

examination should be done. If an objective is to assume responsibility for employees' personal health, then a physical examination should probably be included. On the other hand, if the objective of the employee health program is to maintain a safe environment for personnel, patients, and visitors, a health inventory would probably fulfill this objective. Other considerations are amount of time, money and personnel available to do physical examinations.

Obviously, at a time when all of us must deal with a relatively fixed pool of resources to manage programs such as employee health and infection control, it is imperative that programs establish certain priorities in an attempt to put their money where it will do the most good. The CDC Guideline for Infection Control in Hospital Personnel recommends that "for infection control, complete physical and laboratory examinations should not be routinely required for personnel but should be done when indicated; for example, need for examination or laboratory test may be determined from the results of the health inventory."¹ In general, it would seem unlikely that any additional infectious disease information would be obtained by a physical examination rather than a health inventory. Obviously, the decision to perform a physical examination for purposes other than infection control must be made by assessing the unique needs of the institution and its personnel as well as the program's resources.

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AIDS Precautions for Other High-Risk Groups?

To the Editor:

Your recent Special Report, "A Hospitalwide Approach to AIDS,"¹ is an excellent summary of the logical steps

necessary in dealing with an AIDS patient, based on the current state of knowledge about this syndrome. However, there is one statement with which we must take exception. The report states "Patients who merely belong to one of the high-risk groups, but who do not have other clinical evidence of AIDS, do not need these precautions." This seems a bit dogmatic given the current state of knowledge about AIDS.

It appears that transmission of AIDS may occur from a person who is not necessarily ill with this syndrome.² In fact, it is not yet known at which stage the disorder may be most communicable. Hepatitis B, the disease which epidemiologically appears most similar to AIDS, clearly may be transmitted by an asymptomatic individual. In fact, most infectious diseases have a high asymptomatic to clinically apparent ratio among infected individuals.³ Thus, it might be appropriate to maintain the same precautions among asymptomatic individuals belonging to a group at high-risk for AIDS as for individuals actually suspected of having AIDS. Again using Hepatitis B for comparison, our hospitals maintain blood and body secretion precautions for all individuals belonging to a high-risk group for Hepatitis B (eg, intravenous drug abusers, sexually active homosexual men, patients on hemodialysis, Southeast Asians, etc.), until hepatitis serology confirms the absence of Hepatitis BsAg. Unfortunately, no serological marker which has been shown to reliably predict the presence of the putative AIDS agent is currently available for routine use. It is therefore impossible to rule out the presence of the AIDS agent in an individual patient. The prevalence of infection with the AIDS agent, as opposed to the prevalence of disease, is completely unknown for high-risk populations. While the risk of in-hospital transmission of AIDS by any patient appears to be extremely remote, until the prevalence of the infection in high-risk populations is known and the most infectious stage established, it is pure speculation to state that the patient with documented AIDS is more of a risk for AIDS transmission than the well individual belonging to a high-risk group.

If the remainder of the report's rec-

ommendations are followed, the institution of blood and body secretion precautions in asymptomatic individuals belonging to high-risk groups for AIDS would be a simple and logical extension of the steps outlined to prevent potential transmission of a disorder which is as yet incompletely understood. Perhaps it would be more appropriate to suggest that hospitals handle this issue on an individual basis.

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Dr. Theodore C. Eickhoff, Chairman of the Advisory Committee on Infections Within Hospitals, offers the following response to Drs. Klein and Friedland.

Drs. Klein and Friedland have identified an issue that was of concern to the members of the Advisory Committee on Infections Within Hospitals as we prepared these recommendations, and continues to be of concern today. The introductory paragraphs to our report point out that the recommendations have not been clearly documented by controlled trials to be effective, nor to be ineffective, but that they represented at that time the best judgment of the Advisory Committee and its consultants. We further pointed out that these recommendations might need to be revised and updated as new information or experience indicated the need to do so. Indeed, the information that has emerged in

the six months since these recommendations were prepared about the possible role of HTLV-3 as the leading candidate for the putative AIDS agent suggests that it might indeed be appropriate, at some time in the future, to modify the statement about who does or does not need AIDS precautions.

Nevertheless, the Advisory Committee felt at that time and continues to feel at the present time that to recommend that all patients drawn from "high-risk" groups be placed under AIDS precautions would impose, in practical terms, untenable requirements and complexities on hospitals and hospital personnel. For example, how much homosexual behavior, or how much intravenous drug abuse is necessary in order to place a patient in a "high-risk" group? In addition, a small proportion of AIDS cases continues to occur in persons not clearly

identified with any of the high-risk groups.

Health care personnel are, or at least should be, continually reminded by Infection Control personnel that *all* blood and body fluids should be regarded as potentially infectious. A number of infections in which the risk is known and documented, at least in semi-quantitative terms, such as hepatitis B, hepatitis B surface antigen carriage, secondary syphilis, malaria, etc., are singled out for the slightly more stringent requirements of "blood and body fluid precautions." If, in the future, a serologic marker becomes available which can reliably identify the presence of the putative AIDS agent, then it would surely be appropriate to modify our recommendation accordingly.

Finally, the suggestion that hospitals handle this issue on an individual basis was also considered, and

ultimately discarded as not being particularly helpful to hospitals. The hospitals in which Drs. Klein and Friedland work have had a substantial experience with the management of AIDS patients, and they have by this time undoubtedly formulated their own guidelines for management of AIDS patients. Our recommendations were prepared primarily to provide some guidance for the substantial majority of US hospitals that thus far have had little or no experience with the management of AIDS patients. As we pointed out, hospitals should adapt these recommendations to their individual circumstances, or to implement additional precautions if they were judged to be appropriate.

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