, and criticisms.

REFERENCES

1. Centers for Disease Control. False-positive results of spore tests in ethylene oxide sterilizers—Wisconsin. MMWR 1981; 30: 238-40.
2. Ho JL, et al. Common-source *Pseudomonas aeruginosa* infection in neurosurgery. In: Proceedings of the Annual Meeting of the American Society of Microbiology, 1981. Dallas, Texas. Paper L10, page 80. Abstract.

To the Editor:

Medical research continues evolving into an increasingly sophisticated, technologically intensive endeavor. It is not uncommon now to have multimillion dollar grants awarded to teams of researchers employing myriads of postdoctoral fellows and technicians, just to study the molecular structure of slightly aberrant polypeptides. Admittedly this is an overstatement, but it does highlight the fact that health care practitioners in many smaller institutions are finding it increasingly difficult to conduct original research. However, there is still at least one fruitful area of study available to practitioners of infection control: nosocomial infections caused by nonfermentative gram-negative bacilli—NFB.

NFB are a diverse group of bacteria that have two common features. They are unable to grow in the absence of available oxygen and cannot generate energy fermentatively. Additionally, they have simple nutritional requirements, resist most antimicrobial agents, and are ubiquitous in nature.

Although hundreds of NFB species have been described, less than 40 species are routinely encountered in clinical microbiology laboratories. The most common of these species, *Pseudomonas aeruginosa,* is already an old friend (or enemy) of infection control personnel. It is a significant pathogen with fairly straightforward modes of transmission within hospitals.

What about all of the other NFB isolates? For example, are CDC Va-1 or CDC IIk-2 potential pathogens? What about the pathogenicity of *Alcaligenes faecalis* or *P. acidovorans*? How are NFB other than *P. aeruginosa* transmitted within the hospital? Can hospital water systems be reservoirs for pathogenic NFB? Infection control programs can provide answers to these questions through three relatively simple steps.

1) Insist that your microbiology laboratory identify all NFB isolates to the species level. Laboratory reports that list "*Pseudomonas* species" should be considered unacceptable. Do three isolates of "*Pseudomonas* species" from one ward equal an outbreak? Probably not if, in reality, one is actually *P. maltophilia,* one is *Acinetobacter lwoffi,* and the third is *P. acidovorans.* The problem is, you just won't know until you get accurate information. If your laboratory has limited resources, you should encourage them to use reference laboratories, such as those supported by states and counties. Most of these laboratories do not charge for reference services.

2) Review patient charts for evidence of significant infections caused by correctly identified NFB. Pay particular attention to pure culture isolates, recovered more than once from body sites with documented evidence of infection.

3) Publish your findings. Infection control practitioners are in a unique position to correlate and disseminate this type of information. In this way, you might be responsible for discovering one of the "new" nosocomial pathogens of the 1980s.

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To the Editor:

Following publication of "Guidelines for Prevention of Catheter-Associated Urinary Tract Infections" in *INFECTION CONTROL*'s March/April issue, the Centers for Disease Control received a letter pointing out a problem with the recommendation that concerns bladder irrigation. That recommendation, Number 6a, has now been changed. The recommendation as originally written implied that continuous irrigation of the bladder to prevent anticipated obstruction was inadvisable. This implication was not intended. With the agreement of the Guideline working group, the recommendation has now been changed and combined with recommendation 6e, so that it reads as follows:

> Irrigation should be avoided unless obstruction is anticipated (e.g., as might occur with bleeding after prostatic or bladder surgery); closed continuous irrigation may be used