Letters to the Editor

HIV Prophylaxis with Punctured Gloves?

To the Editor:

The use of gloves is strongly recommended while taking blood specimens, touching wounds, etc, to prevent human immunodeficiency virus (HIV) transmission in hospitals. In many cases, however, the use of gloves does not guarantee protection, but rather promotes a feeling of false safety. First, gloves do not prevent needle sticks, the most dangerous way to transmit HIV to hospital personnel. Furthermore, we and other German hospital epidemiologists recently checked the quality of disposable gloves from different manufacturers and were surprised to find that many European and North American companies produce disposable gloves of very poor quality. Up to 84% of new disposable gloves have small but demonstrable defects (Table 1). With these results in mind, we checked the sterile gloves used in all operating rooms in our hospital. We were rather shocked to find that even sterile gloves used for operations, which were assumed to be of the highest quality, were defective (Table 2).

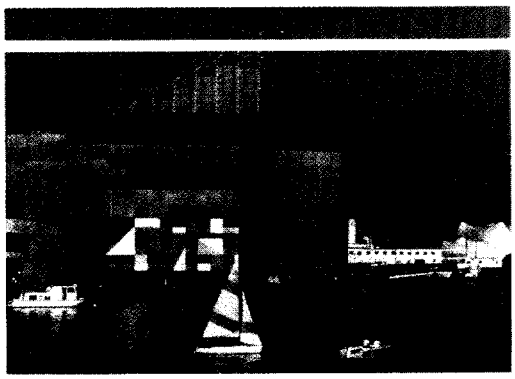
We strongly recommend that all hospitals check the quality of disposable gloves, both sterile and nonsterile. We also recommend the use of latex gloves rather than those made from polyvinylchloride (PVC). The latter, although very comfortable, are more

TABLE 1
HOLES IN NEW DISPOSABLE GLOVES

Manufacturer	Material	No.	% Defective
Tru-Touch	PVC	50	0
Asid Bonz	PVC	50	6
Dahlhausen	PVC	50	20
Becton & Dickinson	PVC	50	12
Hartmann	PVC	100	38
pfm	PVC	70	50
Beiersdorf	PVC	100	76
Travenol	PVC	200	84.5
Vasco S	Latex	50	2
Protemo	Latex	50	14
Glads-Mölnlycke	Latex	50	0
Hartmann	Latex	100	0
Semperit	Latex	100	4
Braun Melsungen	Latex	50	4
Peter Seidel	Latex	50	4
Asid Bonz	Latex	50	4
Best Manufacturing Comp. USA	Latex	50	22

TABLE 2
PERFORATIONS IN NEW STERILE GLOVES FOR OPERATIONS (TRIFLEX, TRAVENOL)

	No.	% Defective
Size 6	34	17.6
Size 6.5	16	6.3
Size 7	8	0
Size 7.5	30	0
Size 8	12	0
Total	100	7



HOSPITAL EPIDEMIOLOGY:

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Preliminary Program

Thursday, March 9

2:00 pm - 5:00 pm	Registration

Friday, March 10: AIDS

8:15 am - 12 noon	General Sessions
12:30 pm - 2:00 pm	Poster Sessions
10:00 am - 3:30 pm	Exhibits
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Saturday, March 11: The Expanding Role of Hospital Epidemiology

8:15 am - 12 noon	General Sessions
12:30 pm - 2:00 pm	Poster Sessions
10:00 am - 3:30 pm	Exhibits
2:00 pm - 5:00 pm	General Session

Sunday, March 12

8:30 am - 1:00 pm	General Session
ADJOURNMENT	

To be sure to receive program and registration materials this fall, complete and return the coupon below or call l-800-257-8290 (in NJ l-609-848-1000), ext. 213.

Reply to:

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often defective than latex gloves and contribute to the pollution of the environment. Polyvinylchloride, when incinerated, produces toxic products in the air and hydrochloric acid. In 1986, we used 2.1 million disposable PVC gloves in our hospital. We have now switched to latex gloves, thus reducing the PVC waste by 18.4 tons per year!

ED. Daschner, MD
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Cooperation Needed in New Era of Infection Control

To the Editor:

A time of transition is upon us. The Joint Commission on Accreditation of Healthcare Organizations is telling us it is time again to take a look at infection control standards and examine the validity, practicality, and impact on our patient outcomes. I believe we need to welcome their scrutinizing eye and that we must actively participate in the development of our own standards. As practitioners we know only too well the system of infection control in our hospitals and the myriad of associated problems.

I also believe we can utilize this opportunity to incorporate new standards that we will deem appropriate in light of the multitude of changes in infection control practice due to the AIDS epidemic, the impact of universal precautions, and the cost containment impetus. I would like to see hospital management systems recognize the absolute need for communication with infection control program directors as consultants within the management and physician framework. Our time needs to be used judiciously. We need to have realistic goals and expected outcomes when we design our programs, especially when evaluating systems for surveillance monitoring, data collection, and analysis of nosocomial infections.

Recent cooperative efforts were requested of our surgical staff in an attempt to resurrect a surgical wound surveillance reporting system. The resultant communication, unfortunately, demonstrates the not too unusual response on the part of a surgeon:

> I would certainly cooperate with a survey such as this, but I find most objectionable a "nurse" would contact another nurse for ongoing information about patient follow-up. Obviously, the nurse epidemiologist can monitor bacteriology specimens without permission or cooperation from anyone. This attempt at surreptitious surveillance should be presented and discussed in some manner with the department of Surgery or with the individual surgeons whose nurses are being contacted. Our nurse will not be able to cooperate with this plan.

The problem identified by the surgeon was the result of a request by a nurse epidemiologist of a surgical' nurse clinician for follow-up of her discharged surgical patients given the short lengths of stay we now experience for most class I procedures.

We need to welcome our physicians and management staff to the new era of infection control with support from the Centers for Disease Control, The Society of Hospital Epidemiologists of America, and our professional organization, the Association of Practitioners in Infection Control.

Terri Rearick, RN
Infection Control Coordinator
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Brief items of interest for the SHEA Newsletter may be sent to Robert A. Weinstein, MD, SHEA Newsletter Editor, Division of Infectious Diseases, Michael Reese Hospital, Lake Shore Drive at 31st St., Chicago, IL 60616. Copy must be typed, double-spaced, and may not exceed five pages.