

# In.CONTROL



*The Newsletter of the NSW Infection Control Resource Centre  
An initiative of the NSW Health Department*

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## INTERESTING TIMES FOR INFECTION CONTROL PROFESSIONALS

I hope all readers of **In.Control** had a very enjoyable festive season and are fully refreshed for the challenges this year will no doubt bring.

AS 2004 gets under way, Australia's epidemiologists and experts in communicable diseases will be maintaining a close eye on the developments of several overseas events. Severe Acute Respiratory Syndrome (SARS) emerged again in China in mid-January when three new cases were confirmed. These were the first infections not linked to laboratory accidents since the World Health Organisation (WHO) declared the global outbreak of SARS over in July. Meanwhile in Vietnam, at the time of going to print, eight deaths were reported from the H5N1 avian influenza outbreak that was sweeping Asia. H5N1 killed six people in Hong Kong in 1997 and 1998. Over in the US and Europe, a mass outbreak of influenza hit during the northern hemisphere winter. The influenza epidemic was caused by a strain called Fujian, a modification of a particular serious type of flu. The influenza that hits the northern hemisphere winter is often a predictor for the strain of influenza that will be seen in Australia's winter in the middle of the year.

The *Interim Australian Infection Control Guidelines for SARS*, dated 16 May 2003, is still the current policy at the time of this newsletter going to print. The Center for Disease Control and Prevention (CDC) released further guidelines regarding SARS, including Infection Control Guidelines (with downloadable PowerPoint slides) in January. They can be accessed at [www.cdc.gov/ncidod/sars/guidance/](http://www.cdc.gov/ncidod/sars/guidance/)

On the home front, Infection Control Coordinators will once again be focusing their energies on managing and reducing health care associated infections, conducting infection control program quality monitoring, and maintaining health care worker safety. Our colleagues working in the area of sexual health will be facing the challenge of influencing a reverse in the rise of HIV infections in NSW in 2003.

The NSW Department of Health issued several new Circulars in late 2003 that will be of interest to many Infection Control Coordinators: *Reportable Incident Briefs to the NSW Department of Health – Circular 2003/88*; *Notification of Infectious Diseases Under the Public Health Act 1991 – Circular 2003/89*; and *Occupational Screening and Vaccination Against Infectious Diseases – Circular 2003/91*. Details of these documents can be found on page 3. NSW Department of Health Circulars can be downloaded and printed directly from the Department's website: [www.health.nsw.gov.au](http://www.health.nsw.gov.au)

The *Australian Immunisation Handbook 8<sup>th</sup> Edition 2003* was also released in late 2003. This Handbook has to be read in conjunction with many NSW Department of Health Circulars and is therefore an essential document for most Infection Control Coordinators. For the first time the Handbook can be accessed online. Details of the website address, or how to obtain a hard copy, can be found in the Book Reviews section on page 12.

The History topic in this issue of **In.Control** is a fascinating look at the Spanish Flu that killed approximately 40 million people globally in 1918-1919. It has been cited as the most devastating pandemic in recorded world history, which even today still inspires deep fascination among historians.

*Philip Melling*

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# NSW DEPARTMENT OF HEALTH: CIRCULARS & INFORMATION BULLETINS (and other related documents)

The following are the latest Circulars and Information Bulletins, from September 2002 to going to print, relating to Infection Control issues that have been released by the NSW Department of Health

2002/80	INFECTION CONTROL GUIDELINES FOR ORAL HEALTH CARE SETTINGS
2002/84	MANAGEMENT OF PEOPLE WITH HIV INFECTION WHO RISK INFECTING OTHERS (supersedes Circular 2001/104)
2002/92	MANAGEMENT OF FRESH BLOOD COMPONENTS (supersedes Circulars 82/319, 84/130, 85/230, 86/177, 86/234, 89/90, 90/29, 91/9, 91/64, 97/128)
2002/93	COMMUNITY SHARPS DISPOSAL BY PUBLIC HOSPITALS AND AUTHORISED OUTLETS OF THE NSW NEEDLE AND SYRINGE PROGRAM
2002/98	TECHNICAL SERIES (TS) 10, STANDARD PROCEDURES FOR HANDLING OF ACCOUNTABLE ITEMS 5 <sup>th</sup> EDITION
2002/104	INFECTION CONTROL PROGRAM QUALITY MONITORING
January 2003	INFECTION CONTROL PROGRAM QUALITY MONITORING INDICATORS USERS' MANUAL
2003/4	RH D IMMUNOGLOBULIN (ANTI-D) (supersedes Circular 97/139)
March 2003	STERILIZATION AND DISINFECTION CORE COMPETENCIES
2003/33	CONTROL OF FOODBORNE LISTERIOSIS IN HEALTH CARE INSTITUTIONS (supersedes Circular 99/95)
2003/35	HEALTH SERVICES STAFF WITH POSSIBLE EXPOSURE TO SEVERE ACUTE RESPIRATORY SYNDROME (SARS)
2003/39	MANAGEMENT OF HEALTH CARE WORKERS POTENTIALLY EXPOSED TO HIV, HEPATITIS B AND HEPATITIS C (supersedes Circular 98/11)
2003/88	REPORTABLE INCIDENT BRIEFS TO THE NSW DEPARTMENT OF HEALTH (rescinds and replaces Circular 97/97)
2003/89	NOTIFICATION OF INFECTIOUS DISEASES UNDER THE PUBLIC HEALTH ACT 1991 (supersedes Circular 2001/9)
2003/91	OCCUPATIONAL SCREENING AND VACCINATION AGAINST INFECTIOUS DISEASES (supersedes Circular 2002/97)

Copies of NSW Department of Health Circulars and Information Bulletins can be obtained from the

NSW HealthWeb site:

<http://www.health.nsw.gov.au>

or

phoning Central Records at the  
NSW Department of Health on (02) 9391 9000

A list of NSW Department of Health Circulars and Information Bulletins relating to  
Infection Control issues can be obtained from  
**THE NSW INFECTION CONTROL RESOURCE CENTRE**  
**(02) 9332 9712**

## **NSW DEPARTMENT OF HEALTH: CIRCULARS**

*Three new Circulars were issued by the NSW Department of Health in late 2003 that will be of interest to infection control professionals.*

### **Reportable Incident Briefs to the NSW Department of Health – Circular 2003/88**

Circular 2003/88 rescinds and replaces Circular 97/58 of 20<sup>th</sup> June 1997 and should be read in conjunction with Circular 2/19 of February 2002.

The health system is responsible for identifying, reporting, investigating, analysing and acting upon health care incidents as they occur. These steps are required so that immediate risks that an incident may create are managed appropriately, effective action is taken to improve the systems of care in order to prevent the recurrence of such an incident, and to make health care safer for patients and staff.

Circular 2003/88 identifies the actions that are required of Health Services for notifying defined health care incidents to the Department of Health and the response to these notifications that is required by the Department of Health.

### **Notification of Infectious Diseases Under the Public Health Act 1991 – Circular 2003/89**

Circular 2003/89 supersedes Circular 2001/9 – *Notification of Infectious Diseases under the Public Health Act 1991*.

The only effective change to Circular 2001/9 is the addition of one notifiable condition, Severe Acute Respiratory Syndrome (SARS). This was made notifiable by hospital chief executive officers (or general managers) from 16 April 2003 and by medical practitioners and laboratories from 6 June 2003.

Circular 2001/9 also listed 'Cancer' under diseases covered by Schedules 3 and Section 68 and Category 3, Schedule 1 of the Act. To be consistent with the title of the Circular, 'Cancer' has been removed. 'Cancer', along with several congenital and perinatal conditions and conditions of infants, remain notifiable under the Act.

### **Occupational Screening and Vaccination Against Infectious Diseases – Circular 2003/91**

Circular 2003/91 supersedes Circular 2002/97 – *Occupational Screening and Vaccination of Health Care Workers Against Infectious Diseases*.

Circular 2003/91 describes the NSW Health system's responsibilities in relation to occupational screening and vaccination of employees and other personnel against infectious diseases. It is recommended that licensed private health care facilities have regard to this Circular in the

development of policies on occupational screening and vaccination.

The Circular states that employers must immediately incorporate this policy into the recruitment and orientation process for all new employees. The policy must also be applied to all existing employees within one year of the release of this Circular.

This Circular has been developed with particular reference to the guidelines in the National Health and Medical Research Council (NHMRC) Australian Immunisation Handbook (current edition) which must be referred to at all times.

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## **INFECTION CONTROL**

### **Education on the Road**

The NSW Infection Control Resource Centre has been offering a variety of courses relating to infection control since the late nineties. The courses aim to skill health care workers in the many areas of infection control.

In addition to the courses we currently offer we can now offer specific education sessions that can be tailored to the individual requirements of your facility. We have designed this as a mobile program, which means that the important issues surrounding Infection control can now be even more accessible to you and your facility.

So whether you are an Aged Care Facility, Day Procedure Centre, small private or a public facility, the "Education on the Road" sessions may be of interest to you.

You may like to enquire about some of our standard education sessions or choose a topic of your choice. Sessions can range from a 60-minute presentation through to a half or full-day workshop.

Sessions may include:

- Principles of Infection Control
- Basic Microbiology
- Specific Infectious Diseases
- Management of Occupational Exposures
- Staff Health and Immunisation
- Waste Management
- Food Handling
- Hand Washing

If you would like further information on **INFECTION CONTROL: EDUCATION ON THE ROAD**, please contact the NSW Infection Control Resource Centre on 9332 9712 or email [saidp@sesahs.nsw.gov.au](mailto:saidp@sesahs.nsw.gov.au)

# MEDIA WATCH AUSTRALIA

In November, the *Mosman Daily* reported on work being done at Royal North Shore Hospital on a new kind of medicine for the treatment of infections. As some strains of bacteria were now resistant to all forms of available antibiotics, microbiologists are working on a new treatment option known as phages. Bacteriophages are viruses which target bacteria, acting more specifically than antibiotics. The hospital is hoping to secure funding to continue its research into the area.

According to United Nations figures, Australia ranks at the top of the world in controlling **HIV/AIDS**, the *Daily Telegraph* reported in November. However, the good news was dampened by recent national statistics showing an increase in **HIV** infections in Australia for the first time in a decade. There were between 700 and 1000 new **HIV** infections in Australia and New Zealand at the end of 2003 and fewer than 100 deaths.

A study, published in *Emergency Medicine*, revealed that one in five people treated for syringe injuries at hospital emergency departments is a child. The data was collected from Sydney's Royal Prince Alfred Hospital (RPA) from 1996 to 2001. The average age of children receiving treatment was six. It is believed that the results would mirror those of other hospital emergency departments. RPA researcher and registrar in emergency medicine, Dr Fenton O'Leary, said parents needed to better educate their children on the dangers of used syringes. 68% of the injuries were caused by needles found in parks, beaches, cinemas and trains, as well as areas around public toilets.

The findings of a report, released in late November by the Australian Institute of Health and Welfare, revealed that the rate of **chlamydia** infections among young people has tripled in the past 10 years. In 1991, there were 98 notified infections per 100,000 among 18-24 year olds. By 2001, the number of cases had risen to 338 per 100,000. **Chlamydia** is a curable sexually transmitted disease. Up to 75% of those infected show no symptoms.

The *Sydney Morning Herald* printed a large article on **food poisoning** in its 20<sup>th</sup> November edition. While winter is renowned for viral outbreaks, summer is the time for spreading bacteria and toxins. Raw meat, poultry, fish and even raw vegetables can contain significant levels of bacteria. Warmth breeds illness-spreading bacteria. The article discussed the golden rules worth considering when catering for summer outdoor entertaining, which can cut the chances of food poisoning. The lurking dangers are:

- **GARDEN AND FRUIT SALADS:** Can spread bacteria such as *Salmonella*, *E.coli*, *listeria*; viruses such as norovirus from food handlers.
- **STEAK:** *Salmonella*, *E.coli* and *Campylobacter*.
- **HAMBURGERS AND SAUSAGES:** *E.coli* in particular.
- **CHICKEN:** *Salmonella*, *Campylobacter*, and *Clostridium perfringens* toxins.
- **MARINADE:** Can spread *Salmonella* or any bacteria already in associated raw meat.
- **FISH:** Less likely to spread bacteria, more likely to spread the viruses hepatitis A and norovirus, and the marine biotoxins ciguatoxin and scombroid.
- **RICE:** Can spread toxins such as *Bacillus cereus*

In December, the State Government launched a website to help parents, carers and teachers get rid of **head lice** from transmission sources in schools and homes following a NSW Health estimate that one in five children in primary schools has had **head lice**. The *Sydney Morning Herald* reported that contrary to claims made on the bottles of lice exterminators, no chemical treatment on the market could completely wipe out a sufferer's **head lice**, because lice were becoming increasingly resilient. The preferred method of eliminating nits is the simple application of ordinary hair conditioner combed through with a wide-toothed lice comb. The website [www.health.nsw.gov.au/headlice/](http://www.health.nsw.gov.au/headlice/) will supplement a Nitbusters program that is run at primary schools. Nitbusters is a joint project between NSW Health, the NSW Department of Education and Training, and the Federation of Parents and Citizens Associations. It has been running in schools for the past two years.

The *Sydney Morning Herald's* Health and Science supplement in December devoted an issue to the common dangers that can affect overseas travelers – mainly infectious diseases. Dr Brad Forsmann, from *The Travel Doctor*, says finding out about health risks in countries you plan to visit is as important as planning your itinerary. Dr Bernie Hudson, a specialist in microbiology and infectious diseases at Royal North Shore Hospital, says **malaria** is the infection most likely to kill a traveler, while the most common vaccine-preventable illness among travelers is **hepatitis A**, which is spread by contaminated food and water. **Hepatitis B** can be picked up by getting a simple holiday tattoo in some countries. The article also gave an overview on **gastroenteritis**, **dengue fever**, **rabies**, **Ross River fever**, **hookworm**, **ringworm**, **myiasis – fly larvae**, **leishmaniasis**, and **schistosomiasis (bilharzia)**, giving the cause, symptoms, treatment, and prevention for each disease. The article also discussed diseases that can be prevented by vaccination, such as **polio**, **meningococcal meningitis**, **hepatitis A**, **hepatitis B**, **yellow fever**, **influenza**, **tetanus/diphtheria/pertussis**, **pneumococcal typhoid**, **Japanese encephalitis**, and **measles/mumps/rubella**. The extensive feature appeared in the December 4<sup>th</sup> edition of the newspaper. Visit these websites:

- Travel Clinics Australia [www.travelclinic.com.au](http://www.travelclinic.com.au)
- The Travel Doctor TMVC [www.tmvc.com.au](http://www.tmvc.com.au)

- World Health Organisation (travel health) [www.who.int/ith/](http://www.who.int/ith/)

An **anthrax** scare involving a Sydney celebrity was investigated by police, the *Daily Telegraph* reported in December, when white powder was found leaking from an envelope in an Australia Post sorting machine. Police confirmed the letter was addressed to a Sydney celebrity, but would not comment on the celebrity's identity or gender. As a result of the scare, the NSW Fire Brigades hazardous materials team, HAZMAT, was called in.

An outbreak of **whooping cough** in NSW saw 390 cases reported in November, according to a report in the *Sun-Herald*. NSW usually experiences a surge in **whooping cough** cases every three or four years. The infectious disease had its last peak in 2000 when up to 600 cases were reported each month.

NSW Health issued an alert to patrons of the Canterbury Hurlstone RSL Club in December following the diagnosis of **hepatitis A** in one of the club's food preparation staff. The warning was limited to patrons who ate at the Club's Encore Restaurant between November 22 and December 9 inclusive.

NSW scientists believe one of the many viruses that cause the **common cold** might eradicate cancer cells. Researchers from the University of Newcastle have found Cocksackievirus A21 can blast human melanoma cells cultured in the laboratory and those grown in genetically susceptible mice. If successful in its next phase, the treatment will be commercialised by ViroTarg, a University of Newcastle joint venture with investors. The preliminary findings were published in the January edition of *Clinical Cancer Research*, the journal of the American Association for Cancer Research.

NSW Health officials in January warned Sydney-siders to be on the alert for symptoms of **measles** amid fears that a foreign tourist may have infected New Year revelers near Circular Quay and people in Manly on New Years Day. The woman came to Sydney from Melbourne on QANTAS flight QF187 at 12.45pm on New Year's Eve. She was in packed crowds at city venues and a party that night, before visiting Manly the next day.

Prisons in NSW are confronting one of Australia's fastest growing epidemics with 60% of women and 40% of men in the state's jails infected with **hepatitis C**. The *Sydney Morning Herald* in January reported that there are now specialist **hepatitis C** clinics in each of the state's 29 correction centres. There are 4000 people with **hepatitis C** in the state's prisons at any one time.

A large feature article in the January 12 edition of the *Sydney Morning Herald* examined some of the suggested causes behind the rise in **HIV** rates in NSW. The article suggested changes in sexual behaviour, mainly unprotected intercourse; an epidemic of sexually transmitted infections,

such as **gonorrhoea**, **syphilis** and **chlamydia**, which increase the chance of **HIV** transmission; and an increase in the community's viral load as new drugs meant fewer people were dying from **AIDS**-related diseases. An increase in recreational drug use was also cited as a possible factor, as drugs, from alcohol to ecstasy, are generally disinhibiting causing more people to take risks. In NSW in the first six months of 2003, **HIV** notifications rose 18% compared with the same period the year before. The AIDS Council of NSW is searching for the best response after years of safe sex messages that may have missed their targets.

Two Chinese flight attendants were admitted to a Sydney hospital in mid-January with **SARS (Severe Acute Respiratory Syndrome)**-like symptoms. The flight attendants were from Guangdong province where last year's outbreak originated. However, following tests, **SARS** was ruled out, the patients discharged from hospital and they returned to China. The incident was covered by all Sydney's news media.

## MEDIA WATCH THE WORLD

In November, *Reuters* news service reported that the World Health Organization (WHO) had voiced concern that people in developing countries received too many injections, often with unsterilised needles and syringes that could transmit blood-borne diseases such as **hepatitis** and **HIV**.

Also in November, the *Daily Telegraph* reported that UNICEF had appointed Kami, an **HIV**-positive Muppet which appears in a South African version of the world-famous television show *Sesame Street*, to promote the rights of **AIDS**-affected children. Kami is a yellow, bear-like Muppet, a lively five-year-old orphan whose parents died from **AIDS**.

Figures released by UNAIDS in late November showed that worldwide about 40 million people are infected with **HIV**. Of that total, 5 million became infected in 2003, including about 700,000 children. About 3 million people died from the disease in 2003. The report also showed:

- The highest **AIDS** prevalence rates in the world are currently in Botswana and Swaziland.
- Infection rates are rising in China, India, Indonesia and Russia.
- Thousands of Chinese peasants were infected during the 1990s through coming into contact with unsterile equipment when they sold their blood.
- Infection rates are falling in Uganda and Senegal, and for pregnant women in the capital cities of Rwanda and Ethiopia.
- In the US, **AIDS** is the leading cause of death for black women aged 25 to 34.

The report was covered by all major news media.

Meanwhile, in January, the Kenya Demographic and Health Survey published a report that believes the number of Africans who carry **HIV/AIDS** has been overestimated by millions. The *Sydney Morning Herald* explained that the international response to the **AIDS** epidemic relies heavily on statistics published by UNAIDS, the joint United Nations program on **HIV/AIDS**. The UNAIDS figures do not count all known cases of **HIV** infection, but are estimates. In Africa, they rely heavily on blood tests from antenatal clinics. But critics say such a system is flawed. The women tested are all sexually active so are unlikely to have used condoms, and most samples are taken from urban clinics where **HIV** infection rates are believed to be twice that in the countryside. The UN replied to the claim by saying a panel of experts regularly updates and refines its figures. As a result, the most recent UNAIDS report estimated **HIV** infection to be 25-28.2 million compared with 22-35 million the previous year.

A paper published in *The Lancet* in late November represented the first big study to test the effectiveness of ultraviolet (UV) light in fighting **sick building syndrome**. Researchers installed UV germicidal irradiation systems in the air conditioning systems of three large office buildings in Montreal. The UV light killed microbes growing in the cooling systems, causing 99% reduction in the concentrations of bacteria, fungi and endotoxins, which are irritants produced by mould. The workers in the buildings reported an overall reduction of 20% in a wide array of symptoms when the UV lights were on. **Sick building syndrome** is a broad term that refers to workplaces in which employees become ill from exposure to something indoors, such as chemicals used for work; glue and other substances being emitted by furnishings; and bacteria, mould and other microbes. The organisms often thrive in moist, dark ventilation systems, causing headaches, coughs and congestion among office workers.

In November, the *Sun-Herald* reported that three people died and nearly 500 other people who ate at a US restaurant have fallen ill in the largest known outbreak of **hepatitis A** in US history.

In late November, a severe and early outbreak of **flu** struck the US and Britain, with **flu** experts warning the world has too few anti-**influenza** medicines to cope with a pandemic, the *Sydney Morning Herald* reported. The **flu** that struck Texas, Colorado and Britain was a strain called Fujian. It was a modification of a particular serious type of flu. In December, the *Daily Telegraph* reported that parts of Western Europe had been hit by a mass outbreak of **influenza** with up to two million cases expected in France in the first week of the month. By Christmas, the US-wide sweep of **influenza** had been classified by federal health officials as an epidemic in the wake of 42 youngsters deaths and 36 states reporting widespread **flu**.

All major electronic and print media reported on the World Health Organisation's plan for treating 3 million people with **HIV** by the end of 2005. The plan was unveiled on

December 1<sup>st</sup>, World **AIDS** Day. The WHO initiative has been regarded by some world health veterans as the most ambitious ever undertaken in public health. The program will include simplified anti-retroviral drug therapy, monitoring the supply and quality of the drugs, and training 100,000 health providers and community workers on how to deliver the drugs. The aim is to more than quadruple the numbers being treated by 2005.

In December, the *Daily Telegraph* reported that **MRSA** is now being carried by pets in Britain. The Health Protection Agency revealed the bacteria was discovered in a dozen animals from across the country.

A December issue of *The Lancet* reported on a new treatment for the **ebola virus** which has increased survival rates in animal tests. A treatment developed by the US Army Research Institute was injected into infected monkeys and a third of them survived, while those untreated all died. The results offer a possible weapon against sudden outbreaks of the highly contagious virus in Africa. Untreated, **ebola** causes massive internal bleeding and kills up to 90% of its victims.

Fears that a second season of **SARS** may be at hand were triggered in January when three cases of **SARS** were confirmed in China. The victims, a 32-year-old TV producer, a 20-year-old waitress and a 35-year-old man, all from the Chinese province of Guangdong, were the first infections not linked to laboratory accidents since WHO declared the global outbreak of **SARS** was over in July. The virus first emerged in Guangdong in late 2002 and went on to infect more than 8000 people in nearly 30 countries. It killed 774 people. At the time of going to print, two of the latest cases had recovered and left hospital. Health officials ordered the slaughter of 10,000 civet cats, a weasel-like animal often eaten as a delicacy in southern China, after researchers reported that the virus found in the new cases resembled a **SARS**-type coronavirus found frequently in civets. Meanwhile in mid-January, *Reuters* news service reported that China's State Food and Drug Administration had approved human trials of a **SARS** vaccine after tests were carried out safely on animals, including monkeys. Doctors would begin human trials soon, although it would take an unspecified amount of time before the vaccine would be marketed.

In December, the British Government announced that a British blood recipient may have become the world's first case of human-to-human transmission of **variant Creutzfeldt-Jakob disease (vCJD)**, the lethal human form of "mad cow" disease linked to eating beef products infected with **bovine spongiform encephalopathy (BSE)**. The *Sydney Morning Herald* reported that in 1996 a donor with no symptoms of **vCJD** gave blood which shortly afterwards was transfused into a patient having surgery for a serious illness. Three years later, the donor developed **vCJD** and died from it. In early 2003, the recipient also died of **vCJD**. While the donor and recipient might have independently contracted **vCJD**, the direct link between the

two cannot be discounted. For the past three years the Australian Red Cross Blood Service (ARCBS) has deferred all donations from anyone who lived in Britain for a total of more than six months between 1980 and 1996. In early 2003, it also banned anyone who had received a blood transfusion in Britain.

The *Washington Post* in December reported that a federal judge has ordered the Pentagon to stop administering an **anthrax** vaccine to American troops without their consent, ruling that troops should not “serve as guinea pigs for experimental drugs”. In blocking mandatory **anthrax** inoculations until a full trial can be held, the judge ruled that **anthrax** vaccine was an experimental drug “being used for an unapproved purpose”.

Research by American and Finnish scientists, who studied more than 6000 children, found those born to mothers who had **influenza** in the last six months of pregnancy were more likely to suffer developmental and emotional problems, the *Sydney Morning Herald* reported in December. Pregnant women who fail to vaccinate against the **flu** could be putting their unborn babies at risk of brain damage, depression and attention deficit hyperactivity disorder, or ADHD. For the past two years in Australia, thousands of women have been warned of the need to be vaccinated. Based on widespread medical speculation about the dangers of the **flu**, Australian immunisation guidelines recommend that women be vaccinated if they are planning to get pregnant or are likely to be pregnant during the **flu** season. The new research appears to justify that position. The researchers suggest that elevated temperature associated with **flu** may have an adverse effect on the foetus that results in abnormal psychological development and behaviour in childhood.

Researchers at the University of East London have found that an ingredient in garlic may offer one of the best defenses against the hospital acquired infections, **methicillin-resistant Staphylococcus aureus (MRSA)** and **Vancomycin-resistant enterococci (VRE)**. The compound, allicin, which occurs naturally in garlic may be able to cure patients with **MRSA**-infected wounds “within days”. The *Press Association* reported that garlic has been used in medicine for centuries, and it should be no surprise that it is effective against this very modern infection.

In January, the *Washington Post* reported that the US Government decided to kill 450 quarantined calves from a Washington state herd after the nations first known case of **BSE**, or “mad cow” disease, was detected. The Bush Administration was trying to restore confidence among the 30 trading partners that banned about \$US1.3 billion in annual US beef shipments after the deadly disease was found in a dairy cow on December 23. US officials believe that the diseased animal came from a farm in Alberta, Canada.

British health experts are calling for medically supervised injecting centres based on the success of Sydney’s

controversial Kings Cross program, according to a report in the *Sydney Morning Herald* in January. A report on the Sydney injecting room last year found that it saved at least four lives a year, and that rates of **hepatitis B** and **C** infections remained steady in the area, despite increasing infection rates elsewhere in Sydney. The international recognition was reassuring for local policy makers who have extended the trial of the Kings Cross centre until 2007. More than 6000 users had registered with the centre.

The outbreak of a highly contagious strain of **bird flu** that has since swept Asia was first reported in South Korea in December. The epidemic forced the slaughter of hundreds of thousands of ducks and chickens. The virus did not appear to be transmissible to humans. A variant of **avian influenza**, identified as **H5N1**, killed six people in Hong Kong in 1997 and 1998. However, in January, eight deaths were reported from an **H5N1 avian influenza** outbreak in Vietnam. Vietnam banned the transport of chickens within 18 southern provinces and slaughtered nearly two million chickens as it tried to contain the outbreak. The virus has since spread through 10 Asian countries with two other deaths reported in Thailand at the time of this newsletter going to print.

The big fear is that **H5N1** could latch onto the **influenza** virus and cause a pandemic on a global scale as the world’s population has no defense against it.

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## HISTORY

### The Spanish Flu 1918-1919

The influenza pandemic of 1918-1919 killed more people than World War I, estimated at 40 million people. It has been cited as the most devastating epidemic in recorded world history. More people died of influenza in a single year than in four-years of the Black Death Bubonic Plague from 1347 to 1351. Known as “Spanish Flu” or “La Grippe” the influenza of 1918-1919 was a global disaster.

In the fall of 1918 the Great War in Europe was winding down and peace was on the horizon. Then, in pockets across the globe, something erupted that seemed as benign as the common cold. The influenza of that season, however, was far more than a cold. In the two years that this scourge ravaged the earth, a fifth of the world's population was infected. The flu was most deadly for people ages 20 to 40. This pattern of morbidity was unusual for influenza which is usually a killer of the elderly and young children. It infected 28% of all Americans. An estimated 675,000 Americans died of influenza during the pandemic, ten times as many as in the World War. Of the U.S. soldiers who died in Europe, half of them fell to the influenza virus and not to the enemy. An estimated 43,000 servicemen mobilized for WWI died of influenza. 1918 would go down as unforgettable year of

suffering, death and yet of peace. As noted in the Journal of the American Medical Association final edition of 1918:

*"The 1918 has gone: a year momentous as the termination of the most cruel war in the annals of the human race; a year which marked, the end at least for a time, of man's destruction of man; unfortunately a year in which developed a most fatal infectious disease causing the death of hundreds of thousands of human beings. Medical science for four and one-half years devoted itself to putting men on the firing line and keeping them there. Now it must turn with its whole might to combating the greatest enemy of all--infectious disease," (12/28/1918).*

The effect of the influenza epidemic was so severe that the average life span in the US was reduced by 10 years. The influenza virus had a profound virulence, with a mortality rate at 2.5% compared to the previous influenza epidemics, which were less than 0.1%. The death rate for 15 to 34-year-olds of influenza and pneumonia were 20 times higher in 1918 than in previous years.

People were struck with illness on the street and died rapid deaths. One anecdote was of four women playing bridge together late into the night. Overnight, three of the women died from influenza. Others told stories of people on their way to work suddenly developing the flu and dying within hours. One physician writes that patients with seemingly ordinary influenza would rapidly "develop the most viscous type of pneumonia that has ever been seen" and later when cyanosis appeared in the patients, "it is simply a struggle for air until they suffocate." Another physician recalls that the influenza patients "died struggling to clear their airways of a blood-tinged froth that sometimes gushed from their nose and mouth." The physicians of the time were helpless against this powerful agent of influenza. In 1918 children would skip rope to the rhyme:

*I had a little bird,  
Its name was Enza.  
I opened the window,  
And in-flu-enza.*

The influenza pandemic quickly circled the globe, despite occurring in the days before jet travel. Most of humanity felt the effects of this strain of the influenza virus. It spread following the path of its human carriers, along trade routes and shipping lines. Outbreaks swept through North America, Europe, Asia, Africa, Brazil and the South Pacific. In India the mortality rate was extremely high at around 50 deaths from influenza per 1,000 people. The Great War, with its mass movements of men in armies and aboard ships, aided in its rapid diffusion and attack.

The origins of this influenza variant are not precisely known. It is thought to have originated in China in a rare genetic shift of the influenza virus. Recently the virus has been reconstructed from the tissue of a dead World War I soldier and has now being genetically characterised. Scientists have discovered that the genetic mixing of pig and human influenza viruses was the most likely trigger for the

Spanish flu. The recombination to its surface proteins created a virus that was new and therefore no one had any immunity to fight it.

The name of Spanish Flu came from the early affliction and large mortalities in Spain where it allegedly killed 8 million in May. However, a first wave of influenza appeared early in the spring of 1918 in Camp Funston, Kansas and in military camps throughout the US. Few noticed the epidemic in the midst of the war. There was virtually no response or acknowledgment to the epidemics in March and April in the military camps. The lack of action was later criticized when the epidemic could not be ignored in the winter of 1918-1919.

These first epidemics at training camps were a sign of what was coming in greater magnitude in the fall and winter of 1918 to the entire world. The war enabled the virus to spread and diffuse. Men across the US were mobilizing to join the military and the war. As they came together, they brought the virus with them and to those they contacted.

The war also brought the virus back into the US for the second wave of the epidemic. It first arrived in Boston in September of 1918 through the port busy with war shipments of machinery and supplies. The virus killed almost 200,000 in October of 1918 alone. In November 1918, the end of the war enabled a resurgence. As people celebrated Armistice Day with parades and large parties, a complete disaster from the public health standpoint, a rebirth of the epidemic occurred in some cities. The flu that winter was beyond imagination as millions were infected and thousands died.

The pandemic affected everyone. With one-quarter of the US and one-fifth of the world infected with the influenza, it was impossible to escape from the illness. Those who were lucky enough to avoid infection had to deal with the public health ordinances to restrain the spread of the disease. The public health departments distributed gauze masks to be worn in public. Stores could not hold sales; funerals were limited to 15 minutes. Some towns required a signed certificate to enter and railroads would not accept passengers without them. Those who ignored the flu ordinances had to pay steep fines enforced by extra officers. Bodies piled up as the massive deaths of the epidemic ensued. Besides the lack of health care workers and medical supplies, there was a shortage of coffins, morticians and gravediggers.

The virus rocketed to the farthest points of the globe as widespread as Alaska, Australia, Britain, China, India, South Africa and Norway. During the first week of November, it would kill 14,000 Londoners. From September 1918 through to March 1919 it killed 33,387 people in New York City, just over 1% of the city's population.

Yet within a matter of months the worst of the epidemic was over. Mysteriously, just as rapidly as the Spanish flu

appeared, it then disappeared, possibly due to the virus mutating once again into a much less infectious strain and losing its virulence. But in its wake it had left approximately 40 million people around the world dead.



**Members of the public wearing masks in 1918**

Today the Spanish flu pandemic still inspires deep fascination among historians. Among medical watchdogs there is also the chilling fear of what the toll could reach should a similar viral illness emerge in our era of jet travel today.

Main source: Stanford University website:  
[www.stanford.edu/group/virus/uda](http://www.stanford.edu/group/virus/uda)

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## INFORMATION SHEETS

The NSW Infection Control Resource Centre has developed six Information Sheets on the following topics:

- Infection Control in Health Care Facilities
- Hand Washing and Hand Hygiene
- Needlestick Injuries and Other Occupational Exposures
- Cleaning Health Care Facilities
- MRSA – Information Sheet for Patients
- MRSA – Information Sheet for Staff

These double-sided A4 sheets are ideal for orientation or inservice.

Copies of these Information Sheets can be obtained free-of-charge by contacting the NSW Infection Control Resource Centre (02) 9332 9712.

## VIDEO & CD-ROM LIBRARY

The NSW Infection Control Resource Centre has a Video and CD-ROM Library containing sixty-six videos and one CD-ROM relating to infection control.

A catalogue, providing a short description of the contents and running time of all the videos, is available to assist you in deciding which videos are suitable for your target inservice or education session audience.

One new video called *Think Sharp - It's Your Life* has been added to the Library since the publication of the last newsletter.

### *Think Sharp – It's Your Life* (1990)

This video will raise your staff's awareness of their responsibility to protect themselves, their fellow staff members and their patients from clinical sharps hazards. The use and disposal of clinical sharps is a potentially hazardous procedure.

*Think Sharp – It's Your Life* covers commonsense principles and practices necessary for eliminating sharps incidents in the hospital environment. This video training package is totally self-contained and comes complete with videotape, detailed training notes and discussion sheets. The program elements have been organised to provide a structured learning experience for participants. Teaching points are reinforced through a variety of sharps incidents portrayed in Part A of the video followed by a separate analysis of each incident in Part B.

Produced by Mayfield Education Centre Audiovisual Productions – Education for Excellence in Health Services

To borrow videos or the CD-ROM free-of-charge, or to obtain your copy of the *Video and CD-ROM Library Catalogue*, contact:

**The NSW Infection Control Resource Centre**  
**Monday to Friday, 8am-5pm**  
**(02) 9332 9712**



# QUESTIONS AND ANSWERS

*In.Control* invites readers to write in with questions that they want answered. Names and organisations will **NOT** be included in the newsletter.

**Q.** One of my colleagues recently attended an infection control course and was told that alginate bags are no longer recommended for soiled linen. Is this true and what are the reasons?

**A.** The information given your colleague was correct. Alginate bags are not cost effective and often disintegrate before they reach the laundry service if they come into contact with moisture. Soiled linen is often moist.

The current recommendations are outlined in the Australian/New Zealand Standard *Laundry Practice 4146:2000*. The Standard states in Section 2.4.1 (page 17): "In addition to being placed in suitable laundry bags, linen which is heavily soiled with blood or other body fluids, or other fluids which could leak and further contaminate other linen, shall be also contained within suitable impermeable bags which are to be securely closed."

Alginate bags are not impermeable. In other words, place the soiled linen in a plain plastic bag (not a clinical waste bag) and securely tie it before placing it in a laundry bag. At the laundry, workers complying with Standard Precautions and wearing protective apparel will open the bag. The soiled linen is then washed and dried with all the other laundry, it is not treated any differently. The combination of detergents, water and hot temperatures ensure that the linen is safe to handle on completion of the wash and drying cycles.

The Australian/New Zealand Standard *Laundry Practice As 4146:2000* can be obtained by contacting Standards Australia:

Tel: 1300 65 46 46 Fax: 1300 65 49 49

E-mail: [sales@standards.com.au](mailto:sales@standards.com.au)

Internet: [www.standards.com.au](http://www.standards.com.au)

Public Health Care facilities should be able to obtain copies of the Standard free-of-charge by contacting the medical library in their Area Health Service.

**Q.** Are patients allowed to take home tissue removed or expelled from their body while there were in hospital?

**A.** This is sometimes requested by persons who have certain cultural or religious beliefs (eg as to treatment of the placenta after birth) or people who want to take home something like their gall stones.

Legally, there is no ownership in excised body parts and patients do not have any legally enforceable rights to take home such tissue. However, there is no objection to such a course of action where it presents no risk to the patient or others. A commonsense approach should be taken. A responsible medical practitioner should be satisfied that arrangements for taking home such tissue do not present a risk to public health.

**Q.** One of my staff sustained a needlestick injury from a deceased patient. How long after a death can you perform a blood test?

**A.** As both hepatitis B and hepatitis C have been proved to be viable in dried blood for considerable time, the risk of transmission of blood borne viruses following a needlestick injury from a recently deceased patient is potentially possible. At what stage after death would transmission of these and other blood borne viruses not occur is unknown and is dependent on many variables. Therefore any exposure to a deceased body's blood or body substances, as in the case of a needlestick injury, should be treated as seriously as an occupational exposure with a living patient.

## EMAIL REMINDER

*Those readers who receive their copy of **In.Control** via email please remember to inform us if you change your email address!*

# BOOK REVIEWS

## The Australian Immunisation Handbook 8<sup>th</sup> Edition 2003

*The Australian Immunisation Handbook 8<sup>th</sup> Edition 2003* was prepared by the Australian Technical Advisory Group on Immunisation and approved by the National and Medical Research Council (NHMRC) on 18<sup>th</sup> September 2003.

*The Australian Immunisation Handbook* is considered to be the primary reference for immunisation matters in Australia. The first edition, *Immunisation Procedures*, was published in 1975. The 8<sup>th</sup> Edition Handbook was published in conjunction with Immunise Australia Program, an initiative of the Australian, State and Territory Governments. It is published approximately every three years, but changes to the Australian Standard Vaccination Schedule or the National Immunisation Program may occur more frequently.

Printed copies of *The Australian Immunisation Handbook 8<sup>th</sup> Edition 2003* are available from the publications page of the Immunise Australia website [www.immunise.health.gov.au](http://www.immunise.health.gov.au), by contacting the Immunisation Infoline on 1800 671 811 or by emailing [handbook@health.gov.au](mailto:handbook@health.gov.au) Printed copies also come with a CD-ROM.

For the first time *The Australian Immunisation Handbook* is being provided in an interactive online form at [www.immunise.health.gov.au/handbook.htm](http://www.immunise.health.gov.au/handbook.htm)

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## Practical Approaches to Infection Control in Residential Aged Care (2<sup>nd</sup> Edition)

*Author: Kevin Kendall*

*Published: August 2003*

*Publisher: Ausmed Publications*

*Price: \$54.95*

For those who work in aged care, from the director of nursing, personal care staff, nurse assistants and ancillary staff, such as cleaners and kitchen hands, *Practical Approaches to Infection Control in Residential Aged Care* presents an exceptional opportunity to learn how to protect yourselves, other staff and residents from the ever-present dangers of infection.

The author, Kevin Kendall, believes that infection control policies should be coffee-stained and dog-eared, not shelved and clean! Although this book, published August 2003, was written specifically with residential aged care staff in mind, Kevin Kendall's wisdom and know-how can be applied to any health-care setting. An Australian book, *Practical Approaches to Infection Control in Residential Aged Care*

has been endorsed by the Royal College of Nursing, Australia, according to approved criteria.

The book can be ordered from the publisher's website [www.ausmed.com.au](http://www.ausmed.com.au) price \$54.95

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## Control of Hospital Infection: A Practical Handbook (4<sup>th</sup> edition)

*Editors: Graham Ayliffe, Adam Fraise, Alasdair Geddes and Kathy Mitchell*

*Published: August 2000*

*Publisher: Edward Arnold*

*Price: \$US79.50*

Written for infection control staff and clinicians, *Control of Hospital Infection: A Practical Handbook* is a guide to infections acquired in hospital, how to prevent them, and how to control them. It tackles the increase in antibiotic-resistant organisms, such as *staphylococcus aureus* and *clostridium difficile*. It reviews decontamination issues associated with the new heat-labile equipment, such as flexible endoscopes, and tackles the problem of hospital infections arising in the community following rapid discharge after minimal access surgery. This fourth edition has an increased emphasis on the immunocompromised host, in association with HIV infection and post-transplant immunosuppression. The text is revised and updated throughout, including a review of infection rates and risk factors, and there is guidance on new disinfectants and methods of sterilization. It includes practical approaches to audit, and evidence-based guidelines.

The book is British-orientated and chapters include new data on surveillance, administration and the control of antibiotic-resistant organisms such as MRSA and VRE, plus hepatitis B, hepatitis C and HIV.

The book can be ordered from [www.amazon.com](http://www.amazon.com) price \$US79.50 plus postage.

## HAND WASHING POSTERS

The NSW Infection Control Resource Centre (NSW ICRC), with funding from NSW Health, has developed a series of six hand washing posters. The posters are in colour and A3 in size (297mm x 420mm). The posters can be viewed on the NSW ICRC website:

<http://www.sesahs.nsw.gov.au/albionstcentre>

To order posters, contact the NSW Infection Control Resource Centre:

tel: (02) 9332 9712

fax: (02) 9380 6572

e-mail: [albicr@sesahs.nsw.gov.au](mailto:albicr@sesahs.nsw.gov.au)

# CURRENT JOURNAL AWARENESS

The following selected articles appeared in recent journals and may be of interest to our readers. Copies of the articles can be obtained free-of-charge by contacting the NSW Infection Resource Centre.

1. **Bacterial transfer and cross-contamination potential associated with paper-towel dispensing** Harrison, W. et al, *American Journal of Infection Control*, vol. 31, no.7, November 2003.
2. **Effect of comparative data feedback on intensive care unit infection rates in a Veterans Administration Hospital Network System**, McKinley, L. et al, *American Journal of Infection Control*, vol. 31, no.7, November 2003.
3. **Influences on compliance with standard precautions among operating room nurses** Osborne, S., *American Journal of Infection Control*, vol. 31, no.7, November 2003.
4. **A cluster of nosocomial *Klebsiella pneumoniae* bloodstream infections in a neonatal intensive care department: Identification of transmission and intervention** Gastmeier, P. et al, *American Journal of Infection Control*, vol. 31, no.7, November 2003.
5. **Venturi atomizers as potential sources of patient cross-infection** Bossart, P. & Wolfe, T., *American Journal of Infection Control*, vol. 31, no.7, November 2003.
6. **Infection control practices among tattooists and body piercers in Sydney, Australia**, Oberdorfer, A. et al, *American Journal of Infection Control*, vol. 31, no.8, December 2003.
7. **Resistance to the migration of microorganisms of a needle-free disinfectable connector**, Yébenes, J. et al, *American Journal of Infection Control*, vol. 31, no.8, December 2003.
8. **Transmission of hepatitis C by blood splash into conjunctiva in a nurse**, Salih Hosoglu, S. et al, *American Journal of Infection Control*, vol. 31, no.8, December 2003.
9. **A prospective incidence study of nosocomial infections in a neonatal care unit** Urrea, M. et al, *American Journal of Infection Control*, vol. 31, no.8, December 2003.
10. **An innovative approach to training hospital-based clinicians for bioterrorist attacks** Filoromo, C. et al, *American Journal of Infection Control*, vol. 31, no.8, December 2003.

Visit the *American Journal of Infection Control* online at:

[www.mosby.com/ajic](http://www.mosby.com/ajic)

11. **A Survey of Latent Tuberculosis Infection Among Laboratory Healthcare Workers in New York City**, Garber, E. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
12. **Prevalence of Tuberculin Skin Test Positivity and Conversions Among Healthcare Workers in New York City During 1994 to 2001**, Cook, S. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
13. **Costs of Implementing and Maintaining a Tuberculin Skin Test Program in Hospitals and Health Departments**, Lambert, L. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
14. **Utility of Dual Skin Tests to Evaluate Tuberculin Skin Test Reactions of 10 to 14 mm in Healthcare Workers**, Marsh, B. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
15. **Potential Nosocomial Exposure to *Mycobacterium tuberculosis* From a Bronchoscope**, Larson, J. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
16. **Relative Versus Absolute Noncontagiousness of Respiratory Tuberculosis on Treatment**, Long, R. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
17. **Use of, Effectiveness of, and Attitudes Regarding Influenza Vaccine Among House Staff**, Lester, R. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
18. **Correlation Between Healthcare Workers' Knowledge of Influenza Vaccine and Vaccine Receipt**, Martinello, R. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.

19. **A Preventable Outbreak of Pneumococcal Pneumonia Among Unvaccinated Nursing Home Residents in New Jersey During 2001**, Tan, C. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
  20. **Ventilator-Associated Pneumonia in a Multi-Hospital System: Differences in Microbiology by Location**, Babcock, H. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
  21. **Impact of a Program of Intensive Surveillance and Interventions Targeting Ventilated Patients in the Reduction of Ventilator-Associated Pneumonia and Its Cost-Effectiveness**, Lai, K. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
  22. **Ventilator-Associated Pneumonia at a Tertiary-Care Center in a Developing Country: Incidence, Microbiology, and Susceptibility Patterns of Isolated Microorganisms**, Kanafani, Z. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
  23. **Is Cutaneous Tuberculosis Infectious? A Case Presentation and Practical Management Plan**, Hui, C. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
  24. **Risk of Acquiring Influenza A in a Nursing Home From a Culture-Positive Roommate**, Drinka, P. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.11, November 2003.
  25. **Effect of Nurse Staffing and Antimicrobial-Impregnated Central Venous Catheters on the Risk for Bloodstream Infections in Intensive Care Units**, Alonso-Echanove, J. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.12, December 2003.
  26. **Preventing Central Venous Catheter—Associated Primary Bloodstream Infections: Characteristics of Practices Among Hospitals Participating in the Evaluation of Processes and Indicators in Infection Control (EPIC) Study**, Braun, B. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.12, December 2003.
  27. **Bloodstream Infections in a Community Hospital: A 25-Year Follow-up**, Scheckler, W. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.12, December 2003.
  28. **Administrative Databases Provide Inaccurate Data for Surveillance of Long-Term Central Venous Catheter—Associated Infections**, Wright, S. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.12, December 2003.
  29. **Improving Water Quality Can Reduce Pyrogenic Reactions Associated With Reuse of Cardiac Catheters**, Duffy, R. et al, *Infection Control and Hospital Epidemiology*, vol. 24, no.12, December 2003.
  30. **Does the Architecture of Hospital Facilities Influence Nosocomial Infection Rates? A Systematic Review**, Dettenkofer, M. et al, *Infection Control and Hospital Epidemiology*, vol. 25, no.1, January 2004.
  31. **An Approach to the Study of Potentially Preventable Nosocomial Infections**, Rosselló-Urgell, J. et al, *Infection Control and Hospital Epidemiology*, vol. 25, no.1, January 2004.
  32. **Serial Nosocomial Transmission of *Plasmodium falciparum* Malaria From Patient to Nurse to Patient**, Alweis, R. et al, *Infection Control and Hospital Epidemiology*, vol. 25, no.1, January 2004.
  33. **Topics in Long-Term Care Performance Improvement in the Long-Term-Care Setting: Building on the Foundation of Infection Control**, Stevenson, K. & Loeb, M., *Infection Control and Hospital Epidemiology*, vol. 25, no.1, January 2004.
- Abstracts from articles in*  
**Infection Control and Hospital Epidemiology**  
*can be viewed on the Internet at:*  
<http://www.slackinc.com/general/iche>
34. **Hand hygiene and skin health**, Kownatzki, E., *The Journal of Hospital Infection*, vol. 55, no.4, December 2003.
  35. **Pioneers in infection control—Joseph Lister**, Newsom, S., *The Journal of Hospital Infection*, vol. 55, no.4, December 2003.
  36. **Ultra-sonic nebulizers as a potential source of methicillin-resistant *Staphylococcus aureus* causing an outbreak in a university tertiary care hospital**, Schultz, C. et al, *The Journal of Hospital Infection*, vol. 55, no.4, December 2003.
  37. **Surveillance of nosocomial transmission of *Candida albicans* in an intensive care unit by DNA fingerprinting**, Taylor, B. et al, *The Journal of Hospital Infection*, vol. 55, no.4, December 2003.
  38. **Patients' case-notes: look but don't touch**, Bebbington, A. et al, *The Journal of Hospital Infection*, vol. 55, no.4, December 2003.
  39. **Contamination of patient hospital charts by bacteria**, Alothman, A. et al, *The Journal of Hospital Infection*, vol. 55, no.4, December 2003.

- 40. **Problems with the decontamination of dental handpieces and other intra-oral dental equipment in hospitals**, Weightman, N. & Lines, L., *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 41. **Making a meal of MRSA—the role of biosurgery in hospital-acquired infection**, Beasley, W. & Hirst, G., *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 42. **How do we assess hospital cleaning? A proposal for microbiological standards for surface hygiene in hospitals**, Dancer, S., *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 43. **Methicillin-resistant *Staphylococcus aureus* bacteraemia in Western Australian teaching hospitals, 1997–1999: risk factors, outcomes and implications for management**, Cordova, S. et al, *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 44. **Plasma cleaning of dental instruments**, Whittaker, A. et al, *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 45. **Performance feedback of hand hygiene, using alcohol gel as the skin decontaminant, reduces the number of inpatients newly affected by MRSA and antibiotic costs**, MacDonald, A. et al, *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 46. **SARS and masks**, Puro, V. et al, *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 47. **Relation between bed occupancy and the incidence of MRSA infection**, Orendi, J., *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.
- 48. **Detergent versus hypochlorite cleaning and *Clostridium difficile* infection**, Dettenkofer, M. et al, *The Journal of Hospital Infection*, vol. 56, no.1, January 2004.

**APIC '04 – 31<sup>st</sup> ANNUAL EDUCATION CONFERENCE & INTERNATIONAL MEETING**

6-10 June  
 Phoenix, Arizona, USA  
 Contact:  
 APIC, 1275 K Street, NW, Suite 1000  
 Washington, DC, 20005-4006, USA  
 Te: (1) 202 789 1890  
 Fax: (1) 202 789 1899  
 Email: [APICinfo@apic.org](mailto:APICinfo@apic.org)

**AUSTRALIAN INFECTION CONTROL ASSOCIATION (AICA) THIRD BIENNIAL CONFERENCE 2004**

*The Clean Green Approach*  
 9-11 June 2004  
 Wrest Point Conference Centre  
 Hobart, Tasmania  
 Information & Contact:  
 E-mail: [aica04@im.com.au](mailto:aica04@im.com.au)  
 Website: [www.aica.org.au](http://www.aica.org.au)

**6<sup>th</sup> INTERNATIONAL CONFERENCE OF THE HOSPITAL INFECTION SOCIETY**

15-18 OCTOBER, 2006  
 Amsterdam, Netherlands  
 Contact:  
 Congress Secretariat, HIS 2006, Concorde Services Ltd,  
 4B/50 Speirs Wharf, Glasgow, G4 9TB  
 Tel: (44) 141 331 0123  
 Fax: (44) 141 331 0234  
 Email: [info@his2006.com](mailto:info@his2006.com)  
 Web: [www.his2006.com](http://www.his2006.com)



**MANAGEMENT OF NEEDLESTICK INJURIES AND OTHER BLOOD BORNE PATHOGENS  
 30 - 31 March, 2004**

This two-day workshop provides an overview of the management of needle-stick injuries and other exposures to blood and body substances that could potentially contain blood-borne pathogens such as hepatitis B, hepatitis C and HIV

**TOPICS COVERED:**

Risk assessment, protocols for post exposure management, prophylaxis, testing, documentation, counseling the exposed person and policy development.

The seminar is aimed at nurses, doctors, social workers, psychologists and managers who provide advice to health care workers after a needle-stick injury (or other exposure) and/or those developing policy.

**VENUE**

The Albion Street Centre  
 150 Albion Street, SURRY HILLS NSW 2010

**COURSE DETAILS:**

\$220 (including GST)  
 Tel: (02) 9332 9720 Fax: (02) 9360 4387  
 E-mail: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)

**INFECTION CONTROL CONFERENCES**

**14<sup>th</sup> EUROPEAN CONGRESS OF CLINICAL MICROBIOLOGY & INFECTIOUS DISEASES**

1-4 May, 2004  
 Prague, Czech Republic  
 Contact:  
 ESCMID-Executive Office,  
 PO Box 6  
 CH-4005 Basel, Switzerland  
 Tel: (41) 616 867 799  
 Email: [escmid-eo@escmid.org](mailto:escmid-eo@escmid.org)

**AUSTRALIAN  
INFECTION CONTROL ASSOCIATION  
THIRD BIENNIAL CONFERENCE 2004**

**WREST POINT CONFERENCE CENTRE  
HOBART, TASMANIA  
9-11 JUNE 2004**

*Infection Control: The Clean Green Approach*

**INVITATION**

On behalf of the conference organising committee it is my great pleasure to invite you to participate in the Australian Infection Control Association Third Biennial Conference 2004 to be held 9-11 June 2004.

The AICA 2004 conference will provide a forum in which current topics on the national agenda and subjects of interest to infection control practitioners from varied backgrounds and health care settings will be addressed.

Delegates will have the opportunity to attend sessions of interest, as the concurrent programs will be tailored for either the novice or expert. A prominent keynote speaker will be sought to address the conference and there will be focus on national speakers to allow delegates to explore local issues of significance in Australia.

We would like your participation in this conference to further develop the important area of infection control and welcome your contribution by submitting an abstract to be considered as an oral or poster presenter.

Yours sincerely  
Anne Wells  
Conference chair

**WHO SHOULD ATTEND?**

Delegates will comprise a wide range of decision-makers and professionals in the field of infection control, including:

- infection control practitioners
- physicians
- nurses
- microbiologists
- researchers
- other influential professionals in associated disciplines

**IMPORTANT DATES**

<b>18 March 2004</b>	Authors notified of acceptance of abstracts
<b>1 April 2004</b>	Authors to confirm intention to present Earlybird registration closes Deadline for authors to register for the conference
<b>9-11 June 2004</b>	AICA Third Biennial Conference

**PLEASE,  
DIARISE THESE DATES  
NOW!**



**HIV  
PRE & POST TEST COUNSELLING  
19 - 22 April, 2004**

This four-day workshop is designed specifically for counselors and health care professionals who will be providing pre and post HIV test counseling.

This is a highly interactive, skills-based workshop focusing on the immediate emotional and psychosocial responses to HIV testing. Other issues to be addressed will include occupational exposures and suicide risk assessment.

The workshop includes case discussions and micro skills practice in small groups.

**PREREQUISITE:**

Basic counseling skills and an introduction to HIV/AIDS course or equivalent knowledge level.

Conditionally registered psychologists: this course has been assessed as suitable for workshop supervision hours for the NSW Psychologists' Registration Board

**VENUE**

The Albion Street Centre  
150 Albion Street, SURRY HILLS NSW 2010

**COURSE DETAILS:**

**\$385 (including GST)**

**Tel: (02) 9332 9720 Fax: (02) 9360 4387**

**E-mail: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)**



**INFECTION CONTROL FOR CLEANERS OF  
HEALTH CARE FACILITIES  
1<sup>st</sup> April (morning), 2004**

This half-day (morning) workshop is for cleaners of health care facilities. It provides an overview of current Infection Control procedures related to cleaning

**TOPICS**

- Standard Precautions
- Preventing Transmission of Blood-Borne Infections (in particular Hepatitis B & C and HIV)
- Waste Management
- Cleaning Blood Spills
- Disposing of Incorrectly Discarded Sharps

*All information will be delivered at a basic and easy to understand level*

**VENUE**

The Albion Street Centre  
150 Albion Street, SURRY HILLS NSW 2010

**COURSE DETAILS:**

**\$77 (including GST)**

**Tel: (02) 9332 9720 Fax: (02) 9360 4387**

**Email: [albeducation@sesahs.nsw.gov.au](mailto:albeducation@sesahs.nsw.gov.au)**



ALBION STREET CENTRE

**INTRODUCTION TO  
INFECTION CONTROL FOR DENTAL ASSISTANTS**

**12<sup>th</sup> May 2004  
23<sup>rd</sup> June 2004**

This one-day workshop is designed for Dental Assistants. It provides an overview of current infection control procedures.

**TOPICS COVERED INCLUDE:**

The Principles of Infection Control  
Introductory Microbiology and Immunology  
Processing Instruments and Equipment  
Staff Health  
Management of Sharps Injuries

**VENUE**

The Albion Street Centre  
150 Albion Street  
SURRY HILLS NSW 2010

**COURSE DETAILS:**  
**\$137.50 (including GST)**  
Tel: (02) 9332 9720  
Fax: (02) 9360 4387

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ALBION STREET CENTRE

**INTRODUCTION TO  
INFECTION CONTROL NURSING**

**3<sup>rd</sup> March, 2004  
2<sup>nd</sup> June, 2004**

This one-day course is designed for Nurses who are beginning practitioners in the field of Infection Control, or who are required to take some Infection

Control responsibilities in the course of their work.

**TOPICS**

The Principles of Infection Control  
The Role of the Infection Control Nurse  
Staff Health  
Waste Management  
Policy and Programs  
Networking and Resources

**VENUE**

The Albion Street Centre  
150 Albion Street  
SURRY HILLS NSW 2010

**COURSE DETAILS:**  
**\$137.50 (including GST)**  
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**Adult Vaccination Record Cards**

The NSW Health Department *Circular 2003/91 – Occupational Screening and Vaccination Against Infectious Diseases* states that each health care facility employee must be issued with a personal record card, detailing the results of all screening tests and vaccinations administered, including date, batch number, type/brand name of each vaccine.

An Adult Vaccination Record Card has been developed to assist the implementation of Circular 2003/91 and may be obtained from the Better Health Centre – Publications Warehouse, tel: (02) 9816 0452 fax: (02) 9816 0492.

**A Quick Look At...  
BARMAH FOREST VIRUS**

- Barmah Forest virus is a pathogen that can infect people through mosquito bites.
- Barmah virus is related to Ross River virus
- The virus is spread by certain types of female mosquitoes.
- The virus is not spread from one person to another.
- Symptoms of Barmah Forest virus infection are similar to that of Ross River virus infection.
- Flu-like symptoms may occur, with fever, chills, headache, and aches in the muscles and joints.
- Some people may develop joint swelling and stiffness, which is particularly noticeable in the mornings.
- A rash sometimes develops, usually on the trunk or limbs. This rash usually disappears after 7-10 days.
- A feeling of tiredness or weakness can occur at times during the illness, which can affect both lifestyle and work performance.
- Symptoms develop between 5-21 days, but usually between 7-10 days after being bitten by an infected mosquito.
- The majority of people will recover completely within a few weeks. Others may experience symptoms on and off for more than three months. In very rare cases, people may experience symptoms for over a year.
- A full recovery can be expected.
- There is no specific treatment for Barmah Forest virus infection.
- Plenty of rest, along with moderate exercise and healthy eating, may help in recovery. Doctors will assist in easing the discomfort of symptoms.
- People with symptoms should see their doctor who can order a blood test to diagnose Barmah Forest virus infection.
- The key to prevention is to avoid being bitten by mosquitoes, especially in the summer and autumn months.

*This information is taken from the Barmah Forest Virus Infection Information Sheet available from [www.health.nsw.gov.au](http://www.health.nsw.gov.au)*