1,000 L of air should be sampled, since the likelihood of detecting 1 CFU/m^3 is reduced with volumes smaller than this.[13] Until now, this number has not been studied during an outbreak. Originally, we used a volumetric air sampler, which was portable and convenient to use, but only sampled 160 L of air in 4 minutes. With large volumes of air (1,200 L), several cultures of air samples throughout the hospital and the oncology unit grew *Aspergillus* species. Given the number of colonies detected with the large-volume air sampler, it is evident why cultures from the low-volume sampler did not grow fungi. Thus, we propose that, when volumetric air sampling is used in an indoor environment, a minimum of 1,000 L of air should be sampled in high-traffic areas during a busy part of the day.

This investigation highlights the importance of evaluating pressure relationships not only in individual rooms but also in attached buildings. To ascertain critical pressure relationships, a pressure gauge with sensitivity to 0.001 in water gauge (250 Pa=1 in water gauge) is essential. Recommendations for the number of air exchanges per hour to maintain a positive pressure in immunocompromised patient rooms exist,[14] but little information is available for determining the proper pressure in rooms for protecting compromised patients.[15] We advocate further research to determine how best to assess an environment with high-risk patients.

In conclusion, critical aspects of both prevention and outbreak investigations are as follows: (1) to develop novel ways to protect patients, especially in older hospitals, and (2) to assess accurately the environment, which includes studying appropriate pressure relationships and obtaining accurate volumetric air samples. Until now, there has been no established standard for air sampling, but this outbreak supports sampling large volumes of air when using volumetric air sampling. We propose that 1,000 L (1 m^3) be the standard minimum when obtaining volumetric air samples to assess the healthcare environment for *Aspergillus*. In addition, further research is needed to determine optimal pressure relationships for protecting immunocompromised patients. We feel that establishing standards for pressure testing and volumetric air sampling can help to prevent nosocomial aspergillosis.

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Risk of Cross-Patient Infection With Use of a Needleless Injector Device

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Needleless injection devices use multiple-dose vials for the administration of local anesthetics to patients, and there is a theoretical risk of iatrogenic infection associated with use of these devices. Suria and coinvestigators investigated the potential for transferring microbial pathogens among patients by using the Syrijet (Keystone Industries, Inc, Cherry Hill, NJ). *Staphylococcus aureus* and coagulase-negative staphylococci were used to determine whether patient skin flora could contaminate the instrument internal canal by postejection reverse flow and whether the staphylococci could survive on the ejection surface, in the internal canal, or in the anesthetic vial.

The ejection surface was contaminated by firing the device while it was in contact with a contaminated surface. Postejection reverse flow drew contaminants into the device, but did not reach the multidose vial, and staphylococci did not grow in the commercial anesthetic solution typically administered with the device. Surface, but not internal, contamination could be removed by swabbing with disinfectant. The authors concluded that, although autoclaving is the only way to ensure sterilization of this device, frequent cleaning of the ejection surface during clinical use minimizes the risk of cross-patient bacterial transfer.

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