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Authors

Mangione, CM
Gerberding, JL
Cummings, SR

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pants from completing the questionnaire mailed to their home and then completing another at a housestaff conference. If in fact the participants were afforded the opportunity to duplicate their responses, this would have led to unjustly weighted results. It is our opinion that participants that have been exposed to HIV desire improved venipuncture equipment. We believe this would be motivation enough to deliberately slant the results of this survey by the participants.

We believe that this ambiguity in the data collection needs to be clarified before any level of confidence can be placed in this study. We cordially invite the authors to clarify, for us and other readers, if this in fact was a factor in their survey.

BOB SCHINSTOCK
BRAD SCHAFFER
Cleveland Chiropractic College
Kansas City, Missouri

1. Mangione CM, Gerberding JL, Cummings SR. Occupational exposure to HIV: frequency and rates of underreporting of percutaneous and mucocutaneous exposures by medical housestaff. *Am J Med* 1991; 90: 85-90.

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The Reply:

We thank the students from Cleveland Chiropractic College for their insightful comments. Anonymous questionnaires were initially distributed at housestaff conferences at the three teaching hospitals. Unfortunately, although these were "mandatory"

conferences, attendance was incomplete. Due to the anonymous nature of the survey, the investigators could not determine who had received the questionnaire. Therefore, to ensure that all eligible interns and residents at the three institutions had an opportunity to respond to the survey, copies were sent to house officers' homes with a cover letter that emphasized that they should only complete the questionnaire if a survey was not completed in a conference. We cannot prove that participants did not turn in two questionnaires, but we have no reason to suspect it.

We believe that our estimate of the prevalence of occupational exposure based on recalled rates of exposures (19% recalled percutaneous exposure to HIV) is reliable because it is of similar magnitude to those estimates found by other investigators practicing in areas with a high prevalence of HIV-infected patients. Specifically, Link [1] found that in a survey of residents in five New York teaching hospitals, 37% of the internal medicine housestaff had sustained needlestick injuries from HIV-infected blood at some point during their training. In the Yale teaching hospitals, Heald and Ransohoff [2] found that 74% of the house officers surveyed had at least one needlestick injury with suture or hollow-bore needles and that 15% (12 of 78) were from patients documented

to be HIV-infected. McGeer and coworkers [3] found that 57% of medical interns had sustained percutaneous exposures to blood or body fluids. In addition, even if our survey method overestimated the prevalence of exposure by 50%, it is still of a magnitude that should be of concern to house officers and their employers.

The prevalence of occupational exposures to HIV-infected blood is difficult to estimate because of the potential confidentiality and employment security issues related to exposure. We believe that it is time to accept that there is a substantial occupational risk involved in the care of HIV-infected patients and that the best strategy is to proceed with the important and difficult task of risk reduction through employee education and equipment changes.

CAROL M. MANGIONE, M.D.
Beth Israel Hospital
Harvard Medical School
Boston, Massachusetts
J. LOUISE GERBERDING, M.D.
STEVEN R. CUMMINGS, M.D.
University of California at San Francisco
San Francisco, California

1. Link NR. Concerns of medical and pediatric house officers about acquiring AIDS from their patients. *Am J Public Health* 1988; 78: 455-9.

2. Heald AE, Ransohoff DF. Needlestick injuries among resident physicians. *J Gen Intern Med* 1990; 5: 389-93.

3. McGeer A, Simor AE, Low DE. Epidemiology of needlestick injuries in house officers. *J Infect Dis* 1990; 162: 961-4.