

Scandinavian Experience Differs

To the Editor,

In the editorial, "Current Handwashing Issues," in the January 1984 issue of *Infection Control* the author states that alcohol, though acceptable as a skin degerming agent, is too drying for constant use. This is not a Scandinavian experience.

Its acceptability as a skin degerming agent, in fact its superiority over medicated or non-medicated soaps, has been well-demonstrated by Rotter et al both concerning ward use and pre-operative surgical scrub.¹⁻³ Its skin acceptability has been demonstrated by Ojajärvi who states: "Alcoholic solutions with skin caring additives are well tolerated even in frequent hand washing and their use should be encouraged."^{4,5}

In Sweden 70% ethanol with 2% glycerol has been the recommended hand disinfectant in wards for more than a decade. After the studies of Ojajärvi⁶ and Rotter¹ we recommend the use of soap and water before the alcohol disinfection only when hands are visibly dirty. Our experience on the acceptability of this recommendation is well in accordance with that of Ojajärvi.⁴

REFERENCES

1. Rotter M, Koller W, Wewalka G: Povidone-iodine and chlorhexidine gluconate-containing detergents for disinfection of hands. *Journal of Hospital Infections* 1980; 1:149-158.
2. Rotter M: Letter to the editor. *Journal of Hospital Infections* 1981; 2:273-280.
3. Rotter M: Hygienic hand disinfection. *Infect Control* 1984; 5:18-22.
4. Ojajärvi J: The importance of soap selection for routine hand hygiene in hospital. *J Hyg Camb* 1981; 86:275.
5. Ojajärvi J: Evaluation of hand washing and disinfection methods used in hospital wards. *Diss Kansanterveysstieteen julkaisuja M* 1981; 61.
6. Ojajärvi J: Effectiveness of handwashing and disinfection methods in removing transient bacteria after patient nursing. *J Hyg Camb* 1980; 85:193-203.

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Dr. Larson was invited to respond to Dr. Nyström's comments.

In response to Dr. Nyström's comments regarding the acceptability of alcohol for routine use as a hand cleansing agent, the evidence that alcohol is efficacious is unquestionable. Its availability in a form acceptable for use on clinical units is the problem in this country. The product that Dr. Nyström describes, 70% ethanol with 2% glycerol, would minimize the problem of skin drying. To my knowledge, however, there are few such products available for general use in the US.

One product of which I am aware, Hibistat (Stuart Pharmaceuticals), is similar to the product which was tested by Dr. Ojajärvi in Finland and would seem to offer excellent antibacterial activity with minimal skin drying. There are probably other such products available (I am certainly not trying to advocate the use of one over others). These products, however, have not "taken off" in the US. The reason most often heard from members of product evaluation committees in several large hospitals is that they fear that since the product can be used without a sink it will discourage conventional hand-

washing. Of course, if the product is efficacious, there would no reason why it would not be preferred over conventional handwashing. In that case, we need to provide the decision-makers with adequate information so that they can make an informed decision about handwashing products.

We have good evidence from our European colleagues that the alcohol-based foams are not only effective in reducing numbers of organisms on the hands, but also in decreasing dissemination of microorganisms from the skin.¹ I would recommend that we give careful consideration to the expanded use, or at least clinical testing, of such alcohol-based products and I appreciate the opportunity provided by Dr. Nyström's letter to comment on this issue.

REFERENCE

1. Meers PD, Yeo GA: Shedding of bacteria and skin squames after handwashing. *J Hyg* 1978; 81:99-105.

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PPD Skin Tests for Workers

To the Editor:

In view of the rise in pulmonary tuberculosis in the Southern California area, what is the advisability of not repeating PPD skin tests on workers in the Skilled Nursing and Allied Health Care fields, who initially had negative

skin reactions. How often should a negative skin reactor be retested?

Harry J. Silver, MD
Los Angeles, California

Harvey A. Elder, MD, was invited to respond to Dr. Silver's query.

Dr. Silver's concern is well-founded and must be addressed by every hospital.

Pulmonary tuberculosis is a contagious disease present in almost every community in the US and active tuberculosis probably presents to every US hospital at a frequency exceeding once every several years. Some hospitals are a common entry into the health care system for patients with active pulmonary tuberculosis. Such hospitals may always have hospitalized patients with active tuberculosis that is unsuspected.

An additional factor is the employee's potential exposure to patients with active tuberculosis. Some populations are less likely to expose employees to active pulmonary tuberculosis and other populations subject employees to a high rate of exposure to active pulmonary tuberculosis.

Therefore the employee health policy regarding PPD skin tests for active tuberculosis must be hospital, community, and job description specific. In some institutions intensive care nurses should be screened at least every six months. In others, intensive care nurses probably do not need to be screened even annually.

Factors playing a determinative role include probable incidence of unrecognized tuberculosis in the clients using the hospital and the probable role of tuberculosis in the hospital employee's culture (a nurse who plays a large role in helping Vietnamese

refugees has a significantly higher risk of acquiring active tuberculosis than a Malasian nurse who has no contact with recent immigrants).

More important than the general question of routine screening for tuberculosis are the specific questions of correctly performed and interpreted skin tests and enforcement of skin test policy.

The guideline for Infection Control in Hospital Personnel¹ is excellent in this respect. We use it and I believe the above is consistent with its recommendations.

REFERENCE

1. Williams WW: Guideline for infection control in hospital personnel. *Infect Control* 1983; 4:329-349.

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