Reply to Roady

To the Editor—We welcome the engagement and comments of Ms. Roady in response to our research article.[1] We agree that the use of rapid ATP testing has a growing body of published support. However, the lack of common acceptance for rapid ATP testing at this point in time is well expressed in the EPIC 3 Guidelines (2014) from an expert committee in the United Kingdom.[2]

Unfortunately, Ms Roady somewhat misses the point of our paper. In our study, we did not attempt to equate rapid ATP testing with detection of bacterial contamination. We showed that the variability that occurs when measuring responses to controlled quantitated microbial cultures is the same variability that occurs when controlled concentrations of pure ATP solutions are measured. The issue is therefore not correlation with detection but data variability.

This variability is undetectable to ATP device users and applies to all sources of detected ATP. The ATP variability problem (ie, imprecision in results) that we have outlined in our most recent paper is common to each of the ATP device brands we tested. This finding does have implications for sampling methodology and analysis.[3]

We set out to validate several branded ATP devices using a standardized approach and focusing on precision and accuracy.[4] The first issue we encountered was uncontrolled variability and the lack of precision at any testing point. The issue of accuracy is problematic because the scale of relative light units (RLU) is neither universally standardized nor standardized among ATP device suppliers.

We welcome the engagement with the industry. We would like to see better quality of results for ATP testing devices, including testing for precision and the development of a common measurement scale. There remains a tremendous upside for ATP use once these issues are resolved.

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REFERENCES

1. Whiteley GS, Derry C, Glasbey T, Fahey P. The perennial problem of variability in adenosine triphosphate (ATP) tests for hygiene monitoring within healthcare settings. *Infect Control Hosp Epidemiol* 2015;36:658–663.
2. Loveday H, Wilson JA, Pratt RJ, Golsorkhi M, Tingle A, Bak A, Browne J, Prieto J, Wilcox M. *EPIC 3 National Evidence Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. J Hosp Infect* 2014;86:Supplement 1.
3. Whiteley GS, Derry C, Glasbey T. Sampling plans for use of rapid adenosine triphosphate (ATP) monitoring must overcome variability or suffer statistical invalidity. *Infect Control Hosp Epidemiol* 2015;36:236–237.
4. International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use. *ICH Harmonised Tripartite Guideline for Validation of Analytical Procedures: Text and Methodology* Q2(R1). ICH Guidelines 2008.

Infection Control Implications of Protracted Lengths of Stay With Noninfluenza Viral Influenza-Like Illnesses in Hospitalized Adults During the 2015 Influenza A (H_3N_2) Epidemic

To the Editor—Infection control (IC) precautions for hospitalized adults with influenza consist of standard, contact, and droplet precautions with single rooms recommended or with patients cohorted, but guidelines for viral influenza-like illnesses (ILIs) are not standardized.[1] During the January 2015 influenza A (H_3N_2) epidemic in our location, the high volume of patients with ILIs became problematic, creating a major strain on bed availability.

In January 2015, a total of 54 adults were admitted with influenza A (H_3N_2) and 37 adults were admitted with viral ILIs diagnosed by multiplex polymerase chain reaction (PCR) assay of nasopharyngeal swab samples. Of the 54 influenza case patients, 53 (98%) had influenza A (H_3N_2) and 1 (2%) had influenza B. One patient had a dual-positive rapid influenza diagnostic test for influenza A and influenza B, but PCR testing was positive for influenza A (H_3N_2).[2–6]

Of the 37 adults with viral ILIs, 16 (43%) had respiratory syncytial virus (RSV), 10 (27%) had rhinovirus/enterovirus (R/E), 5 (14%) had human parainfluenza virus type 3 (HPIV-3), 4 (11%) had human metapneumovirus (hMPV), and 2 (5%) had coronavirus (Table 1). Elderly patients, more commonly admitted for viral ILIs, had longer LOS for viral ILIs than for influenza. RSV patients were older (mean age, 83 years), with LOS similar to that of influenza patients. Importantly, HPIV-3 patients had the longest LOS of any viral ILI (mean, 19 days) and were more seriously ill, with 1 death due to HPIV-3 pneumonia. Two patients had co-colonization

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