

um compounds,^{1,4} phenolics,^{1,3,4} alcohols,^{4,6} sodium hypochlorite,⁴ and iodophor disinfectants.^{1,6} In only one of these studies was a hydrogen peroxide compound tested. Saurina et al⁴ tested 3% hydrogen peroxide against eight vancomycin-resistant *Enterococcus faecium* using a standard quantitative suspension test and found that insufficient kill occurred at the 3- and 10-minute test times. We too have tested not only *E faecium* (vancomycin-sensitive and -resistant) but also *Enterococcus faecalis* (vancomycin-sensitive and -resistant), *Enterococcus gallinarum*, and *Enterococcus casseliflavus* in the standard Association of Official Analytical Chemists suspension system⁷ and found that 10-minute exposure to 3% hydrogen peroxide did not always kill the enterococci. We also tested these same microorganisms in the standard test against a product that is a mixture of hydrogen peroxide, peracetic acid, and acetic acid (Spor-Klenz; Calgon Vestal Division, Steris Corp, St Louis, MO) and found that all enterococci were killed in the 10-minute standard test time.

We then tried testing the efficacy of this product against enterococci on various hospital fabrics, because we were interested in being able to "spot disinfect" items such as drapes in patients rooms. Four types of fabrics were tested: 100% cotton (clothing), 100% cotton terry (towels), 60% cotton-40% polyester blend (scrub suits), and 100% polyester (drapes). Small swatches of fabric were contaminated with 10⁶ colony-forming units of these enterococci and allowed to dry. Half of the fabrics were sprayed with Spor-Klenz, and the other half were left untreated. At 10 minutes after spraying, all samples (treated and untreated) were put into growth medium, and the medium was checked for growth at 48 hours. All of the control swatches, which were untreated, showed growth. However, none of the samples sprayed with the hydrogen peroxide-peracetic-acetic acid mixture showed growth for any of the 19 different enterococci tested on any of the four fabrics.

These studies indicate that the hydrogen peroxide-peracetic-acetic acid mixture provides an additional option that meets standards, as well

as our laboratory fabric test, for enterococcal control.

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Infection Control Practices of General Dental Practitioners

To the Editor:

I share the concerns of John Hardie¹ published in the December 1998 issue of *Infection Control and Hospital Epidemiology* concerning hand washing, use of gloves, and risks for transmission of infectious disease between patients and dentists. Hidden video cameras have shown that dentists wash their hands 23% of times before donning gloves and change gloves 56% of times between patients.² Gloved hands impart a false sense of security to the dentists and the patients, because the gloves do not provide effective protection to the dentist from accidental needlesticks or injuries from sharp instruments and

do not protect patients from blood-borne viruses,³ especially if the dentist gets a needlestick or a sharps injury while working in the mouth.^{4,5} Moreover, the patient is at increased risk from bacterial infections during invasive dental procedures if the dentist does not hand wash adequately before donning and using the gloves to handle sharp instruments inside the mouth.¹ Studies of the examination gloves, as currently presented in unsterile boxes of 100 without cuffs folded over the palms, reveal that the external surfaces used on patients and instruments routinely become contaminated with *Staphylococcus aureus*, coagulase-negative staphylococci, or alpha streptococci during the process of donning by persons with unwashed hands.⁶ These bacteria are the most common causes of sepsis following dentistry, especially in patients with a history of rheumatic fever, valvular heart disease, or immunosuppression.

Therefore, it would seem prudent for dentists to wash hands more assiduously prior to the performance of most dental procedures, whether or not gloves are donned. Time for adequate hand washing being precious, it might prove less hazardous for patients undergoing invasive procedures if dentists were to use a sterile glove or finger cot on the nondominant hand feeling for landmarks, while the dominant hand manipulates the syringe, scalpel, pique, probe, or power-driven handpiece.

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