

they were introduced at our clinical setting, they were evaluated by our nursing department in a clinical setting and were found acceptable.

Patients who were diagnosed as having *Clostridium difficile* were promptly treated with oral vancomycin and placed on body substance isolation but were not placed in private rooms. Environmental disinfection was performed daily with Sanimaster III, containing quaternary ammonium compounds, diluted according to manufacturers' recommendations.

Proper use of gloves, according to our infection control guidelines, calls for changing of gloves between all patient contacts where the possibility exists for contaminating the gloves with blood, body fluids, or secretions. This includes changing gloves between patients after taking a rectal temperature.

In response to the comment that the attention given to the outbreak and the education of personnel must have played a role in reducing *C difficile* cases, I would point out that this issue was addressed in our discussion.

We were well aware that the termination of the outbreak could have been explained by factors other than by the intervention employing disposable thermometers, and we specifically mentioned several alternative explanations in our report. These included the possibility that the outbreak was waning of its own accord or we were seeing a delayed effect from our efforts at reinforcing our infection control policies. Also discussed was the possibility that the

increased attention given to the problem, including the introduction of disposable thermometers, created a Hawthorne effect.

Contrary to MS Pfaff's comment, it was not our intention to dismiss other intervention strategies. We acknowledged in our report that the risk of acquiring *C difficile*-associated diarrhea, especially in an acute care setting, is likely to be multifactorial. Our study addressed just one of the potential modes of transmission of *C difficile*. Other modes of transmission would require distinctly different intervention strategies.

The strict adherence to appropriate infection control guidelines remains a key determinant in controlling outbreaks of this type; however, the point that we attempted to make in this study is that we have implicated a fomite (electronic thermometer) that is prone to contamination with *C difficile*, is difficult to sanitize adequately between uses, is shared by multiple patients, and is used at a potential portal of entry for the organism.

We further noted that the presence of *C difficile* on the handles of the electronic thermometers would nullify the effectiveness of some infection control measures designed to prevent cross infection. Thus, changing gloves or washing hands between taking rectal temperatures would not be protective because the new gloves or clean hands would become contaminated upon handling the electronic thermometer prior to use. Transfer of *C difficile* from the hands to the thermometer tip prior to insertion could introduce the

organism into the gastrointestinal tract.

It should be noted that failure to follow appropriate infection control practices (i.e., change gloves between patients) when taking a rectal temperature also could result in contamination of the disposable rectal thermometers with *C difficile*. The difference here is that if gloves are changed, the disposable thermometers should remain free of *C difficile* contamination.

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Corrections

In the June 1992 issue of *Infection Control and Hospital Epidemiology*, in the article by Koziol et al (1992;13:343-348) on page 345, the "45" that appeared after the formula in the first column indicates "reference 45," not an instruction to multiply the result by 45.

The references for the Letter to the Editor titled "Pseudo-Outbreak of Blastomycosis Associated with Contaminated Bronchoscopes" (1992;13:324) should read as follows:

REFERENCES

1. Centers for Disease Control. Nosocomial infection and pseudo infection from contaminated endoscopes and bronchoscopes-Wisconsin and Missouri. *MMWR*. 1991;40:675-678.
2. Romance L, Nicolle L, Ross J, Collins D, Hamon J, Kepron W. A pseudo outbreak with multiple resistant *Pseudomonas aeruginosa* due to a contaminated bronchoscope. *Infection Control Canada*. September/October 1989:13-18.

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