Medical News

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Additional news items in this issue: *MRSA Infection in Patients With Cystic Fibrosis,* page 197; *Risk Factors for Antibiotic-Resistant* E coli *Isolated From UTI Patients,* page 205; *New Agents Cause Nosocomial Fungemia,* page 216; *Risk Factors for Postoperative Infections in Pediatric Liver Transplantation,* page 242; *Hospital-Acquired Malaria Transmitted by Contaminated Gloves,* page 247; *Vancomycin Use and VRE Colonization in Dialysis Patients,* page 257.

CDC's Hospital Infections Program Changes Name, Becomes a Division

The Hospital Infections Program, National Center for Infectious Diseases (NCID), CDC, is operating under its proposed new name: Division of Healthcare Quality Promotion (DHQP). A reorganization plan has been submitted, and approval is pending. Dr. James Hughes, NCID Director, indicated that the change reflects both the broadened scope of the program and the increased national and international recognition of healthcare-associated infections and related adverse events as a major public health burden.

Dr. Julie L. Gerberding, DHQP Director, noted that infections that occur in outpatient, long-term–care, dialysis, and home-care settings are also major contributors to the problem. DHQP will work to improve quality and prevent infections across the entire spectrum of healthcare delivery.

DHQP's proposed organizational components will include (1) Office of the Director; (2) Epidemiology and Laboratory Branch; (3) Prevention and Evaluation Branch; and (4) Healthcare Outcomes Branch.

FROM: Centers for Disease Control and Prevention. *NCID FOCUS.* 2000;9(6).

TB Associated With Use of Atomizer During Bronchoscopy

Southwick and coinvestigators recently reported the possible transmission of TB associated with the practice of reusing an atomizer. Three patients with identical strains of *Mycobacterium tuberculosis* underwent bronchoscopy on the same day at hospital A. Each patient's clinical history, hospital A's infection control practices for bronchoscopies, and specimen and isolate handling at each of three laboratories involved were reviewed. The investigation searched for possible community links between patients. Restriction fragment-length polymorphism (RFLP) was performed on TB isolates.

The first patient who underwent bronchoscopy had biopsy-confirmed granulomatous pulmonary TB. A sputum sample collected from the third patient 6 weeks after the bronchoscopy produced an isolate with an identical RFLP pattern to isolates collected during the bronchoscopies. No evidence existed for community transmission or laboratory contamination; the only common link was the bronchoscopy. Different bronchoscopes were used for each patient.

Hospital ventilation and wall-suctioning were functioning well. Respiratory technicians reported sometimes reusing the nozzles of atomizers on more than one patient. A possible mechanism for transmission was contamination from the first patient of the atomizer if it was used to apply lidocaine to the pharynx and nasal passages of other patients.

The authors concluded that a contaminated atomizer may have caused TB transmission during bronchoscopy. Hospital A changed to single-use atomizers after this investigation.

FROM: Southwick KL, Hoffmann K, Ferree K, Matthews J, Salfinger M. Cluster of tuberculosis cases in North Carolina: possible association with atomizer reuse. *Am J Infect Control* 2001;29:1-6.

Hospitals Lax in Reinstating Policy

On July 8, 1999, the American Academy of Pediatrics and the US Public Health Service (PHS) jointly recommended reducing infant exposure to thimerosal, a commonly used vaccine preservative that contains mercury. Recommendations were made to postpone the first hepatitis B vaccine dose until 2 to 6 months of age for infants born to hepatitis B surface antigen (HBsAg)-negative (ie, not hepatitis B virus [HBV]-infected) women. Infants born to HBsAg-positive (ie, HBV-infected) women, or to women whose HBsAg status was unknown, were recommended to receive postexposure prophylaxis, with the first dose of hepatitis B vaccine administered within 12 hours of birth.

By mid-September 1999, when adequate supplies of preservative-free hepatitis B vaccine became available, the PHS advocated a return to previous infant hepatitis B vaccination practices, including administering the first dose of hepatitis B vaccine to newborns in hospitals that had discontinued the practice. In 2000, preliminary assessments of the impact of these policy changes on routine hepatitis B vaccination practices by public health officials in Wisconsin, Oklahoma, Oregon, and Michigan revealed that many hospitals have not reinstated policies to ensure routine administration of hepatitis B vaccine to newborns despite the availability of preservative-free hepatitis B vaccine. These findings indicate that there is an urgent need to restore routine newborn hepatitis B vaccination practices and to point out the need for assistance from professional and government groups.

FROM: Centers for Disease Control and Prevention. Impact of 1999 AAP/USPHS joint statement on thimerosal in vaccines on infant hepatitis B vaccination practices. *MMWR* 2001;50:94-97.