screening tests. Serum specimens from eight probable Group O infections from Cameroon were tested with 10 HIV antibody screening test assays licensed by the U.S. Food and Drug Administration (FDA). All FDA assays based on synthetic peptides or recombinant antigens failed to detect at least one of the infections; assays based on whole-virus lysates performed better.

The test used most commonly in U.S. blood banks failed to detect HIV-1 antibodies in two specimens. These findings ate consistent with other reports on the sensitivity of European HIV antibody tests for group O infections. However, the researchers caution that these tests should not be abandoned hastily because use of these antigens and formats has resulted in significant advances in assay sensitivity and specificity for the subtypes of HIV-1 commonly found in the United States and Europe. Modifications to increase sensitivity for group O infections needs to be evaluated to ensure that addition of group O antigens does not result in the loss of sensitivity and specificity for antibodies against the more prevalent HIV-1 viruses.

Data from U.S. blood transfusion services indicate that a very small number of blood donors in the U.S. come from countries in which group O viruses appear endemic. Momover, of the more than 400,000 AIDS cases in the U.S. reported through August 1994, only 13 represented persons who reported Cameroon, Gabon, or the Central African Republic as their country of origin.

Nevertheless, the potential for divergent strains to infect persons living in the U.S., and, in some cases, to remain undetected by current HIV antibody tests, is of concern for public health and blood-banking communities. The researchers note that active surveillance for variants of HIV-1 and HIV-2 will be important to evaluate the sensitivity of HIV screening tests for detecting these variants as they are identified and to modify tests judiciously to correct for deficiencies in sensitivity

FROM: Schable C, Zekeng L, Pau C, et al. Sensitivity of United States HIV antibody tests for detection of HIV-1 group O infections. *Lancet* November 12, 1994;344:1333-1334.

New Publication Focuses on Healthcare Worker Safety

Advances in *Exposure Prevention (AEP)* is a new publication that focuses on reducing healthcare workers' risk of occupational infection by blood-borne pathogens. Dr. Janine Jagger of the University of Virginia, editor, is the developer of EPINet (Exposure Prevention Information Network), a software system that assists hospitals in tracking needlestick injuries. *AEP* will report needlestick injury data regularly—much of the data will be based on EPINet data. According to Jagger, the research findings presented in *AEP* will allow hospitals to compare their needlestick injury rates to those of other hospitals. In addition, *AEP* will report results of field trials of new devices, actions of federal agencies regarding workplace regulations, new device approvals, and new data on occupationally acquired infections. For information, call (804) 982-3763 or FAX (804) 982-0821.

AHA Asks Joint Commission to Clarify Role

The American Hospital Association (AHA) recently called for the Joint Commission on Accreditation of Healthcare Organizations to develop a strategic plan to clarify its role as the primary accrediting body for U.S. hospitals and healthcare facilities. Affirming its strong support for public disclosure of hospital-specific quality information, the AHA nonetheless pointed out the urgent need to address the inconsistency and variability in the surveys, surveyors, and educational programs to ensure the quality and value of the survey process. The AHA call to action was prompted by the fact that 15 to 20 state hospital associations are exploring options to accreditation by the Joint Commission. This action by even a few states could jeopardize the future of accreditation.

AHA Chairman of the Board Carol Roberts said the AI-IA is committed to having effective methods to assure the public about the quality of the nation's hospitals and healthcam systems and supports the Joint Commission as the most appropriate vehicle to achieve this objective. The AI-IA is a sponsoring agency of the Joint Commission along with the American Medical Association, the American Dental Association, the American College of Surgeons, and the American College of Physicians.

FROM: *AHA* News December 12, 1994.

CDC Responds to Media Reports That Florida Dentist Not Source of HIV Infection for Six Patients

It has been 4 years since the results of an investigation of a Florida dentist with AIDS, Dr. David Acer. The investigation concluded that HIV was transmitted from the dentist to six patients, The exact method of transmission has never been determined but has prompted a myriad of theories in both the mass media and scientific publications. For instance, transmission by contaminated instruments has been widely postulated despite lack of evidence, and the "murder theory' was highlighted in a television show in 1993. Most recently, there have been numerous newspaper articles and a "60 Minutes" television segment broadcast in June 1994 that posed the question "What if the dentist didn't do it?"

Dr. Carol Ciesielski of the CDC, primary investigator of the Florida dental cases, addressed some of the misinformation and rumors about the case in a recent issue of the *Annals of Internal Medicine.*' She pointed out that the media relied heavily on information from depositions related to private litigation generated by the case and on the findings of investigators hired by the dentist's insurance company to find information that could cast doubt on the conclusion that the patients had been infected by the dentist. These findings were used to suggest that each of the six patients had other risk factors for HIV infection and that the results of the HIV DNA sequence analysis are inconclusive. However, Dr. Ciesielski explained that important facts were omitted from the reports that contradict their conclusions.

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For example, the media suggested that patient A (identified by the media as Kimberly Bergalis) was infected by a sexual partner. The CDC explained that they were aware of the sexual activities discussed by patient A during a taped deposition. However, the important fact that patient A's two boyfriends had tested negative for HIV was omitted.

In another instance, the media suggested that patient B, an elderly woman, had been infected through an extramarital affair. However, the investigation showed that, since the late 1970s, her only sexual partner had been her husband, who is not infected. It was also implied that patient B had received a blood transfusion during surgery in the early 1980s, although her hospital charts showed no record of any transfusion.

One proposed theory was that the dentist intentionally transmitted these infections, and it was reported by the media that an acquaintance of the dentist reported that the dentist had implied that he had intentionally infected his patients. However, this same acquaintance said during a sworn deposition that the dentist specifically did not tell him that he had intentionally infected the patients. In addition, interviews with the family, staff, healthcare providers, patients, and others have not provided any support for this theory.

Dr. Ciesielski also discussed the available details of the epidemiologic investigation regarding the possibilities for HIV transmission to have occurred, including transmission from contaminated instruments and the patients being exposed to the dentist's blood from an accidental injury during the procedure. The CDC also presented the conclusions of the laboratory studies that showed that the DNA of the HIV strains that infected the six patients were closely related to the strain infecting the dentist. In a related article in the same issue of the *Annals*, Dr. Harold Jaffe et al report the conclusions of an investigation of another Florida dentist who died of AIDS and the lack of evidence for dentist-to-patient or patient-to-patient transmission of HIV among 1,279 patients.[2] The results of this investigation are consistent with other studies such as this, with the exception of the David Acer case in which transmission did occur. Over 22,000 patients are known to have been treated by HIV-infected dentists and surgeons and are not known to have been infected with HIV

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2. Jaffe HW, McCurdy JM, Kalish ML, et al. Lack of HIV transmission in the practice of a dentist with AIDS. *Ann Intern Med* 1994;121:855-859.

DOT Simplifies Requirements for Transport of Medical Waste

After 3 years of argument over a proposed and final rule pertaining to infectious substances and medical waste, the Department of Transportation (DOT) released proposed rules that are more reasonable.

The new rules define "infectious substances" (formerly termed *etiologic* agents), regulated medical waste, and the packaging and labeling requirements for each. In drafting these rules, the DOT responded to many concerns regarding the overly broad definition of regulated medical waste and the unduly strict packaging requirements for transporting regulated medical waste.

In a prior proposal, all regulated medical waste was to be considered "infectious substances" and subject to the mote rigorous packaging, transport, and recordkeeping requirements that are required of infectious substances. In the new proposed rule, infectious substances will be limited to "viable microorganisms ... which cause human disease." The only portion of regulated medical waste that would be considered "infectious substances" would be untreated cultures and stocks of infectious agents. Thus, hospitals that treat their cultures and stocks on-site would be exempt from these requirements.

The DOT also has simplified the definition of regulated medical waste to be more generic and based on criteria rather than a list. The new definition of regulated medical waste, in part, includes waste that "contains an infectious substance and is generated in the diagnosis, treatment, or immunization of human beings or animals, research, ... or the production or testing of biologic products." Originally, the proposed rules had an extremely broad definition of medical waste, and at one point even had considered including laundry among the materials to be regulated.

The new definition of medical waste would now allow healthcare facilities and states to define the content of regulated medical waste. A public meeting was scheduled for January 17, 1995, in Washington, DC. Written comments are due March 21, 1995.

FROM: *Federal* Register December 21, 1994; 59(244):65860-65869.

CDC Rates the Level of Sanitation of Cruise Ships

Every cruise ship coming into a U.S. port that has an international itinerary and carries 13 or more passengers is inspected semiannually by the CDC. A ship's inspection score is published every 2 weeks in the Summary of Sanitation Inspections of International Cruise Ships (ie, the "Green Sheet"). A ship's level of sanitation is acceptable if its score is 86% or higher.

The Green Sheet is available through the Internet, ftp.cdc.gov//pub/ship_inspections/shipscore.txt; the CDC FAX information Services, telephone (404) 332-4565 (request document no. 510051); or the CDC's National Center for Environmental Health, Vessel Sanitation Program, Room 107, 1015 North American Way, Miami, FL 33132; telephone (305) *5364307;* FAX (305) 536-4528.

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