Medical News

EDITED BY ELAINE LARSON, PHD, RN

AMA Training Program on 'OSHA Regulations on Bloodborne Pathogens' Available for Hospitals and Clinics

The American Medical Association (AMA) has developed a training program on the new bloodborne pathogen regulations recently passed by the Occupational Safety and Health Administration (OSHA). The program was funded by an educational grant from Becton Dickinson and Company, Franklin Lakes, New Jersey.

The regulations, intended to protect healthcare workers from the occupational hazards associated with acquired immunodeficiency syndrome, hepatitis, and other bloodborne pathogens, became effective March 6, 1992, and affect hospitals, clinics, and physicians' offices. Training and documentation requirements must be completed by June 4, 1992, and overall compliance with the regulations will be enforced beginning July 6, 1992.

With program participation of AMA, OSHA, the Centers for Disease Control, the National League for Nursing, physicians, infection control experts, and Becton Dickinson, this training program is designed to facilitate both hospital and clinic compliance. The training program, entitled "For Your Protection: The OSHA Regulations on Bloodborne Pathogens," demonstrates the proper procedures for handling blood and blood products, including the use and disposal of sharps.

The program also outlines requirements for protective equipment, changes in work practices, postexposure management, and training and documentation procedures. The training kit includes a 25-minute video and teacher and study guides. Physicians and nurses enrolled in the program will qualify for continuing education credit.

For more information contact Becton Dickinson and Company, 1 Becton Dr., Franklin Lakes, NJ 07417-1880. Telephone (201) 847-6800.

From the Centers for Disease Control

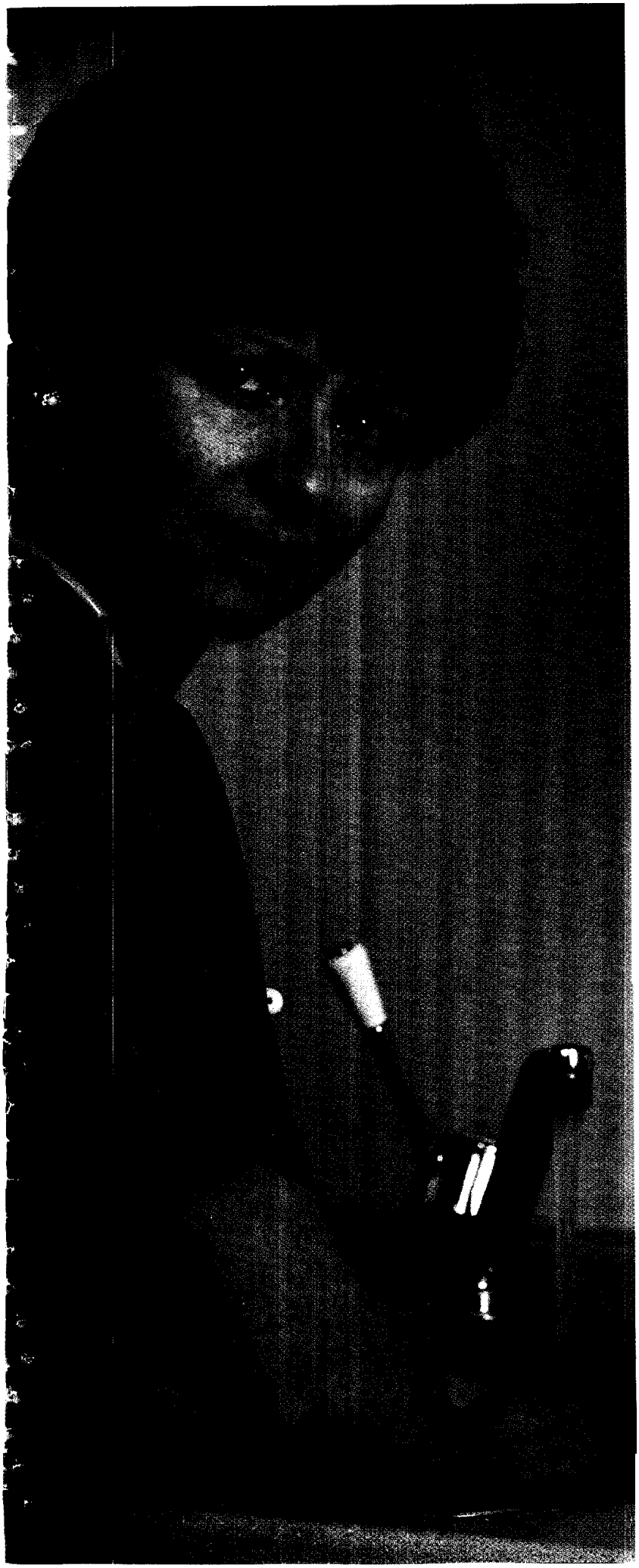
MEASLES AT AN INTERNATIONAL GYMNASTICS COMPETITION—INDIANA, 1991

September 7, 1991, the Indiana State Department of Health (ISDH) was notified of three suspected measles cases among athletes from New Zealand (NZ) participating in an international gymnastics competition September 6-16, 1991, in Indianapolis (Marion County), Indiana. Among those potentially at risk for measles were approximately 700 athletes and 1,200 coaches, trainers, and managers from 51 countries; an estimated 2,500 volunteers and staff; international media, families, and employees; and approximately 60,000 spectators attending the competition. This report summarizes the epidemiologic investigation of these cases.

Sixteen NZ delegation members arrived August 29, 1992, and stayed on one floor of a hotel. Throughout the following week, they practiced in a curtain-divided area shared with three other teams and visited nearby shopping and eating establishments. On August 30, two 15-year-old female athletes (patients 1 and 2) developed cough, coryza, and conjunctivitis, followed by onset of rash on September 4. Patient 2's symptoms were mild and improved within 24 hours of onset or rash. A third athlete (patient 3), a l&year-old female, developed symptoms on September 5 and rash on September 7. All three patients had measles IgM antibody in the acute serum specimens (≥1:40 by indirect fluorescent antibody [IFA] test). Complement-fixation testing of both the acute and convalescent specimens collected seven weeks later demonstrated four-fold or greater rise in IgG measles antibody for patients 1 and 3 and a fourfold decline in measles IgG antibody for patient 2. The three patients had documented histories of live-virus measles vaccination in NZ at 11, 13, and 15 months of age and reported exposure to a person with physician-diagnosed mea-

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sles at their NZ practice gymnasium, approximately 2 weeks before onset of rash.

Following onset of rash, patients 1 and 3 were isolated in their hotel rooms for at least four days. Remaining NZ delegation members born after 1956 were isolated until serologic evidence of measles immunity could be determined; within 12 hours, all were demonstrated to be seropositive (measles IgG≥1:40 by IFA).

An investigation by the ISDH identified numerous groups with probable measles exposure. Because of the large-scale exposure, the seriousness of measles illness, the extreme infectiousness of the measles virus,[1] and the difficulty in obtaining timely evidence of measles immunity from throughout the world, the ISDH recommended that all participants, volunteers, staff, and hotel employees born after 1956 receive live-virus measles vaccine.[2]

During September 812, six vaccination clinics were held. The vaccine was administered using an automatic hypodermic injection apparatus. Among the 1,300 persons vaccinated were 608 international delegates, 264 Indianapolis and 139 other Indiana residents, 152 out-of-state volunteers, and 137 hotel employees. More than 1,100 (85%) persons were vaccinated within 72 hours after the opening ceremonies on September 6, when most widespread exposure occurred.

Three persons experienced adverse events following vaccination; all were local reactions at the injection site and resolved without serious consequences. Two of these three patients were treated with antibiotics and improved promptly; the third was thought to have had an allergic reaction and was treated with corticosteriods.

Surveillance for secondary cases included the following: twice-daily reports from delegations on whether any member had prodromal measles symp toms; daily review of visits to the competitions medical station and observation of the venue for persons with measles symptoms; letters to participants, volunteers, and staff advising them of the outbreak and control measures, signs and symptoms of measles, the need to seek healthcare, and the importance of notifying local public health officials if symptoms occurred; daily telephone calls to all emergency moms and urgent-care centers in Marion County during September 16-23; and notification of states whose residents attended the competition. No additional cases associated with the outbreak have been reported.

REFERENCES

1. Preblud SR, Katz LS. Measles vaccine. In: Plotkin SA, Mortimer EA, ed. *Vaccine.* Philadelphia, Penn: WB Saunders; 1988:182-222.
2. Centers for Disease Control. Measles prevention: recommendations of the Immunization Practices Advisory Committee (ACIP). *MMWR.* 1989;38.

MMWR. 1992;41:109-112.

OUTBREAK OF INFLUENZA A IN A NURSING HOME IN NEW YORK, DECEMBER 1991 -JANUARY 1992

During December 1992 and January 1992, an outbreak of influenza A occurred among residents of a nursing home in New York. From mid-October through mid-November 1991, influenza vaccine was administered to 295 (88%) of the 337 residents of the nursing home. The residents shared common dining and recreational areas; the mean age of residents was 83 years (range= 51-103 years); 256 (76%) were female. The prevalence of underlying illness in vaccinated and unvaccinated patients was not determined.

From December 9 through January 10, 65 (19%) of the residents had onset of influenza-like illness (fever ≥100°F with cough or sore throat). Among those with influenza-like illness, 34 (52%) developed pneumonia, 19 (29%) required hospitalization, and two died. In addition to fever, symptoms included cough (72%), congestion (57%), pharyngitis (38%), and rhinitis (8%). Isolates from throat-swab specimens obtained from two patients were identified as influenza A(H3N2) by the New York State Wadsworth Center for Laboratories and Research.

Influenza-like illness occurred among 52 (18%) vaccinated residents and 13 (31%) unvaccinated residents (relative risk = 1.8, 95% confidence interval [CI_{95}] = 1.1-2.9). Pneumonia following influenza-like illness occurred among 27 (9%) vaccinated residents and seven (17%) unvaccinated residents. The calculated vaccine efficacy for preventing influenza-like illness and pneumonia was 43% (CI_{95} = 5%-66%) and 45% (CI_{95} = −18%-74%), respectively.

On January 6, the New York State Department of Health was notified of the outbreak and recommended amantadine therapy for patients with influenza-like illness. However, medical staff administered amantadine only to a limited number of residents.

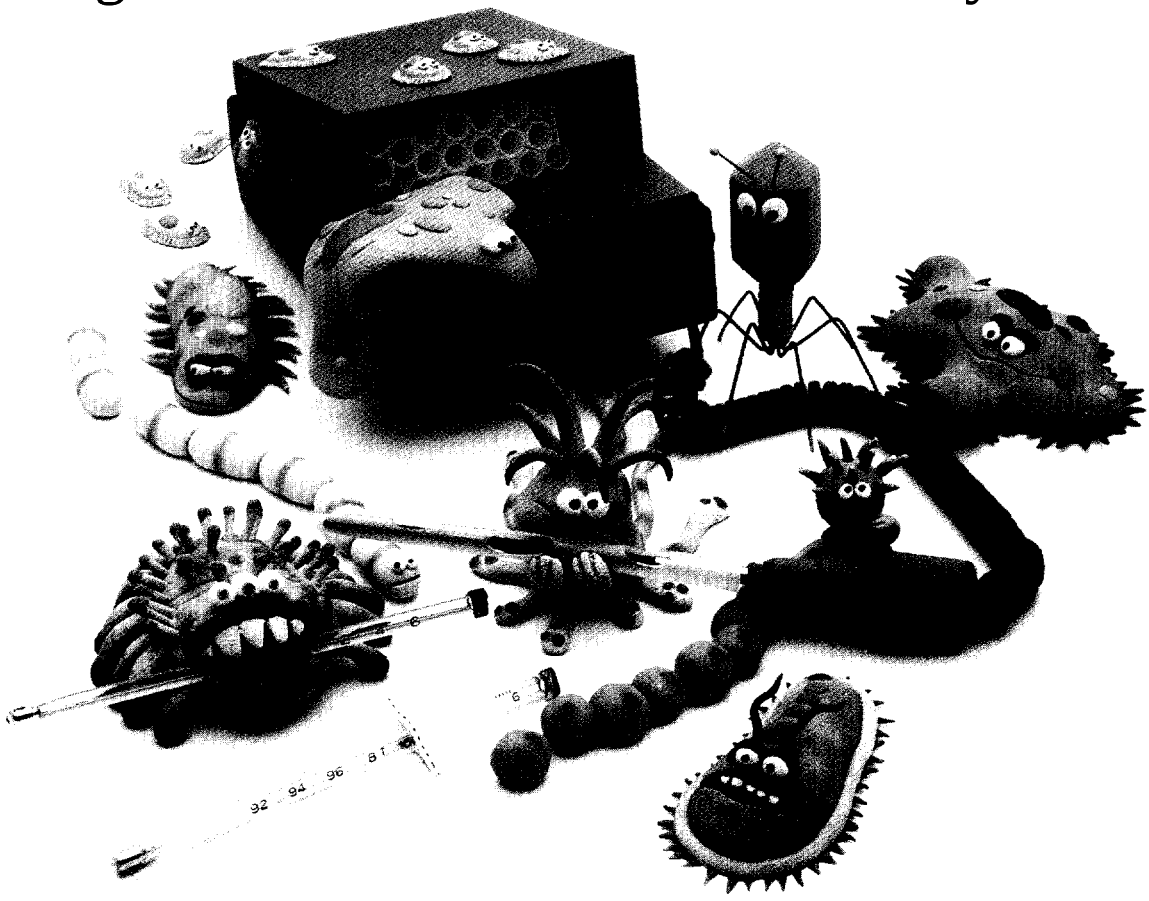
Questionnaires were distributed to nursing home employees with patient contact to determine the vaccination coverage and incidence of influenza-like illness among these staff. Of 449 employees, 339 (76%) completed questionnaires. Thirty-three (10%) employees had been vaccinated in the fall before or during the outbreak. From November 1 through January 9, 65 (19%) had influenza-like illness; the calculated vaccine efficacy for preventing influenza-like illness in nursing home employees was 86% (CI,, = 34%99%).

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1. Smith, Leon; Prince, Herbert N.; Johnson, Edward: Bacteriologic Studies on Electronic Hospital Thermometers: Infection Control 1981: Vol. 2, No. 4: p. 316

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