Medical News

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New FDA Guidance for Blood Donors Exposed to Anthrax or CJD

The Food and Drug Administration (FDA) has released recommendations for assessing blood donor suitability and blood product safety in the event of exposure to anthrax. The document, *Guidance for Industry: Recommendations for Assessment of Donor Suitability and Blood and Blood Product Safety in Cases of Possible Exposure to Anthrax,* includes recommendations for donor deferral, product quarantine and retrieval, and notification of prior transfusion recipients. Although the FDA is soliciting public comment, it is implementing this guidance document immediately due to public health concerns.

The FDA also updated recommendations intended to reduce the risk of exposure to Creutzfeldt–Jakob disease (CJD) and the human form of "mad cow disease" known as variant CJD (vCJD). The recommendations minimize the possible risk of transmission of CJD and vCJD from blood and blood products. The document, *Revised FDA Guidance on Preventive Measures to Reduce the Possible Risk of Transmission of Creutzfeldt–Jakob Disease (CJD) and Variant Creutzfeldt–Jakob Disease (vCJD) by Blood and Blood Products,* provides comprehensive guidelines for all registered blood and plasma establishments for deferral of donors at high risk and supersedes documents issued in November 1999 and August 2001.

FROM: U.S. Food and Drug Administration (www.fda.gov).

OSHA Reopens TB Record, CDC Revises TB Guidelines

A proposed regulation for preventing occupational exposure to tuberculosis (TB) has been delayed since the Occupational Safety and Health Administration (OSHA) issued it in 1997. OSHA announced in the January 24, 2002, issue of the *Federal Register* that it is reopening the TB record to obtain public comment on TB risks and the findings of the Institute of Medicine's Committee on Occupational TB Exposure. Comments are limited to the draft final risk assessment and are due by March 25, 2002. Additional information is available in the Federal Register Online via GPO Access (www.access.gpo.gov).

The Centers for Disease Control and Prevention (CDC) is also in the process of revising its 1994 *Guidelines for Preventing the Transmission of* Mycobacterium tuberculosis *in Health Care Facilities.* Plans are under way for the CDC revision to address a reduction in the frequency of skin testing for most settings, an expanded scope to include outpatient and non–facility-based services, and expanded information on ultraviolet germicidal irradiation and portable air cleaners.

FROM: Occupational Safety and Health Administration. Occupational exposure to tuberculosis. *Federal Register* 2002;67:3465; Centers for Disease Control and Prevention (www.cdc.gov).

UK Rescinds Recommendation for Disposable Instruments to Reduce Risk of CJD

The United Kingdom's Department of Health recently announced the reintroduction of reusable surgical instruments for tonsillectomy and adenoidectomy surgery. This decision was prompted, in part, by adverse events (eg, increased bleeding in tonsillectomy patients) following the introduction of disposable instruments. The use of reusable surgical instruments was stopped in January 2001 because of concerns related to the risk of transmission of variant Creutzfeldt–Jakob disease (vCJD). The Spongiform Encephalopathy Advisory Committee (SEAC) said there was a theoretical risk of transmission from reusable surgical instruments because the infective prion agent is not completely destroyed by normal sterilization.

The SEAC had endorsed using tonsillectomy as a pilot scheme to assess the impact of using single-use instruments in clinical practice. The Department of Health and Medical Devices Agency investigated the incidents and initially issued a hazard notice in October 2001, but was eventually forced to suspend the routine use of single-use instruments. The Agency said it has found that other single-use instruments have led to adverse incidents that are an actual risk to patients compared with the theoretical risk of vCJD transmission.

FROM: UK Department for Environment, Food & Rural Affairs (www.defra.gov.uk).

Hepatitis B Immunization of Infants: Pediatrician Practices

Researchers from the Centers for Disease Control and Prevention recently conducted a survey of pediatricians to explore practices and attitudes toward administration of the first dose of hepatitis B vaccine to infants.

A survey was sent to 600 pediatricians. Three hundred eighty (68%) of the 563 pediatricians who were located responded to the survey. Of these 380 pediatricians, 279 provided routine immunizations to children. Of the 270 pediatricians who vaccinated children with hepatitis B vaccine and indicated their practice regarding the birth dose, 50% offered the first dose of hepatitis B vaccine at birth to all infants; the rest either offered the vaccine at birth only to infants of hepatitis B surface antigen (HBsAg)–positive mothers and mothers whose serostatus is unknown, or did not offer the birth dose to any infants. Practicing in the inner city, working for a medical school or government hospital, and living in a state with universal immunization supply policies were associated with the respondent's giving the birth dose. The strongest perceived barriers to giving the birth dose in the hospital were the difficulty tracking these vaccines (39%), the increased cost (27%), and the lack of reimbursement from insurance companies (26%). If a combination vaccine that includes hepatitis B; diphtheria, tetanus, and pertussis (diphtheria and tetanus toxoids and acellular pertussis vaccine); and polio (inactivated poliovirus vaccine) antigens become available in the near future, then 38% of physicians who currently give the birth dose to all infants would prefer to wait until 2 months of age to initiate hepatitis B immunization.

According to the researchers, this study demonstrates that most pediatricians are abiding by current recommendations, which fits the model of physician agreement before adoption. However, as new vaccines are introduced into the mandated childhood immunization program, physicians will trend toward combination vaccines and delaying administering the hepatitis B vaccine until 1 to 2 months of age. The delay in immunization will necessitate the early and focused identification of HBsAg-positive pregnant women to ensure that these particular infants are immunized at birth. Finding methods to improve the universal screening of women for HBsAg is warranted, because, in 1993, only 22% of infants born to mothers of unknown HBsAg status received the birth dose of HBV vaccine.

FROM: Cooper A, Yusuf H, Rodewald L, Malik T, Pollard R, Pickering L. Attitudes, practices, and preferences of pediatricians regarding initiation of hepatitis B immunization at birth. *Pediatrics* 2001;108:E98.

Epidemiology of Community-Acquired MRSA in Minnesota

Naimi et al. from the Minnesota Department of Health reviewed records from 10 Minnesota health facilities to identify cases of methicillin-resistant *Staphylococcus aureus* (MRSA) infection that occurred from 1996 to 1998 and to identify which cases were community acquired. Susceptibility testing and pulsed-field gel electrophoresis (PFGE) subtyping were performed on available isolates. A total of 354 patients (median age, 16 years) with community-acquired MRSA infection were identified. Most case patients (299 [84%]) had skin infections, and 103 (29%) were hospitalized. More than 90% of isolates were susceptible to all antimicrobial agents tested, with the exception of beta-lactams and erythromycin. Of 334 patients treated with antimicrobial agents, 282 (84%) initially were treated with agents to which their isolates were nonsusceptible. Of 174 Minnesota isolates tested, 150 (86%) belonged to one PFGE clonal group. Community-acquired MRSA infections were identified throughout Minnesota. Although most isolates were genetically related and susceptible to multiple antimicrobials, they were generally nonsusceptible to initial empirical therapy.

FROM: Naimi TS, LeDell KH, Boxrud DJ, et al. Epidemiology and clonality of community-acquired methicillin-resistant *Staphylococcus aureus* in Minnesota, 1996-1998. *Clin Infect Dis* 2001;33:990-996.

Perioperative Prophylaxis With Vancomycin May Be Cost-Effective for Coronary Artery Bypass Graft Surgery

Routine use of vancomycin for perioperative prophylaxis is discouraged, principally to minimize microbial resistance to it. However, outcomes and costs of this recommendation have not been assessed. Zanetti et al. from Channing Laboratory, Brigham and Women's Hospital, used decision-analytic models to compare clinical results and cost-effectiveness of no prophylaxis, cefazolin, and vancomycin in coronary artery bypass graft surgery. They focused on patients who underwent coronary artery bypass graft surgery because this is a large, relatively homogeneous population with substantial risk for serious surgical-site infection.

In the base case, vancomycin resulted in 7% fewer surgical-site infections and 1% lower all-cause mortality and saved $117 per procedure, compared with cefazolin. In turn, cefazolin resulted in substantially fewer infections and deaths and lower costs than no prophylaxis.

The authors concluded that perioperative antibiotic prophylaxis with vancomycin is usually more effective and less expensive than perioperative antibiotic prophylaxis with cefazolin. Data on vancomycin's impact on resistance are needed to quantify the trade-off between individual patients' improved clinical outcomes and lower costs and the future long-term consequences to society.

FROM: Zanetti G, Goldie SJ, Platt R. Clinical consequences and cost of limiting use of vancomycin for perioperative prophylaxis: example of coronary artery bypass surgery. *Emerg Infect Dis* 2001;7:820-827.

Surveillance of Postpartum Infections Using Automated HMO Data

The epidemiology of postpartum infections has not been well characterized. In part, this is because of the limitations of surveillance systems, which usually monitor infections that are recognized during hospitalization.