

Medical News

EDITED BY GINA PUGLIESE, RN, MS; MARTIN S. FAVERO, PhD

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Infection Surveillance and Control Programs: United States, 1992-1996

Nguyen and coinvestigators, from CDC's Hospital Infections Program, and the Association for Professionals in Infection Control and Epidemiology, Inc (APIC), recently published a study describing US infection surveillance and control programs (ISCPs), updating previous studies from the 1970s. In January 1997 a voluntary survey was mailed to APIC members. Only one response per facility was requested. The survey asked for information from the years 1992 to 1996 (study period), and questions pertained to characteristics of the healthcare facility in which the respondent worked, characteristics of the ISCP and its personnel, and the overall level of administration support for infection control activities.

Completed questionnaires were received from 187 healthcare facilities in 40 states and the District of Columbia. The majority (76.5%) of responding facilities were non-government owned, and 57.2% were classified as general acute-care facilities. The number of licensed beds at these facilities remained stable throughout the study period, but all other measures of facility size and activity (eg, number of patient days and number of nurses) decreased by as much as 29%. In 1992, ISCPs were most likely to be organizationally located in the nursing department, but by 1996, many had been transferred to departments of medical records, quality assurance, or risk management. Throughout the study period, the number of facilities performing surveillance for healthcare-associated infections in outpatient settings increased by 44.0%, from 100 to 144.

In 1996, only 47.6% of facilities had a hospital epidemiologist (HE), and HEs devoted a median of $\leq 15\%$ of their time to infection control activities. HEs often were trained in infectious diseases, but few were certified in infection control. Infection control professionals (ICPs) were much more common than were HEs (ICPs were reported at 97.9% of respondents' facilities in 1996), and they spent the majority (80% in 1996) of their time on infection control activities. During the study period, increasing numbers of facilities had ICPs who had certification in infection control. Furthermore, most respondents did not report a change over time in the level of administration support for infection control activities.

Several changing parameters, such as departmental shifts and increased outpatient surveillance, reflect adjustments in healthcare priorities during the study period. As the

transformation of the healthcare system continues, continued evaluation of the status of ISCPs on a national level will be necessary. Diligent monitoring, proactive measures, and collaboration between infection control organizations and government agencies will be vital for the prevention and control of healthcare-associated infections in the future.

FROM: Nguyen GT, Proctor SE, Sinkowitz-Cochran RL, Garrett DO, Jarvis WR. Status of infection surveillance and control programs in the United States, 1992-1996. *Am J Infect Control* 2000;28:392-400.

Transmission of HCV From Anesthesiology Assistant to Five Patients

Dr. Ross, from the Institute of Virology, Essen, Germany, and colleagues have reported an outbreak of hepatitis C virus (HCV) in a municipal hospital. Their findings suggest that an anesthesiology assistant contracted HCV from a chronically infected patient and subsequently transmitted the virus to five other patients (four of which are included in this report).

Between July 1 and October 13, 1998, HCV infection was diagnosed in four patients (patients 2, 3, 4, and 6 in this report) who had undergone surgery in the same hospital 6 to 18 weeks earlier. Six patients were found to have hepatitis C viremia. The HCV infection of patient 1 was first diagnosed in 1996. She probably contracted the virus through a contaminated blood transfusion or clotting-factor concentrates during heart-valve replacement in 1980. Patients 2, 3, and 6 had acute icteric hepatitis C 6 to 18 weeks after surgery, whereas patients 4 and 5 were asymptomatic after surgery. Only patient 1 had ever received blood or blood products.

All six patients and the anesthesiology assistant were positive for serum HCV antibodies and HCV RNA. At the time of the investigation, patient 1 and the assistant had high plasma levels of HCV RNA (2.6×10^7 copies of HCV RNA/mL and at least 1×10^6 copies of HCV RNA/mL, respectively). Genotyping revealed HCV type 1a infection in all cases.

The anesthesiology assistant, who participated in all four operations, was almost entirely responsible for the administration of general anesthesia, including preparation of narcotic drugs, placement of venous and arterial catheters, intubation of the patients, and the subsequent artificial respiration. He usually did not wear gloves, claiming they diminished his sense of touch and therefore impaired his work. He