Advances in Exposure Prevention: Summary of Latest Issue

Volume 6, number 5, 2003 (published October 2003)

• Perry J, Jagger J. “First, Do No Harm: An HCV-Infected Surgeon’s Difficult Choice” (pp. 49-52). William Fiser, M.D., was a cardiac surgeon in private practice for 20 years when he discovered, after a routine physical exam in 1999, that he was infected with hepatitis C virus (HCV). Although he didn’t have a documented exposure to which he could tie his infection, it was presumed to be occupationally acquired since he had sustained numerous injuries from suture needles over the course of his career and had no other risk factors for HCV. At the same time he learned he was infected with HCV, his office receptionist, on whom he had performed heart surgery less than a year before, was also diagnosed with HCV. The realization that he may have infected one of his patients raised compelling moral issues he couldn’t ignore. Should he continue to practice? Should the CDC conduct an epidemiological investigation to see if he had infected other patients? Dr. Fiser shares his experience, and also his views on such issues as mandatory testing of surgeons for bloodborne pathogens.

• Perry J. “New York Cardiac Surgeon Infects 3, Probably 7, and Possibly More Patients with HCV” (p. 51—sidebar). Describes cases of surgeon-to-patient transmission of hepatitis C at a Long Island hospital. The state epidemiologist found, after an investigation in 2002, that the surgeon had infected multiple patients with HCV over the previous decade.

• Perry J, Jagger J. “Smallpox Vaccine Administration: Meeting OSHA’s Safety Requirements” (pp. 53-54). Those who administer the smallpox vaccine have a two-fold risk: exposure to patients’ blood and body fluids, and exposure to vaccinia, the virus used for smallpox vaccination, through accidental inoculation from a needlestick. This article describes what healthcare employers and those in charge of smallpox vaccination programs need to do to meet OSHA’s requirements for worker safety.

• Perry J. “Implementing Safety Devices: Healthcare Facilities Share Their Experiences” (pp. 55-57, 60). A web-based resource from the U.S. National Institute for Occupational Safety and Health (NIOSH) shares insights from healthcare facilities around the country on the process of implementing safety devices to prevent needlestick injuries. The article describes some of the “lessons learned” from these facilities, in order to help readers avoid some common pitfalls.

• Perry J. “Tips from Long-Term Care Facilities, Home Health Agencies, and Dental Clinics [on safety device implementation]” (p. 57—sidebar). Summarizes some of the key “lessons learned” from these three (non-hospital) healthcare settings; from the NIOSH website described above.

• OSHA Q&A: Enforcing the Bloodborne Pathogens Standard” (p. 58). In March 2003, Congressman Cass Ballenger (R-DC), author and co-sponsor of the Needlestick Safety and Prevention Act (NSPA), wrote to the Occupational Safety and Health Administration (OSHA) for
an update on its progress in implementing and enforcing the bill’s requirements. Highlights from
his questions and OSHA’s responses are included.

• **Perry J. “Measuring Progress: What Market Data Show” (p. 58).** Market data
  (provided by Becton Dickinson) on sales of safety devices in four major device categories
  indicate significant progress has been made in implementing safety devices nationwide over the
  last two years.

• **Perry J. “OSHA Steps Up Enforcement, Discourages Exemptions” (p. 59).** Since the
  revised bloodborne pathogens standard (BPS) took effect in April 2001, OSHA has ramped up its
  enforcement efforts and issued a compliance directive and letters of interpretation that clarify the
  requirement to use safety devices. Data on OSHA’s enforcement activities during 2001-2002 are
  discussed, as well as a letter of interpretation sent to the American Academy of Pediatrics in
  2001, which underscores that use of safety devices is not optional.

• **Perry J. “CDC Reports Two Cases of Occupationally Acquired West Nile Virus
  Infection” (p. 59).** In 2003, the Centers for Disease Control and Prevention reported two U.S.
  cases of occupationally acquired West Nile virus (WNV), a flavivirus that is mostly transmitted
  via mosquito bites. Both cases involved laboratory workers infected by means of a sharp-object
  injury.