

## Letters to the Editor

### Getting the Word Out

#### To the Editor:

Dissemination of timely data to a hospital community can be a daunting task. Healthcare workers working various schedules across three shifts per day, 7 days per week; large numbers of part-time and outside agency staff; lack of mailboxes; and inability to schedule regular meetings create a challenge to providing up-to-date information. It is especially difficult in the operating room environment.

Our Infection Control Committee is responsible for distributing data, including various surgical-site infection rates, the impact of recent intervention on these rates, changes in antimicrobial prophylaxis in the operating room, and other relevant trends involving healthcare workers and positive surgical patients.

As an additional method to reach the operating room staff beyond meetings and providing documents to be read at home, single-page charts on brightly colored paper are laminated and placed in the operating room lunchroom. These "placemats" are quickly read by *all* of the operating room staff, irrespective of their schedule, while eating or chatting. To keep these missives timely, the mats are removed after 7 to 10 days. This technique has been extremely successful in reaching this remote group.

A second innovative method for distribution of important, time-sensitive information is the use of picture mouse pads. These pads have a clear flap under which charts or reports can be inserted. Given the ubiquitous presence of computers throughout the hospital, placing infection control data in the mouse pads provides an easy and effective method to reach house staff, attending physicians, and nurses who regularly provide clinical services to patients. We placed our most recent critical care antibiogram in the mouse pads. This is an extremely effective method to reach

our target audience and the information can easily be changed with little cost or effort.

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### Requiem for Reuse of Single-Use and Reusable Devices?

#### To the Editor:

I read with great interest the editorial by Favero<sup>1</sup> and the article by Heeg et al.<sup>2</sup> (sponsored by Boston Scientific Corporation, one of the world's largest producers of single-use devices) regarding the reuse of single-use devices in the September issue of the Journal. We all want safe disposables and safe reused disposables for our patients, but how about the safety of reusable devices that have been sterilized 50 or 100 times?

The U.S. Food and Drug Administration (FDA) is giving U.S. hospitals a year to comply with the premarket requirements (registration and listing, reporting adverse events associated with reuse of medical devices, quality system regulations, and proper labeling). Strangely enough, the FDA considers U.S. hospitals "manufacturers" if they reprocess a simple disposable oxygen mask or a disposable ventilation tube. On the other hand, the FDA guidelines do not apply to dialyzers, which are much more difficult to reprocess than a simple oxygen mask, or to healthcare facilities other than hospitals. Can a nursing home still reprocess disposables, but not a hospital? Shouldn't the strict FDA requirement apply to both single-use and multiple-use devices? How safe are cleaning, disinfection, and sterilization procedures in hospitals in the United States and throughout the

world? Some of the answers to these questions are provided in the article by Heeg et al.

I must admit that I don't know what an "oxymoron" is, but whatever it may be, decontaminated single-use and reusable medical devices are obviously placing patients at risk for cross-contamination. Neither the reusable nor the single-use devices could be cleaned effectively, as demonstrated by residual native human blood after the meticulous cleaning procedure. One reusable papillotome contaminated with 8.36 log<sub>10</sub> of *Pseudomonas aeruginosa* retained 3.84 log<sub>10</sub> of *P. aeruginosa* after the disinfection procedure, and 3 of 9 reusable papillotomes, 7 of 9 stone retrieval baskets, and 3 of 9 reusable biopsy forceps could not be sterilized by steam or ethylene oxide.

I have only one major criticism: Did the authors also check reusable instruments with the electron microscope after they had been cleaned, disinfected, and sterilized 100 or 200 times? We did. The surfaces of these instruments looked much worse than those reported by Heeg et al. after reprocessing disposable devices. The authors concluded that none of the reprocessed single-use instruments was effectively cleaned, disinfected, or sterilized. However, the conclusion should be that neither reprocessed single-use nor reusable instruments were effectively cleaned and sterilized.

#### REFERENCES

1. Favero MS. Requiem for reuse of single-use devices in US hospitals. *Infect Control Hosp Epidemiol* 2001;22:539-541.
2. Heeg P, Roth K, Reichl R, Cogdill CP, Bond WW. Decontaminated single-use devices: an oxymoron that may be placing patients at risk for cross-contamination. *Infect Control Hosp Epidemiol* 2001;22:542-549.

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