

the application of pertinent knowledge and evades the discipline and inconvenience necessary for its effectiveness.”<sup>2</sup>

#### REFERENCES

1. Rein MF: Editorial: Nosocomial sexually transmitted diseases. *Infect Control* 1984; 5:117-122.
2. Altemeier WE, Burke JF, Pruitt BA Jr, et al (eds): *American College of Surgeons Manual on Control of Infection in Surgical Patients*. Philadelphia, JB Lippincott Co, 1976, p 4.

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#### To the Editor:

Recently we read the Editorial “Nosocomial Sexually Transmitted Diseases” by Michael F. Rein, MD.<sup>1</sup> We discussed the article at our quarterly Infection Control Meeting. Many questions arose because of the following statement: “. . . the CDC National Nosocomial Infection Study has chosen to define all neonatal infections as nosocomial.” Would you be more specific and assist us in answering these questions by informing us of guidelines or criteria on which you base this study.

#### REFERENCES

1. Rein, MF: Editorial: Nosocomial sexually transmitted diseases. *Infect Control* 1984; 5:117-122.

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*Michael F. Rein, MD, offers the following response to the preceding queries.*

I appreciate Birnbaum’s interest in my Editorial. He notes that I frequently recommended the use of body discharge precautions in hospitalized patients with sexually transmitted diseases (STD) and questions whether such precautions should be instituted on a “diagnosis-specific basis.” Birnbaum suggests that such precautions really constitute basic hygienic practice which would be applied prudently to all patients regardless of diagnosis. His observation really relates to all infections, not just STD, but my response is from the point of view of venereology.

I must in theory agree with

Birnbaum. Body discharge precautions include “strict handwashing before and after any contact with patient and/or secretion-contaminated articles,” avoidance of direct contact with potentially contaminated secretions, and proper disposal of soiled dressings in waxed paper bags.<sup>1</sup> As Birnbaum points out, many of these elements might well be applied to any patient (although routine incineration of all used bed linens would rapidly become oppressively expensive). In a setting where such precautions were routinely practiced on all hospitalized patients, formal institution of body discharge precautions would indeed be unnecessary. In my experience, however, such precautions are not routinely taken with all patients. Even the most dedicated hospital staff occasionally requires reminders which are provided by the appropriate door cards. One might also argue that the hospital has a legal and ethical responsibility to its staff to indicate the presence of a known infectious risk.

Are these precautions necessary and effective? Frankly we do not know. There are few adequately controlled studies of any isolation procedure. With the exception of ocular prophylaxis of the newborn and the use of caesarean section for mothers with genital herpes, I know of no adequate data specifically concerning the prevention of nosocomial STD. In the absence of good data, recommendations must be based on reasonable, theoretical considerations. These are the bases for my suggestions.

Birnbaum notes that applying these precautions on a disease-specific basis tends to separate STD patients from others, to isolate them in the psychosocial sense. This need not be the case. Precaution cards do not indicate the specific diagnosis, and body discharge precautions do not mandate private rooms. For most STD (the exceptions being viral and chlamydial infections), patients become noncontagious very quickly after initiating therapy, and in general precautions can be discontinued within 48 hours.

At least as important is the concept that body discharge precautions, or less frequently wound and skin precautions, are probably *all* that one need do. Perhaps because of their

social consequence the STDs are often regarded with fear that is distinctly out of proportion to their clinical significance. Further, these pathogens are in some respects different from those often involved in nosocomial infection. A few *Pseudomonas* contaminating the fingers are unlikely to produce disease in normal hospital staff, but a few *Treponema pallidum* or herpes simplex viruses may in fact do so. Hospital staff may be relieved to learn that by taking only relatively limited precautions, the risk of infection of health care personnel can be essentially eliminated. Patients with sexually transmitted diseases need not be isolated in the social or the physical sense.

Given current standard patient care practices, I continue to believe that the application of the recommended precautions are rational.

Nurse Casares raises questions about the definition of neonatal infections as nosocomial, and I must apologize for being unclear in the Editorial. The Hospital Infections Program (Center for Infectious Diseases, Centers for Disease Control, Atlanta, GA 30333) has developed a Site Definition Manual which defines nosocomial infections for the National Nosocomial Infections Study (NNIS). These guidelines ensure consistency in reporting practices among participating hospitals. It was this definition that I cited, but I did so incompletely. The NNIS regards as nosocomial those neonatal infections thought to be acquired either intrapartum or during hospitalization. As such, gonococcal or chlamydial ophthalmia neonatorum or neonatal herpes simplex virus infection would be regarded as nosocomial. On the other hand, infections acquired in utero by transplacental transmission of pathogens would not be regarded as nosocomial. Sexually transmitted diseases in the latter category would include congenital syphilis and cytomegalovirus infections. The major significance of these definitions is that criteria be applied uniformly. They seem reasonable because indeed transmission does take place in the hospital, and many of these diseases are preventable either by diagnosis and treatment of maternal infection or by suitable prophylaxis applied to the neonate. Indeed surveillance data may