ICPs and Infection Control Guidelines

To the Editor:

As I read the article in the June 1987 issue of ***Infection Control*** (Bryan CS: "CDC Says . . .": The Case of IV Tubing Replacement), the following quote caught my eye: "Unfortunately, we have observed a reluctance among infection control practitioners to recommend changes when CDC says otherwise." This statement is a generalization that all infection control practitioners (ICPs) fit this mold. Many ICPs view CDC guidelines as just that: "guidelines."

The day my issue of ***Infection Control*** arrived was the day our infection control committee had a meeting scheduled with a proposal to be presented for 72-hour tubing changes for TPN lines. In July of 1986, delivery systems for IV tubing were changed to 72 hours with considerable cost savings without compromising safety. Changing tubing, site, and dressings on a 72-hour basis, besides being practical, has maintained a higher level of microbiologic control.

I am fortunate to be able to work with a cooperative medical team that does not have the attitude that we will wait until CDC publishes our guidelines. In the real world patient care decisions are based on common sense, studies when available, and cost containment.

APIC also plays an important role in policy change, without compromising patient safety. If ICPs never initiate change, rituals will prevail rather than rationale.

Hi-Desert Medical Center had used disease-specific isolation from July of 1983 until June 1987, when it seemed more realistic to change to blood and body substance precautions. Thanks go to Marguerite M. Jackson, Director, Epidemiology Unit UCSD Medical Center, who generously shared her guidelines so that I didn't have to reinvent the wheel to use a more realistic approach to infection control.

Infection control practitioners are probably guilty of not sharing the many changes they effect, rather than being guilty of reluctance to change. Sometimes some of the best guidelines are those that ICPs develop and if they are shared, may become a CDC guideline or a policy of another institution.

Eileen L. Upton, RN, MEd A
Infection Control Practitioner
Hi-Desert Medical Center
Joshua Tree, California

Infection Risk in the Bearded Patient

To the Editor:

Notwithstanding the bearded examples set by Pasteur, Koch, and Erlich, the presence of beards in the laboratory or clinical setting has been periodically questioned. Jelenko[1] expressed grave reservations about their wear by surgical team members, and Prioleau[2] concluded that hair fashions do not constitute a valid basis for disregarding the generally accepted principles of aseptic technique. Barbeito and others[3] performed a series of terminal experiments on bearded volunteers and observed that washing reduces the quantitative plate count of beard bacteria, but more organisms persist in the beard than on the faces of similarly treated clean-shaven men. In a report on the bacteria present in the hair of staff and patients in an intensive care unit, Cozanitis[4] reminds us that host factors are important in determining whether infections are liable to occur or not, and that ICU patients are critically ill and potentially much more likely to develop infections with commensal organisms. York[5] correctly notes that the critical experiment to show whether infections are actually caused by hair has probably never been done. Although more than a decade has passed since his writing, neither that experiment nor an instance where beard hair has been related to an infection has appeared in the literature.

In that regard, we submit the case of patient X admitted to our ICU following complex biliary surgery. Because he could not tolerate oral feeding, patient X was placed on total parenteral nutrition that eventually required the placement of several central line catheters sited in the subclavian vein. The large, full beard worn by this patient was not only troublesome to keep clean, but swept over the catheter site as he talked or rolled his head. Attempts to persuade the patient to shave the beard were futile.

The patient experienced several febrile episodes over the course of two weeks, resulting in the isolation of three organisms from separate blood cultures. ***Staphylococcus aureus,*** a coagulase-negative staphylococcus, and ***Candida albicans*** were cultured in succession. Cultures taken from the beard, obtained by imprinting blood plates into the beard, successfully demonstrated both the coagulase-negative staph and the S ***aureus.*** Phage typing was not accomplished, but the MIC profiles were identical for both types of staph from both sources. The patient followed a rapidly deteriorating course of infection and died.

While this can hardly be regarded as proof that the beard caused infection via the catheter site, it seems sufficiently compelling to recommend that shaving as a part of the routine preparation for any central line catheter placement be tested in a continued study.

REFERENCES

1. Jelenko C III: Short thoughts on long hair, editorial. Surg Gynecol Obst 1970; 130:516-517.
2. Prioleau WM: Long face and scalp hair presents problems in aseptic technique, editorial. *Am Surg* 1969: 35:599-600.
3. Barbeito MS. Mathews CT. Taylor LA: Microbiological laboratory, hazard of bearded men. *Appl Microbial* 1967; 15:899-906.
4. Cozanitis DA: Microorganisms in the hair of staff and patients in an intensive care unit. *Annesthesist* 1977; 26:581-585.
5. York E: Beards and bacteria. J Maine *Med Assoc* 1972: 63:67.

Dale R. Hamilton, SM(AAM), PhD
Bryan Kobylik, RN, MSN
Laboratory Service and
Infection Control Section
Alvin C. York VA Medical Center
Murfreesboro, Tennessee

https://doi.org/10.1086/645783 Published online by Cambridge University Press