

Medical News

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Additional news items in this issue: *Using NNIS Data to Reduce UTIs*, page 538; *VRE in ICUs*, page 538; *Nosocomial Infections in Medical ICUs in the United States*, page 548; *Surgical Patients With Clostridium difficile-Associated Diarrhea*, page 560; *Satellite Broadcast: Biological Warfare*, page 567.

OSHA Reopens Record for TB Rule

The Occupational Safety and Health Administration (OSHA) published its proposed standard to regulate occupational exposure to TB on October 17, 1997, in the *Federal Register*, with the official comment period ending on October 5, 1998. On June 17, 1999, OSHA announced that it is now reopening the rule-making record for 45 days to submit two additional reports to the docket: OSHA's report on TB control practices in homeless shelter settings and the National Institute for Occupational Safety and Health's (NIOSH) Health Hazard Evaluation (HHE) of a medical-waste treatment facility. OSHA invites public comment on the findings of these reports and the underlying issues of the coverage of homeless shelters and medical-waste treatment facilities within the scope of a final TB standard.

OSHA also seeks comment on including TB and AIDS clinics and probation and parole officers within the scope of the standard, as well as expanding the coverage of the standard to include all social service workers. In addition, OSHA is submitting to the docket four other documents, previously unavailable, that relate to issues addressed during the public hearings. These documents are as follows: "The American College of Occupational and Environmental Medicine's Guidelines for Protecting Health Care Workers Against Tuberculosis"; "Laboratory Performance Evaluation of N95 Filtering Facepiece Respirators" (*Morbidity and Mortality Weekly Report*, December 11, 1998); "The Costs of Healthcare Worker Respiratory Protection and Fit-Testing Programs" (Kellerman SE, et al, *Infection Control and Hospital Epidemiology*, September 1998); and "The Relative Efficacy of Respirators and Room Ventilation in Preventing Occupational Tuberculosis" (Fennelly K and Nardell E, *Infection Control and Hospital Epidemiology*, October 1998).

Comments also are requested on whether OSHA should require laboratories to decontaminate medical wastes containing *Mycobacterium tuberculosis* before these wastes are sent off-site for disposal, in light of the recent evidence of transmission of TB to a worker in a medical-waste treatment facility. OSHA also is interested in comments regarding the adequacy of qualitative fit-testing for N95 respirators for determining a face-seal leakage of no greater than 10%. This request for information on fit testing was prompted by the results of a study conducted by NIOSH that report the inability of some N95 respirators to be fit tested.

Comments to OSHA must be postmarked no later

than August 2, 1999. Two copies of the comments should be sent to Docket Office, Docket H-371, Rm N2625, Occupational Safety and Health Administration, US Department of Labor, 200 Constitution Ave NW, Washington, DC 20210.

FROM: Department of Labor. OSHA. Occupational exposure to tuberculosis: notice of limited reopening of rulemaking record. *Federal Register* June 17, 1999;64: 32447-32449.

Postexposure HAV Vaccination

Hepatitis A vaccination stops outbreaks of hepatitis A infection, but its efficacy against infection after exposure has not been proven. Sagliocca, from the Azienda Hospital Santobono Pausilipon, Naples, Italy, and colleagues investigated the use of hepatitis A vaccine to prevent secondary infections with hepatitis A virus (HAV) in a randomized controlled trial of hepatitis A vaccine in household contacts of people with sporadic HAV infection (index cases). Households (index cases and contacts) were randomly assigned to the vaccine group or unvaccinated group, according to the study week in which they were enrolled. All household contacts in the vaccine group received vaccination at the time of entry to the study.

During 45 days of follow-up, secondary infection had occurred in 10 (13.3%) of 75 households (two families had two cases each) in the untreated group and in 2 (2.8%) of 71 households in the vaccine group. The protective efficacy of the vaccine was 79% (95% confidence interval, 7-95). The number of secondary infections among household contacts was 12 (5.8%) of 207 in the unvaccinated group and 2 (1.0%) of 197 in the vaccinated group. Therefore, 18 individuals needed to be vaccinated to prevent one secondary infection.

The researchers concluded that hepatitis A vaccine is effective in the prevention of secondary infection of HAV and should be recommended for household contacts of primary cases of HAV infection rather than immunoglobulin. They note that, given that 20% of acute HAV cases in Italy and 30% in the United States report prior contact with an icteric person who has HAV, many cases of HAV could be prevented.

FROM: Sagliocca L, Amoroso P, Stroffolini T, Adamo B, Luciano-Sagliocca ME, Lettierio G, et al. Efficacy of hepatitis A vaccine in prevention of secondary HAV infection. *Lancet* 1999;353:1136-1139.