concern.

The observations of Eitzen and Morris on the use of OR Scrub in their newborn nursery are similarly difficult to evaluate without specific data. Their study on use of OR Scrub in surgical cases points out that the product reduces colony counts on the hands of health care personnel, but no microbiologic data concerning *S. marcescens* and *P. aeruginosa* were offered.[3]

The purpose of our initial abstract and manuscript was to alert the medical community of potential problems related to the use of OR Scrub in critical care areas. Any antiseptic soap that would allow the growth of a common nosocomial pathogen would be of concern to infection control personnel. As we emphasized in our article, extrinsic and intrinsic contamination of several commonly used antiseptic soaps has been previously reported. A better understanding of the limitations of antiseptic agents and potential mechanisms for producing contamination will hopefully decrease the risk of serious nosocomial infections. Our article and those of other investigators underscore the need for continued surveillance of products used in hospitals. At the present time, there are severe gaps in our knowledge about antiseptic soaps; the efficacy of antiseptic soap in reducing nosocomial infection rates in the intensive care unit setting has been demonstrated for only one product.[4] Further studies are needed to critically evaluate the efficacy of these products and their role in the delivery of better health care.

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2. Over the counter drugs generally recognized as safe, effective and misbranded. *Federal Register* 1978; 43(Jan 6):1210-1233.
3. Eitzen HE, Ritter MA, French MLV, et al: A microbiological in-use comparison of surgical handwashing agents. *J Bone Joint Surg* 1979; 61A:403-406.
4. Maki D, Hecht J: Antiseptic containing handwashing agents reduce nosocomial infection—A prospective study. Read before the Interscience Conference on Antimicrobial Agents and Chemotherapy, Miami Beach, FL, October 4-6, 1982.

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Cost of Hepatitis B Prevention in Hospital Employees

To the Editor:

I read with interest "Cost of hepatitis B prevention in hospital employees: Post-exposure prophylaxis" in *Infection Control* August 1984.[1] I have some doubts about the recommendations illustrated in the figure. Would not one dose of HBIG plus a simultaneously initiated hepatitis B vaccination give a less expensive and more long-lasting protection for the person exposed to hepatitis B than two doses of HBIG?

REFERENCES

1. Kirkman-Liff B, Dandoy S: Cost of hepatitis B prevention in hospital employees: Post-exposure prophylaxis. *Infect Control* 1984; 5:385-389.

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The authors of the article in question were invited to respond.

The prevention strategy suggested by Nyström has been adopted recently by the Immunization Practices Advisory Committee (ACIP) of the Centers for Disease Control.[1] When our work was undertaken in 1982, the post-exposure procedure presented in the figure was the official recommendation of the ACIP and, thus, the one used for our calculations of cost.

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1. Recommendations of the Immunization Practices Advisory Committee of the Centers for Disease Control. Post-exposure prophylaxis of hepatitis B. *MMWR* 1984; 33:285-290.

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Airborne Route of Cross-Infection

To the Editor:

In a Letter to the Editor, "Reasonableness in Kidney Transplant Precautions," in the January 1984 issue of *Infection Control*,[1] a statement is made regarding the closing of the door and the absence of infection by the airborne route. This is of some interest to me in view of communication I have had with John Burke, MD, of the Massachusetts General Hospital. Burke feels that the airborne route, although less efficient a method of transferring bacteria than the contact route, is still an ever-present source of cross-infection (written communication, July 1984).

REFERENCES

1. Crow S: Letter to the editor: Reasonableness in kidney transplant patients. *Infect Control* 1984; 5:11.

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Sue Crow, RN, BSN, Nurse Epidemiologist, was invited to respond to Dr. Beck's comments.

I agree that airborne contamination is an important factor in wound infections during surgery. However, the issue in question had to do with caring for kidney transplant patients postoperatively. Once the wound is closed, the risk of airborne contamination is greatly reduced.

There are no studies regarding the position of the door during routine postoperative care. Keeping the door closed is important when a patient has a disease that may be airborne, such as tuberculosis or chickenpox, but for a postoperative patient, including a kidney transplant, I see no need to close the door.

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