

examination should be done. If an objective is to assume responsibility for employees' personal health, then a physical examination should probably be included. On the other hand, if the objective of the employee health program is to maintain a safe environment for personnel, patients, and visitors, a health inventory would probably fulfill this objective. Other considerations are amount of time, money and personnel available to do physical examinations.

Obviously, at a time when all of us must deal with a relatively fixed pool of resources to manage programs such as employee health and infection control, it is imperative that programs establish certain priorities in an attempt to put their money where it will do the most good. The CDC Guideline for Infection Control in Hospital Personnel recommends that "for infection control, complete physical and laboratory examinations should not be routinely required for personnel but should be done when indicated; for example, need for examination or laboratory test may be determined from the results of the health inventory."¹ In general, it would seem unlikely that any additional infectious disease information would be obtained by a physical examination rather than a health inventory. Obviously, the decision to perform a physical examination for purposes other than infection control must be made by assessing the unique needs of the institution and its personnel as well as the program's resources.

REFERENCES

1. Williams WW: Guideline for Infection Control in Hospital Personnel. *Infect Control* 1983; 4:326-349.

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AIDS Precautions for Other High-Risk Groups?

To the Editor:

Your recent Special Report, "A Hospitalwide Approach to AIDS,"¹ is an excellent summary of the logical steps

necessary in dealing with an AIDS patient, based on the current state of knowledge about this syndrome. However, there is one statement with which we must take exception. The report states "Patients who merely belong to one of the high-risk groups, but who do not have other clinical evidence of AIDS, do not need these precautions." This seems a bit dogmatic given the current state of knowledge about AIDS.

It appears that transmission of AIDS may occur from a person who is not necessarily ill with this syndrome.² In fact, it is not yet known at which stage the disorder may be most communicable. Hepatitis B, the disease which epidemiologically appears most similar to AIDS, clearly may be transmitted by an asymptomatic individual. In fact, most infectious diseases have a high asymptomatic to clinically apparent ratio among infected individuals.³ Thus, it might be appropriate to maintain the same precautions among asymptomatic individuals belonging to a group at high-risk for AIDS as for individuals actually suspected of having AIDS. Again using Hepatitis B for comparison, our hospitals maintain blood and body secretion precautions for all individuals belonging to a high-risk group for Hepatitis B (eg, intravenous drug abusers, sexually active homosexual men, patients on hemodialysis, Southeast Asians, etc.), until hepatitis serology confirms the absence of Hepatitis BsAg. Unfortunately, no serological marker which has been shown to reliably predict the presence of the putative AIDS agent is currently available for routine use. It is therefore impossible to rule out the presence of the AIDS agent in an individual patient. The prevalence of infection with the AIDS agent, as opposed to the prevalence of disease, is completely unknown for high-risk populations. While the risk of in-hospital transmission of AIDS by any patient appears to be extremely remote, until the prevalence of the infection in high-risk populations is known and the most infectious stage established, it is pure speculation to state that the patient with documented AIDS is more of a risk for AIDS transmission than the well individual belonging to a high-risk group.

If the remainder of the report's rec-

ommendations are followed, the institution of blood and body secretion precautions in asymptomatic individuals belonging to high-risk groups for AIDS would be a simple and logical extension of the steps outlined to prevent potential transmission of a disorder which is as yet incompletely understood. Perhaps it would be more appropriate to suggest that hospitals handle this issue on an individual basis.

REFERENCES

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2. Curran JW, Lawrence DH, Jaffe H, et al: Acquired Immunodeficiency Syndrome (AIDS) associated with transfusions. *N Engl J Med* 1984; 310:69-75.
3. Evans AS: Epidemiological concepts and methods, in Evans AS (ed): *Viral Infections of Humans. Epidemiology and Control*, ed 2. New York, Plenum Publishing Corp 1982, pp 19-21.

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Dr. Theodore C. Eickhoff, Chairman of the Advisory Committee on Infections Within Hospitals, offers the following response to Drs. Klein and Friedland.

Drs. Klein and Friedland have identified an issue that was of concern to the members of the Advisory Committee on Infections Within Hospitals as we prepared these recommendations, and continues to be of concern today. The introductory paragraphs to our report point out that the recommendations have not been clearly documented by controlled trials to be effective, nor to be ineffective, but that they represented at that time the best judgment of the Advisory Committee and its consultants. We further pointed out that these recommendations might need to be revised and updated as new information or experience indicated the need to do so. Indeed, the information that has emerged in