

# ទាយបាប ការទាម្ចារទេរីទូទិន ប្រវាំសីប្រាក់

# WEEKLY EPIDEMIOLOGICAL SURVEILLANCE REPORT

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ไทยใจ-มิถุนายน 2530

## การสอบสวนโรค

## อาหาร เป็นพิษ - บุหรี่รัมย์

## Food poisoning - Buriram

ระหว่างวันที่ 17 - 19 เมษายน 2529 เกิดการระบาดของโรคอาหารเป็นพิษในหมู่ที่ 11 ตำบลเมืองยาง อำเภอเมืองรอง จังหวัดบุรีรัมย์ ผู้ป่วย 30 ราย ซึ่งส่วนใหญ่เป็นผู้ป่วยจากการอุจจาระร่วง ปวดท้อง อาเจียน และเป็นไข้ ได้รับการนำส่งโรงพยาบาลลงรอง อำเภอเมืองรอง จังหวัดบุรีรัมย์ ได้ร่วมรวมข้อมูลผู้ป่วยจากโรงพยาบาลลงรองและค้นหาผู้ป่วยเพิ่มเติมด้วยการสัมภาษณ์ประชาชนทั้งหมดในหมู่บ้านดังกล่าวโดยใช้แบบสำรวจกำหนดนิยามของผู้ป่วยในการสอบถามการระบาดครั้งนี้ว่า หมายถึงผู้ที่ได้รับการรินิจฉัยจากแพทย์ว่า เป็นโรคอาหารเป็นพิษ หรือผู้ที่มีอาการอุจจาระร่วง ปวดท้อง ร่วมกับอาเจียน หรือร่วมกับไข้ และเป็นผู้ที่อาศัยในหมู่บ้านดังกล่าว และป่วยในวันที่ 17 - 19 เมษายน 2529 จากการสอบถามรวมผู้ป่วย 121 ราย เป็นชาย 54 ราย หญิง 67 ราย คิดเป็นอัตราป่วย สำหรับเพศชาย หญิง และอัตราป่วยรวม เท่ากับร้อยละ 24.1, 29.6 และ 26.9 ตามลำดับ ผู้ป่วยกระจายในทุกกลุ่มอายุ ไม่มีผู้ป่วยเสียชีวิต อาการของผู้ป่วยประกอบด้วยอุจจาระร่วง 92 ราย (ร้อยละ 76) ปวดท้อง 90 ราย (ร้อยละ 74) ไข้ 85 ราย (ร้อยละ 70) อาเจียน 65 ราย (ร้อยละ 54) จากการศึกษาด้วยวิธี case control พบว่ากลุ่มผู้ป่วยและกลุ่มผู้ไม่ป่วยมีอัตราการบริโภคเนื้อกระเบื้องเท่ากัน ร้อยละ 99.2 (120/121) และ 35.7 (25/70) ตามลำดับ ( $p < 0.01$ ) แสดงว่า เนื้อกระเบื้องอาจเป็นสิ่งที่แพร่กระจายโรคในการระบาดครั้งนี้ ระยะพักตัวของโรคตั้งแต่น้อยกว่า 5 ชั่วโมง ถึง 65 ชั่วโมง (มัธยฐาน 12 ชั่วโมง) จากอาการของผู้ป่วยและระยะพักตัวของโรคตั้งกล่าวข้างต้น คงจะสรุปได้ยากว่า เชื้ออะไรเป็นสาเหตุของการระบาดครั้งนี้ สำหรับเนื้อกระเบื้องที่ประชาชนนำมากิน

บริโภคเป็นเนื้อจากกระเบื้องในหมู่บ้านนั้นที่ป่วยตายในวันที่ 16 เมษายน 2529 ได้ส่งตรวจอุจจาระของผู้ป่วย 5 ราย และเนื้อกระเบื้อง 2 ตัวอย่าง ผลการตรวจบราคกว่าไม่พบเชื้อแบคทีเรียที่เป็นสาเหตุของอาการอุจจาระร่วงจากตัวอย่างอุจจาระที่ส่งตรวจ สำหรับเนื้อกระเบื้องที่ส่งตัวอย่างที่ 1 ตรวจไม่พบ เชื้อต่อไปนี้ Salmonell sp., Shigella sp., Staph. aureus, Vibrio sp. และ Clostridium perfringen เนื้อกระเบื้องที่ 2 ตรวจพบ Staph. aureus (numerous amount) และ Bacillus cereus (moderate amount) อย่างไรก็ตามจากการของผู้ป่วยและระยะพักตัวไม่เข้ากับลักษณะของอาหาร เป็นพิษที่เกิดจาก Staph. aureus หรือ Bacillus cereus ได้แนะนำประชาชนไม่ให้บริโภคสัตว์ที่ป่วยตาย จากการเฝ้าระวังโรคต่อมามีพนักงานว่ามีผู้ป่วยเพิ่มขึ้นอีก

#### ผู้รายงาน

ศูนย์ระบาดวิทยาภาคตะวันออก เชียงใหม่ จังหวัดนครราชสีมา  
โรงพยาบาลลنانางร่อง สำนักงานสาธารณสุขอำเภอเงยนาางร่อง  
และฝ่ายแผนงานและประมีนผล สำนักงานสาธารณสุขจังหวัดบุรีรัมย์

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#### บทความ

## Recommendations for Prevention of HIV Transmission in Health-Care Settings

U. S. Department of Health and Human Services  
Public Health Service  
Centers for Disease Control  
Atlanta, Georgia 30333

#### **Introduction**

Human immunodeficiency virus (HIV), the virus that causes acquired immunodeficiency syndrome (AIDS), is transmitted through sexual contact and exposure to infected blood or blood components and perinatally from mother to neonate. HIV has been isolated from blood, semen, vaginal secretions, saliva, tears, breast milk, cerebrospinal fluid, amniotic fluid, and urine and is likely to be isolated from other body fluids, secretions, and excretions. However, epidemiologic evidence has implicated only blood, semen, vaginal secretions, and possibly breast milk in transmission.

The increasing prevalence of HIV increases the risk that health-care workers will be exposed to blood from patients infected with HIV, especially when blood and body-fluid precautions are not followed for all patients. Thus, this document emphasizes the need for health-care workers to consider all patients as potentially infected with HIV and/or other blood-borne pathogens and to adhere rigorously to infection-control precautions for minimizing the risk of exposure to blood and body fluids of all patients.

The recommendations contained in this document consolidate and update CDC recommendations published earlier for preventing HIV transmission in health-care settings: precautions for clinical and laboratory staffs (1) and precautions for health-care workers and allied professionals (2); recommendations for preventing HIV transmission in the workplace (3) and during invasive procedures (4); recommendations for preventing possible transmission of HIV from tears (5); and recom-

mendations for providing dialysis treatment for HIV-infected patients (6). These recommendations also update portions of the "Guideline for Isolation Precautions in Hospitals" (7) and reemphasize some of the recommendations contained in "Infection Control Practices for Dentistry" (8). The recommendations contained in this document have been developed for use in health-care settings and emphasize the need to treat blood and other body fluids from all patients as potentially infective. These same prudent precautions also should be taken in other settings in which persons may be exposed to blood or other body fluids.

### Definition of Health-Care Workers

Health-care workers are defined as persons, including students and trainees, whose activities involve contact with patients or with blood or other body fluids from patients in a health-care setting.

### Health-Care Workers with AIDS

As of July 10, 1987, a total of 1,875 (5.8%) of 32,395 adults with AIDS, who had been reported to the CDC national surveillance system and for whom occupational information was available, reported being employed in a health-care or clinical laboratory setting. In comparison, 6.8 million persons—representing 5.6% of the U.S. labor force—were employed in health services. Of the health-care workers with AIDS, 95% have been reported to exhibit high-risk behavior; for the remaining 5%, the means of HIV acquisition was undetermined. Health-care workers with AIDS were significantly more likely than other workers to have an undetermined risk (5% versus 3%, respectively). For both health-care workers and non-health-care workers with AIDS, the proportion with an undetermined risk has not increased since 1982.

AIDS patients initially reported as not belonging to recognized risk groups are investigated by state and local health departments to determine whether possible risk factors exist. Of all health-care workers with AIDS reported to CDC who were initially characterized as not having an identified risk and for whom follow-up information was available, 66% have been reclassified because risk factors were identified or because the patient was found not to meet the surveillance case definition for AIDS. Of the 87 health-care workers currently categorized as having no identifiable risk, information is incomplete on 16 (18%) because of death or refusal to be interviewed; 38 (44%) are still being investigated. The remaining 33 (38%) health-care workers were interviewed or had other follow-up information available. The occupations of these 33 were as follows: five physicians (15%), three of whom were surgeons; one dentist (3%); three nurses (9%); nine nursing assistants (27%); seven housekeeping or maintenance workers (21%); three clinical laboratory technicians (9%); one therapist (3%); and four others who did not have contact with patients (12%). Although 15 of these 33 health-care workers reported parenteral and/or other non-needlestick exposure to blood or body fluids from patients in the 10 years preceding their diagnosis of AIDS, none of these exposures involved a patient with AIDS or known HIV infection.

### Risk to Health-Care Workers of Acquiring HIV in Health-Care Settings

Health-care workers with documented percutaneous or mucous-membrane exposures to blood or body fluids of HIV-infected patients have been prospectively evaluated to determine the risk of infection after such exposures. As of June 30, 1987, 883 health-care workers have been tested for antibody to HIV in an ongoing surveillance project conducted by CDC (9). Of these, 708 (80%) had percutaneous exposures to blood, and 175 (20%) had a mucous membrane or an open wound contaminated by blood or body fluid. Of 396 health-care workers, each of whom had

only a convalescent-phase serum sample obtained and tested  $\geq 90$  days post-exposure, one—for whom heterosexual transmission could not be ruled out—was seropositive for HIV antibody. For 425 additional health-care workers, both acute- and convalescent-phase serum samples were obtained and tested; none of 74 health-care workers with nonpercutaneous exposures seroconverted, and three (0.9%) of 351 with percutaneous exposures seroconverted. None of these three health-care workers had other documented risk factors for infection.

Two other prospective studies to assess the risk of nosocomial acquisition of HIV infection for health-care workers are ongoing in the United States. As of April 30, 1987, 332 health-care workers with a total of 453 needlestick or mucous-membrane exposures to the blood or other body fluids of HIV-infected patients were tested for HIV antibody at the National Institutes of Health (10). These exposed workers included 103 with needlestick injuries and 229 with mucous-membrane exposures; none had seroconverted. A similar study at the University of California of 129 health-care workers with documented needlestick injuries or mucous-membrane exposures to blood or other body fluids from patients with HIV infection has not identified any seroconversions (11). Results of a prospective study in the United Kingdom identified no evidence of transmission among 150 health-care workers with parenteral or mucous-membrane exposures to blood or other body fluids, secretions, or excretions from patients with HIV infection (12).

In addition to health-care workers enrolled in prospective studies, eight persons who provided care to infected patients and denied other risk factors have been reported to have acquired HIV infection. Three of these health-care workers had needlestick exposures to blood from infected patients (13-15). Two were persons who provided nursing care to infected persons; although neither sustained a needlestick, both had extensive contact with blood or other body fluids, and neither observed recommended barrier precautions (16,17). The other three were health-care workers with non-needlestick exposures to blood from infected patients (18). Although the exact route of transmission for these last three infections is not known, all three persons had direct contact of their skin with blood from infected patients, all had skin lesions that may have been contaminated by blood, and one also had a mucous-membrane exposure.

A total of 1,231 dentists and hygienists, many of whom practiced in areas with many AIDS cases, participated in a study to determine the prevalence of antibody to HIV; one dentist (0.1%) had HIV antibody. Although no exposure to a known HIV-infected person could be documented, epidemiologic investigation did not identify any other risk factor for infection. The infected dentist, who also had a history of sustaining needlestick injuries and trauma to his hands, did not routinely wear gloves when providing dental care (19).

## Precautions To Prevent Transmission of HIV

### Universal Precautions

Since medical history and examination cannot reliably identify all patients infected with HIV or other blood-borne pathogens, blood and body-fluid precautions should be consistently used for all patients. This approach, previously recommended by CDC (3,4), and referred to as "universal blood and body-fluid precautions" or "universal precautions," should be used in the care of all patients, especially including those in emergency-care settings in which the risk of blood exposure is increased and the infection status of the patient is usually unknown (20).

1. All health-care workers should routinely use appropriate barrier precautions to prevent skin and mucous-membrane exposure when contact with blood or other body fluids of any patient is anticipated. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patients, for handling items or surfaces soiled with blood or body fluids, and for

## Recommendations for Prevention of HIV Transmission in Health - Care Settings

(ต่อจากหน้า 436)

performing venipuncture and other vascular access procedures. Gloves should be changed after contact with each patient. Masks and protective eyewear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose, and eyes. Gowns or aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.

2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids. Hands should be washed immediately after gloves are removed.
3. All health-care workers should take precautions to prevent injuries caused by needles, scalpels, and other sharp instruments or devices during procedures; when cleaning used instruments; during disposal of used needles; and when handling sharp instruments after procedures. To prevent needlestick injuries, needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant containers for disposal; the puncture-resistant containers should be located as close as practical to the use area. Large-bore reusable needles should be placed in a puncture-resistant container for transport to the reprocessing area.
4. Although saliva has not been implicated in HIV transmission, to minimize the need for emergency mouth-to-mouth resuscitation, mouthpieces, resuscitation bags, or other ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
5. Health-care workers who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling patient-care equipment until the condition resolves.
6. Pregnant health-care workers are not known to be at greater risk of contracting HIV infection than health-care workers who are not pregnant; however, if a health-care worker develops HIV infection during pregnancy, the infant is at risk of infection resulting from perinatal transmission. Because of this risk, pregnant health-care workers should be especially familiar with and strictly adhere to precautions to minimize the risk of HIV transmission.

Implementation of universal blood and body-fluid precautions for all patients eliminates the need for use of the isolation category of "Blood and Body Fluid Precautions" previously recommended by CDC (7) for patients known or suspected to be infected with blood-borne pathogens. Isolation precautions (e.g., enteric, "AFB" [7]) should be used as necessary if associated conditions, such as infectious diarrhea or tuberculosis, are diagnosed or suspected.

### **Precautions for Invasive Procedures**

In this document, an invasive procedure is defined as surgical entry into tissues, cavities, or organs or repair of major traumatic injuries 1) in an operating or delivery room, emergency department, or outpatient setting, including both physicians' and dentists' offices; 2) cardiac catheterization and angiographic procedures; 3) a vaginal or cesarean delivery or other invasive obstetric procedure during which bleeding may occur; or 4) the manipulation, cutting, or removal of any oral or perioral tissues, including tooth structure, during which bleeding occurs or the potential for bleeding exists. The universal blood and body-fluid precautions listed above, combined with the precautions listed below, should be the minimum precautions for all such invasive procedures.

1. All health-care workers who participate in invasive procedures must routinely use appropriate barrier precautions to prevent skin and mucous-membrane contact with blood and other body fluids of all patients. Gloves and surgical masks must be worn for all invasive procedures. Protective eyewear or face shields should be worn for procedures that commonly result in the generation

of droplets, splashing of blood or other body fluids, or the generation of bone chips. Gowns or aprons made of materials that provide an effective barrier should be worn during invasive procedures that are likely to result in the splashing of blood or other body fluids. All health-care workers who perform or assist in vaginal or cesarean deliveries should wear gloves and gowns when handling the placenta or the infant until blood and amniotic fluid have been removed from the infant's skin and should wear gloves during post-delivery care of the umbilical cord.

2. If a glove is torn or a needlestick or other injury occurs, the glove should be removed and a new glove used as promptly as patient safety permits; the needle or instrument involved in the incident should also be removed from the sterile field.

#### Precautions for Dentistry\*

Blood, saliva, and gingival fluid from all dental patients should be considered infective. Special emphasis should be placed on the following precautions for preventing transmission of blood-borne pathogens in dental practice in both institutional and non-institutional settings.

1. In addition to wearing gloves for contact with oral mucous membranes of all patients, all dental workers should wear surgical masks and protective eyewear or chin-length plastic face shields during dental procedures in which splashing or spattering of blood, saliva, or gingival fluids is likely. Rubber dams, high-speed evacuation, and proper patient positioning, when appropriate, should be utilized to minimize generation of droplets and spatter.
2. Handpieces should be sterilized after use with each patient, since blood, saliva, or gingival fluid of patients may be aspirated into the handpiece or waterline. Handpieces that cannot be sterilized should at least be flushed, the outside surface cleaned and wiped with a suitable chemical germicide, and then rinsed. Handpieces should be flushed at the beginning of the day and after use with each patient. Manufacturers' recommendations should be followed for use and maintenance of waterlines and check valves and for flushing of handpieces. The same precautions should be used for ultrasonic scalers and air/water syringes.
3. Blood and saliva should be thoroughly and carefully cleaned from material that has been used in the mouth (e.g., impression materials, bite registration), especially before polishing and grinding intra-oral devices. Contaminated materials, impressions, and intra-oral devices should also be cleaned and disinfected before being handled in the dental laboratory and before they are placed in the patient's mouth. Because of the increasing variety of dental materials used intra-orally, dental workers should consult with manufacturers as to the stability of specific materials when using disinfection procedures.
4. Dental equipment and surfaces that are difficult to disinfect (e.g., light handles or X-ray-unit heads) and that may become contaminated should be wrapped with impervious-backed paper, aluminum foil, or clear plastic wrap. The coverings should be removed and discarded, and clean coverings should be put in place after use with each patient.

#### Precautions for Autopsies or Morticians' Services

In addition to the universal blood and body-fluid precautions listed above, the following precautions should be used by persons performing postmortem procedures:

1. All persons performing or assisting in postmortem procedures should wear gloves, masks, protective eyewear, gowns, and waterproof aprons.
2. Instruments and surfaces contaminated during postmortem procedures should be decontaminated with an appropriate chemical germicide.

\*General infection-control precautions are more specifically addressed in previous recommendations for infection-control practices for dentistry (8).