

Linen Handling and Storage Within the Hospital

To the Editor:

I am in need of information pertaining to infection control guidelines for the handling and storage of linen within the hospital. I have found many publications concerning this subject, but all have been quite general. I specifically need literature on clean linen storage within the hospital: What measures should be taken to assure a more dust-free environment within linen storage areas—not just linen closets and carts, but also the linen distribution rooms and the shelves contained in them?

Also information on the recommended guidelines for clean soiled linen: delivery, wash cycle, recommended detergents and chemicals, (and the purpose of each in the wash cycle), and the processing of clean linen.

Alcarcius Shelton Boodram
Shelton Laundry, Inc.
Urbana, Illinois

The preceding letter was referred to Karen Hadley, Infection Control Coordinator, for a reply.

The Director of our laundry department thought that this might represent a laundry company that is considering, for the first time, the operation of a hospital laundry. He generously gave me a copy of a 173 page handbook on hospital laundry procedures and management, and I have sent this to Mr. Boodram for his information.

As for the specific questions asked in the letter, ie, what measures should be taken to assure a more dust-free environment in linen storage areas, closets, carts and linen distribution rooms, the following might be helpful:

- Once the laundry is placed on carts, covers should be placed over the carts, and linen closets should be equipped with doors. The covers should be kept on and the doors kept closed except when laundry is being removed or restocked.
- In our hospital, the linen distribution room is in the same area as the washers, dryers and pressers. In addition to daily general housekeeping, on a bi-weekly basis, a worker comes in the evening when

everything is shut down, covers everything, and blows down the lint with an air hose, then vacuums with an industrial vacuum. This is necessary because of the high lint build-up.

Regarding the second request for guidelines for cleaning soiled linen, the handbook's chapters on *Detergency in the Institutional Laundry* (which is 28 pages long), and *Infection Control in the Laundry*, should be consulted. I don't know that the process for cleaning soiled linen can be described in a brief manner.

Karen Hadley, R.N.
Infection Control Coordinator
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The Use of Germicidal Hand Rinse

To the Editor:

I am the Director of the Home Health Services of St. Francis Hospital, Litchfield, Illinois, Medicare approved and licensed facility.

We offer five services to patients

residing in Montgomery and portions of Macoupin Counties.

Much of our service area includes rural homes. Working conditions are not always sanitary. Our handwashing procedure varies, therefore. If indoor plumbing is available and facilities clean, staff use patient facilities before and after treatment. We have found a germicidal hand rinse that can be used without water. Our question concerns that of *need* for vigorous washing under the stream of water.

I would appreciate any input you would have concerning this matter.

Kathy Schwab, R.N.

Director of Home Health
St. Francis Hospital
Litchfield, Illinois

Ms. Schwab's letter was referred to Sue Crow, Nurse Epidemiologist, for a reply.

I am not familiar with any well-developed clinical studies that have been published that compare hand-washing with soap and water, friction, and running water with the one-step antiseptics currently available. Because of the success of using soap and water, friction, and running water to remove most transient microorganisms from the skin I would personally recommend this method whenever possible. However, as you stated, there are some situations where running water is not available. One-step antiseptics, such as alcohol based foams, are acceptable in this type of situation, however, you must keep in mind that after repeated use, any antiseptic will produce a drying effect on the skin. Dry skin can lead to dermatitis which increases the microbial skin colonization.

Also, if I were going to use a one-step antiseptic hand rinse I would use the smallest size available in order to decrease the risk of bacterial contamination of the container.

Sue Crow, R.N., M.S.N.

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Herpes genualius

To the Editor:

Herpes simplex lesions acquired by

hospital personnel are of concern to the Infection Control Practitioner. Herpetic whitlow has been identified as a risk, especially for respiratory therapists and intensive care unit nurses. This infection has received particular attention because of significant morbidity, difficulty in diagnosis and inability to specifically identify the source of infection in most cases.¹ Hospital personnel providing mouth to mouth resuscitation have contracted oral herpes by direct inoculation.² Here we describe two nurses who, possibly as a result of their work, developed herpetic lesions at an unusual site, the knee.

Case 1 — A nurse on the adolescent ward noted onset of a cluster of vesicles over her right patella within several days after placing her knee on a patient's bed so as to stabilize herself for a dressing change. The patient did not have any obvious herpetic lesions. The nurse did not describe any associated lymphadenopathy or systemic symptoms. The nurse was unmarried and denied sexual activity. Moreover, she denied any history of herpes simplex lesions. A dermatologist diagnosed herpes and a viral culture grew herpes simplex which was not further subtyped.

Case 2 — A nurse in the pediatric intensive care unit noted a 3 cm cluster of vesicles over the medial femoral condyle of her left knee. A clinical diagnosis was made by a dermatologist; no culture of the knee lesion was obtained. A pelvic examination by her gynecologist revealed no genital herpetic lesion, and a viral culture of the cervix did not grow herpes simplex. The nurse was sexually active, and she denied any prior history of herpetic lesions. The nurse had placed her knee on the beds of several patients during the two-week period before the onset of the symptoms. She noted no herpetic lesions on any of the patients to which she was assigned.

The circumstantial data suggest the possibility that two nurses acquired herpes of the knee, "Herpes genualius," as a result of patient care activities. Both reported placing their knees on patient bed linen occasionally in order to stabilize themselves when restraining patients, administering medications, or positioning themselves for access to dressings. Thus, direct patient care providers wrestling

with patients may acquire a traumatic inoculation of herpes in a manner similar to rugby players³ or wrestlers.⁴

REFERENCES

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The preceding letter was referred to Dr. Frederick G. Hayden for a reply.

The accompanying letter describes two cases of presumed herpes simplex virus (HSV) infection, which suggest possible nosocomial acquisition because of the unusual site of occurrence, the knee, and because of the work habits of the affected nurses. The report provides an interesting Latin appellation for this condition but, as correctly emphasized by the authors, only weak circumstantial evidence to support the association. Only one of the cases was confirmed virologically, and the type of infection (primary vs. non-primary initial) was not documented by appropriate serologic studies or careful search for infection at other body sites. The lack of constitutional illness or regional adenopathy suggests that these may not have been primary infections. Further, the postulated mode of transmission was not substantiated by pertinent historical information (eg, type of apparel, use of stockings, duration and type of patient care activity, history of trauma or prior skin disease) or virologic data (environmental sampling,