

Journal Watch

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Journal Watch presents a brief description of articles recently published in other journals and thought to be of relevance or interest to the AIC readership. Readers are encouraged to refer to the articles for further information.

Post-discharge surgical site infections

This report looks at the epidemiology of surgical site infections (SSI) that develop after hospital discharge. Delgado-Rodriguez *et al.* describe a prospective study of 1,506 surgical patients in a Spanish tertiary hospital, 97.8 per cent of whom were able to be followed up by telephone for evidence of SSI at 30 days post-discharge. The authors also obtained confirmation of infection by the attending physician.

Thirteen general surgical procedures were assessed and information on risk factors collected. SSI was diagnosed prior to hospital discharge in 123 (8.3 per cent) cases and after discharge in 103 (7.5 per cent) cases. A greater proportion of post-discharge SSI occurred in clean surgical procedures such as herniorrhaphy, breast surgery and vascular surgery. Patients with post-discharge SSI were found to be more similar to non-infected patients with regard to most classic risk factors for surgical site infection. Risk factor analysis showed that most predictors for in-hospital SSI were not predictive for post-discharge SSI.

Delgado-Rodriguez M, Gomez-Ortega A, Sillero-Arenas M et al. Epidemiology of surgical-site infection diagnosed after hospital discharge: a prospective cohort study. Infect Control Hosp Epidemiol 2001; 22:24-30.

Predictors of surgical site infection

An article on surgical site infection (SSI) by Kaye *et al.* proposes an alternative method to the ASA score for assessing the chronic disease status of patients. The authors argue that the ASA score (used by the National Nosocomial Infection Surveillance (NNIS) programme to measure risk of SSI) is limited as a risk adjustment measure because of its subjectivity and poor inter-rater reliability. Also, the ASA score is not always readily available, and there is often limited variation among patients undergoing the same procedure.

The chronic disease score is an objective measure of health status as a function of age, sex, and 29 chronic diseases and is obtained from automated prescription drug prescribing data. The authors studied the relationship between this score and SSI and whether the score can supplement the NNIS risk index. Using a retrospective case-control design comparing

191 infected patients with 378 uninfected controls, they found that the chronic disease score and the ASA score were highly correlated. The chronic disease score was found to improve the prediction of infection by the NNIS risk index and augmented the ASA score for risk adjustment.

Kaye KS, Sands K, Donahue JG et al. Preoperative drug dispensing as predictor of surgical site infection. Emerging Infectious Diseases 2001; 7(1):57-65.

Norwegian scabies outbreak

Obasanjo *et al.* report a large outbreak of Norwegian (crusted) scabies that occurred in a large teaching hospital in Baltimore, in which 773 health care workers and 204 patients were exposed to the mite. The initial outbreak was traced to a patient admitted to the AIDS service with an unrecognised case of scabies. A possible second wave of transmission occurred following the admission of another infected HIV patient a few weeks later. Overall, 113 (15 per cent) of the exposed HCWs and 82 (40 per cent) of the patients developed symptoms consistent with scabies infestation.

The report focuses on the additional measures over and above those specified in the CDC guidelines that were found necessary to control the outbreak. It was also found necessary to treat the immuno-compromised patient with two applications of 5% permethrin and a course of oral ivermectin in order to control the infestation. The authors recommend the adoption of prophylactic topical scabicide for all exposed HCWs, treatment of all cases of Norwegian scabies with two applications of scabicide 1 week apart, and maintaining isolation and barrier precautions until 24 hours after completing the second course of treatment.

Obasanjo OO, Wu P, Conlon M et al. An outbreak of scabies in a teaching hospital: lessons learned. Infect Control Hosp Epidemiol 2001; 22(1):13-18.

Nosocomial tuberculosis associated with atomiser reuse

Published evidence of nosocomial transmission of respiratory infections by the reuse of respiratory equipment is difficult to

find. Southwick *et al.* report a cluster of three patients who acquired *M. tuberculosis* following bronchoscopy on the same day at one hospital in North Carolina. An epidemiological investigation revealed no community links between the three patients, and all three isolates were shown to be identical by restriction fragment length polymorphism.

After exhaustive investigation of the infection control practices in the bronchoscopy suite of the hospital, the most probable source of transmission was thought to be contamination of the nozzle of the atomiser used to apply lidocaine to the pharynx and nasal passages. Although these items were meant to be single patient use only, respiratory technicians reported sometimes reusing the nozzles of the atomisers on more than one patient.

Southwick KL, Hoffman K, Ferree K et al. Cluster of tuberculosis cases in North Carolina: possible association with atomizer reuse. Am J Infect Control 2001; 29:1-6.

Infection control research priorities

As the scope of infection control expands to include many different types of health care facilities, some aspects of

personnel health and occasionally the epidemiology of other problems associated with health care delivery, there is a need to refocus priorities in research to cover these newer aspects of the field. This is the belief of Lynch *et al.* who used a panel of 50 experts and the views of participants at the 4th Decennial Conference to develop a consensus on the most important subject areas for research in the coming decade.

The expert panel reduced 102 separate items to 21 high-ranked research priorities. Amongst the highest ranked were ways to improve compliance with best practice, development of methods to improve the appropriateness of antimicrobial use, measuring the financial impact of complications and the cost-effectiveness of interventions, and the development of meaningful surveillance indicators. The need for research designs that use multidisciplinary teams with strong collaborative arrangements was highlighted.

Lynch P, Jackson M & Saint S. Research priorities project, year 2000: establishing a direction for infection control and hospital epidemiology. Am J Infect Control 2001; 29:73-78.

Diary of events

***** STATE *****

9-11 August 2001

Northern Exposure - Turning the Tide
3rd Joint Conference of the Infection Control
Practitioners Association of Queensland and the
Queensland Wound Care Association
Cairns, Queensland

Tel: (07) 3858 5538 Fax: (07) 3858 5510
E-mail: <wic01@im.com.au>

1-2 November 2001

2001: The New Generation
Infection Control Association of New South Wales Inc
24th Annual State Conference
Star City Hotel, Sydney

Chris Novak, Hotelier's International
Tel: 1800 101 646 Fax: (07) 3210 1606
E-mail: lorraine@hoteliersint.com

***** NATIONAL *****

5-7 June 2002

Australian Infection Control Association
Second Biennial Conference 2002
Rethinking our Vocabulary
Sheraton Brisbane Hotel and Towers, Queensland

Conference Secretariat:

PO Box 1280 (11/97 Castlemaine Street)
Milton Queensland 4064
Tel: (07) 3858 5599 Fax: (07) 3858 5510
E-mail: aica2002@im.com.au

***** INTERNATIONAL *****

4-7 November 2001

2001 Conjoint Meeting:
Canadian Association for Clinical Microbiology and
Infectious Diseases, the Community and Hospital
Infection Control Association and the Canadian
Infectious Diseases Society
Victoria Conference Centre
Victoria, British Columbia, Canada
E-mail: chicacda@mb.sympatico.ca
E-mail: bruce.gamage@bccdc.hnet.bc.ca

15-18 September 2002

**Fifth International Conference of the Hospital
Infection Society**
Edinburgh, Scotland

Conference Secretariat: Concorde Services/HIS 2002
Glasgow, Scotland
Tel: (44) 141 331 0123
Fax: (44) 141 331 0234
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