

risk factors, such as incisions, indwelling IV and urinary catheters, and tracheostomy tubes.

Before a patient can come off this type of isolation, certain criteria must be met. The resistant organism must no longer be present at the site, whether or not the infection (eg, the drainage) has cleared. If a wound was infected but has now healed, the skin at the site must still be cultured. In addition, MRSA especially, may have colonized the skin or mucous membranes of the patient. Although one study found that in the presence of a tracheostomy, the site was more often positive than the nares.¹ We require a culture of both anterior nares to be negative for the resistant organism before the patient can be taken off isolation. The other requirement is that infection control personnel must be consulted before the patient comes off isolation, and we check that the culture results are final reports, not preliminary or interim findings, before permitting the discontinuance of isolation. Preliminary reports have occasionally been changed later and the extra day is well worth the wait.

Although the new category of Isolation for Antibiotic-Resistant Organisms is very demanding on the staff and costly for the institution, we have found that in a large institution such as ours (533 beds), it has prevented premature removal of patients from other types of isolation when their infection, but not necessarily their colonization, cleared. We believe keeping patients on this rather stringent kind of isolation has curtailed the spread, especially of MRSA, because personnel are anxious to avoid new cases, and are thus very strict in enforcing the necessary precautionary measures for themselves and other hospital personnel.

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HIV Infection per Needlestick in Health Care Workers

To the Editor:

As an active participant in one¹ of several studies²⁻⁶ designed to examine the actual risk of transmission of human immunodeficiency virus (HIV) through contaminated needles in a nosocomial setting, I am concerned that the relative risk published to date^{1,6} has been based on an assumption that all patients who are HIV-antibody positive are viremic and capable of transmitting HIV per needlestick to health care personnel.

As pointed out in a recent survey⁷ of 39 HIV-antibody positive individuals who were in various clinical stages of infection, almost half (46.2%) of these patients lacked evidence of viremia, based on serum and peripheral mononuclear cell cultures. If we assume that almost half of the health care workers who have been enrolled to date in needlestick exposure studies

were not exposed to blood containing HIV, then our denominators used to calculate risk should be halved and the relative risk should be doubled.

At present, I worry that the published data foster a false sense of security, not only in health care workers but also in investigators participating in these epidemiologic studies. In this vein, such studies might be terminated before true relative risk can be obtained.

The future capability to perform more extensive virologic examinations of specimens routinely should allow us to categorize HIV-infected individuals more definitively into certain exposure risk groups, much like what has already been done in patients with hepatitis B.⁸

While the present HIV/needlestick studies provide us with relative risk based on HIV-antibody positivity, I think the ultimate goal of these studies should be to stratify this risk.

Certainly, these studies have already provided us with at least one valuable, and yet, not unexpected revelation—that a large portion of the accidental exposures that have occurred could have been prevented had routine infection control policies been followed. We must take this strong message to our fellow health care professionals.

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Infection Control Practitioners and AIDS

To the Editor:

Infection control practitioners across the country are experiencing a crisis, particularly if they are located in large metropolitan hospitals. However, the eventual outcome of this crisis is potentially the same for all practitioners, regardless of hospital location. Now is the time for assessing our needs and acknowledging the support systems required to meet the challenge of the AIDS crisis in our hospitals in an effort to plan for the future.

Unfortunately, hospital administrators are suffering a similar crisis concomitantly. Fiscal restraints become increasingly pervasive each year, as we all know, and human immunodeficiency virus (HIV) infection does not generate revenue. Nonetheless, we are looking to our administrators for necessary support for additional educational funding and "person power" to meet the needs of

effectively facing this epidemic in our everyday work experience.

Therefore, the struggle to balance an already, oftentimes, demanding profession with the impact of this epidemic is voiced as frustrating and burdensome by many of us. Our ability to communicate the required support systems is often inadequate.

Creative solutions are needed. The need to continue nosocomial surveillance programs, and meet the other needs we are all so familiar with in our hospitals is being greatly outweighed by this slow, insidious, progressive epidemic.

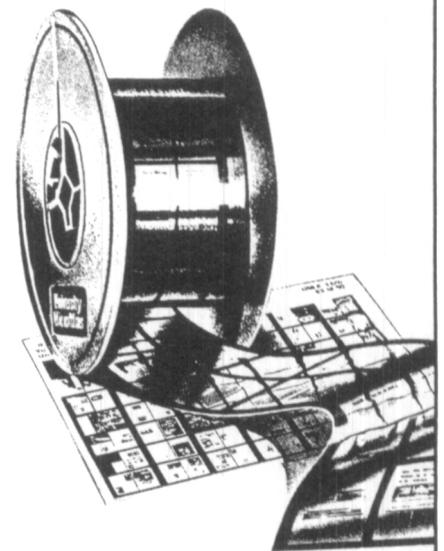
Please acknowledge that support is required by our own organization, as well as by the Centers for Disease Control. An improved system to realistically assess the need for infection control personnel based on bed occupancy, acuity, and size of the population with HIV infection being treated is needed. "One practitioner for every two hundred and fifty beds" is now archaic, therefore, no longer applicable. It is actually self-defeating.

The challenge is before us to respond, voice our professional needs, and responsibly represent ourselves to the hospital communities at large. Our lack of problem assessment will only continue to foster the chaos pervading this period of the AIDS crisis.

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Letters to the Editor should be addressed to INFECTION CONTROL Editorial Offices, C41 General Hospital, University of Iowa Hospitals and Clinics, Iowa City, IA 52242. All letters must be typed double spaced and may not exceed four pages nor include more than one figure or table. The editors reserve the right to edit for purposes of clarity or brevity.

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