Letters to the Editor

Postexposure Varicella Management: Further Comments

To the Editor:

The authors of "Postexposure Varicella Management of Nonimmune Personnel: An Alternative Approach" (1994;15:329-334) would like to respond to Dr. Edward O'Rourke's editorial "New Isolation Strategies: Is There a Need?" (1994;15:300-302). We appreciate Dr. O'Rourke's concern with the approach we describe and would like to respond to several of his specific comments.

He asks (re: our approach), "Is it the only alternative?" and mentions risk of oncology, a neonatal ICU, or a transplant service as "really is not acceptable when incurred only to minimize the disruption of staff schedules caused by an exposure." We state in the last sentence of the article, 'We suggest this approach be considered in appropriate settings." We do not claim that it is the only approach.

Dr. O'Rourke asks, "Is it really safe to assume that employees will wear masks constantly ... or will they change masks every 30 to 60 minutes or when the masks become moist?" Masking protocol for nonimmune employees is a hospital policy, just as is the wearing of masks for respiratory isolation or strict isolation, and yes, we do expect that employees follow hospital policy. The nonimmune exposed employee signs an agreement to do just that and is monitored by the supervisor. Employees who do not wish to comply are required to stay off work, this has seldom occurred.

Dr. O'Rourke asks, 'Will the message to employees be we no longer take varicella exposures as seriously?" This could not be further from the truth. We are very serious about varicella, and employees are made aware of this as soon as they are hired, during their pre-employment physical and educational programs. We have had only a few hospital exposures that occurred because an employee failed to report a home exposure; we challenge whether other institutions who furlough employees can say the same. Cooperation with our program is more likely because employees know they will not need to use their sick or vacation time for their furlough.

Dr. O'Rourke's suggestion of allowing exposed staff to work in nonclinical areas with other immune employees is impractical and ignores the financial issues in healthcare today. We don't know too many hospitals where a nurse or physician could be assigned to "chart review" for 12 days. In addition, an area with immune employees may be one in which the nonimmune employee is not trained to work.

We need to emphasize major points in this discussion. First, we had 45 employees wear masks and only four developed varicella; this was a common finding in the survey comments as well-not all "exposures" result in disease in employees. Second, the employee does not work with varicella. With education regarding prodromal symptoms and screening for symptoms, it is likely that if disease occurs, the employee will refrain from work. Finally, the concept of masking for long periods in healthcare settings is not unique to our approach, nor is it expected to fail. Surgical personnel mask in the operating room, and tuberculosis patients are masked in emergency rooms and clinic waiting rooms. In both cases, the masking period can extend to many hours.

In short, we feel this is a workable, practical, and safe solution that has been demonstrated in our institution. We encourage the readers to evaluate this approach or other alternatives to meet the challenge of providing quality healthcare in this era of rising costs and shrinking budgets.

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The author replies.

I would like to reply to the thoughtful letter from Donna Haiduven, David Stevens, and Carmen Hench. The disruption of both hospital routine and the employee's life following exposure of nonimmune employees to varicella is a difficult and unfortunately common experience. The point of my editorial is that we need to keep patient safety first, even as we explore less disruptive mechanisms to manage the exposed employee problem.

Given the clarification in their letter, we apparently do not disagree regarding the approach to varicella exposure when high-risk patients are involved. They appear to agree with me that such policies as advocated in their article should not be applied in high-risk settings, although no such statement was made in their article. Perhaps my disagreement then is with the rather vague last sentence of their article, which mentions using the strategy in "appropriate settings" but does not indicate clearly what those settings are. However, even with this caveat, I remain pessimistic about their alternative approach because high-risk patients often are found outside the nursery, oncology, or transplant wards.

Regarding the wearing of masks by exposed employees for up to 8 hours a day, I am impressed that the authors have such confidence that there will be excellent compliance just

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