exposure to the HCW while she was symptomatic. The four HCWs were contacted, and chemoprophylaxis initiated for them and for the two hospitalized patients.

DISCUSSION

Nosocomial pertussis has been reported previously, most commonly in pediatric wards of hospitals or in residential facilities for the disabled.[10,11] The index case, as in this report, usually has been a patient with undiagnosed infection. Infected employees, although rarely the source case, may be involved in propagating infection within the healthcare institution[12] or within their own households. Thus, diagnosis of a healthcare worker with pertussis, particularly in an acute-care pediatric institution, is of utmost importance.

Although the diagnosis of pertussis in our index case was delayed, PCR was able to diagnose infection in both the patient and HCW within 24 hours of processing the specimen. Prolonged contact between the HCW and the patient confirms the potential for nosocomial acquisition of infection, particularly when high-risk activities such as suctioning are performed. The infection control service should work together with the Occupational Health Department to identify all HCWs with substantial exposure to an infective case.

Current recommendations for chemoprophylaxis of pertussis after substantial exposure are the same as those for treatment of infection.[13] The value of confirming the diagnosis in the HCW is to restrict them from work during the most contagious catarrhal phase of infection and thus from the potential of further spread within the institution. In autumn and winter months, when respiratory symptoms due to other infectious agents may be prevalent, a confirmed diagnosis of pertussis is useful to advise the symptomatic HCW to refrain from working, as has been recommended.[14] Polymerase chain reaction has proven to be a useful and rapid test in this regard; the high sensitivity and rapid turnaround time makes this test useful for the diagnosis of nosocomially acquired pertussis.

This case report supports the utility of pertussis PCR in the diagnosis of nosocomially acquired infection.

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Calendar

March 18-21, 1998. The Second Australian Wound Management Association Conference, Wound Management Toward 2000—A Blossoming Paradigm, will be held in Brisbane and hosted by the Queensland Wound Care Association, Inc, on behalf of the Australian Wound Management Association. Proposed topics include, but are not limited to, the following: chronic wound healing; chronic venous ulcers; commercialization of medical interventions; molecular mechanisms of normal and aberrant wound repair; proto-oncogene control of fetal wounds; skin-graft storage analyses; cell biology of animal models of impaired wound healing; mechanisms of cell death by apoptosis in vascularized skin flaps; in vitro models of wound fibroblasts; acute, chronic, and burn wounds; optimizing scar outcome using dermal substitutes and cultured epithelial autograft; comorbidities of attendees of wound clinic—co-existing diseases, dependencies, and cognitive status; hyperbaric oxygen therapy.

October 15, 1997, is the deadline for submission of abstracts. Faxed abstracts will not be considered.

To request further information, contact the Second AWMA Conference, PO Box 1280, Unit 11, 97 Castlemaine St, Milton QLD 4064, Australia; e-mail, wm98@im.com.au; telephone, 61 (0)7 3369 0477; fax, 61 (0)7 3369 1512.

https://doi.org/10.1017/S0195941700000643 Published online by Cambridge University Press