Council of State and Territorial Epidemiologists

CSTE UPDATE

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ELEVATED BLOOD LEAD LEVEL SURVEILLANCE SURVEY
(Dennis Perrotta, PhD - Texas)

As a follow-up of the CSTE 1990 position statement supporting the state-based surveillance of elevated blood lead levels, CSTE and the Lead Poisoning Branch, CDC are interested in characterizing existing activities and laws related to lead poisoning. To that end, CSTE members and other state health department staff that work in childhood lead poisoning prevention will be receiving a questionnaire inquiring about laws, regulations, and activities related to surveillance and screening.

Childhood exposure to lead, at levels once thought to be safe, continues to be of major public health concern in the United States. This effort will help determine the resource requirements and direction of the national effort to address this health problem affecting millions of children in the United States. Please take a moment to complete the questionnaire or direct it to the appropriate person.

For further information or questions, contact Dr. Dennis Perrotta, Texas State Health Department (512-458-7268).

CSTE SURVEY OF ENVIRONMENTAL, OCCUPATIONAL AND INJURY EPIDEMIOLOGISTS
(Dennis Perrotta, PhD - Texas)

In support of last year's position statement designed to expand the representation of non-infectious disease epidemiology activities, CSTE members recently completed a questionnaire to determine the interest and needs in the states. Fifty-eight responses have been received (with four more "promised") representing 50 states and two territories.

Nearly half described themselves as "combo epidemiologists" ("I do it all") while 25% are environmental epidemiologists. The remainder are injury, occupational, perinatal, or chronic disease epidemiologists. Of those that did not attend the 1990 CSTE meeting, the majority identified travel/resource restrictions and an agenda that did not relate to their duties as reasons for not attending. A large number of excellent suggestions for the 1991 meeting agenda were received.

Many thanks to those who participated. A more in-depth review is underway.

CSTE RECOMMENDATIONS REGARDING CDC'S GUIDELINES FOR HIV-INFECTED HEALTH CARE WORKERS PERFORMING INVASIVE PROCEDURES

(Larry Foster, MD, MPH - Oregon)
(Michael Osterholm, PhD - Minnesota)
(CSTE Executive and HIV/AIDS Committees)

The following statement was drafted, reviewed and adopted by CSTE's Executive and HIV/AIDS committees. General principles which should serve as the basis for CDC's guidelines development include:

1 CDC should avoid issuing guidelines which are internally inconsistent or contradictory.
2 CDC should develop these guidelines according to the same principles currently followed for the development of less controversial guidelines. In other words, the guideline content should be based upon scientific information, not the perceptions of vocal members of the public. The guidelines should be based upon the best available estimate of the risk of HIV transmission from infected health care worker (HCW) to patient. The implementation costs of the guidelines should be proportional to the best available estimate of degree risk. The guidelines should not propose measures that are very costly per transmission to be prevented, relative to other possible ways to spend the same resources for HIV prevention.
3 CDC should deal with the discordance between public perception and scientific information with effective communication of risk, not by modifying the technical content of the guidelines to fit public perception.
4. CDC should avoid the logical implausibility of recommending restriction of an HIV-infected surgeon who voluntarily notifies his or her institution of his or her status but not recommending routine periodic screening of other surgeons who perform the same procedures.

   If restrictions of surgeons who voluntarily report themselves becomes the standard practice, virtually none will report themselves. Therefore, if CDC judges the risk of surgeon-to-patient transmission to be high enough to justify restriction of the surgeon, then CDC must recommend periodic HIV screening of all surgeons to prevent this risk.

   Furthermore, our experiences with HIV, plus our more extensive, but analogous HBV experience, suggests that the risk of patient-to-HCW transmission is much greater than the risk of transmission in the reverse direction. This means that surgeons who are undergoing periodic screening themselves will likely demand pre-operative screening of patients.

   It is apparent, therefore, that a recommendation to routinely restrict voluntarily identified HIV-infected surgeons would result in a costly ongoing program of periodic screening of surgeons and pre-operative screening of patients.

CSTE's specific recommendations for the guidelines include

1. The guidelines should describe all available information about the degree of risk for HIV transmission from HCW to patient during invasive procedures. This description should include all that is known directly about such HIV transmission from surveillance and from retrospective study of patients operated on by HIV-infected surgeons. It should include all pertinent information from analogous information available for HBV transmission. It should conclude that the best available information suggests that the risk of such transmission is very low, but not zero.

2. The guidelines should call for intensified surveillance to better quantitate the risk of HCW-to-patient HIV transmission. This should include concentrated investigation of NIR AIDS cases, and, where possible NIR reported HIV-infected (non-AIDS) cases with assistance provided by CDC to state and local health departments. It should include, where possible, HIV testing of patients operated on by surgeons retrospectively identified to be HIV infected.
3. For educational purposes, the guidelines for HIV prevention in the surgical setting should be as similar as possible to those for HBV, recognizing, of course, the lack of pre-exposure vaccine for HCW's and post-exposure prophylaxis for exposed patients.
4. The guidelines should strongly emphasize universal precautions -- barrier techniques and special care to avoid sticks and cuts during invasive procedures. These should call for development of modified techniques for very risky procedures to reduce the risk, and for training of both in-training and practicing HCW's in those new techniques.
5. For educaitonal purposes, the guidelines should point out that some procedures may pose a risk of transmission from HCW to patient as well as from patient to HCW, while other procedures, such as phlebotomy, only pose a risk of transmission from patient to HCW.
6. The guidelines should call for the development of better engineering controls, such as a surgical glove which is impenetrable to sharps yet provides adequate tactile sensitivity.
7. The guidelines should state that the best available information about degree of risk of HIV transmission from a HCW to a patient during an invasive procedure does not support routine restriction of voluntarily identified HIV-infected HCW's from performing invasive procedures.
8. The guidelines should similarly state that periodic HIV screening of HCW's who perform invasive procedures and routine pre-operative screening of patients are not justified.
9. The guidelines should suggest a process to be followed if an HIV-infected worker chooses to seek advice about restriction from performance of invasive procedures or if an institution learns of the status of an HIV-infected worker. This process should provide for strict confidentiality. It should include a review by a panel which includes experts in HIV transmission information (infectious disease specialist or public health epidemiologists) and experts in the pertinent invasive procedures (surgeon of the same specialty). It should recognize that such review could be conducted within large institutions, or, in situations where confidentiality and expertise are problematic, by a panel convened by the state licensing board or public health authority. The choice between an institutional panel and a state agency panel should be made after considering the individual state's laws regarding professional licensure.
10. The guidelines should address HIV-associated dementia. Most states provide for the reporting of an licensed HCW with dementia to the appropriate licensing board for evaluation and possible restriction of practice because of mental impairment. The guidelines should recommend that HIV-HCW's with dementia be reported to appropriate licensing board in the same manner that individual state's laws prescribe reporting of other HCW's with dementia.
11. Tuberculosis is a reportable condition. Reporting of tuberculosis in a HCW is critical to protecting patients from possible tuberculosis infection. The guidelines should recommend that HIV-infected HCW's who develop tuberculosis, or other communicable and reportable conditions, be reported to the local or state public health authority in the same manner as other individuals who develop these conditions.

The Centers for Disease Control is convening a meeting in Atlanta on February 21-22, 1991, to review current information on risks of transmission of HIV and HBV to patients during invasive procedures and to access the implications of these risks. CDC is expected to release guidelines sometime after that meeting.

REVISIONS IN PRINCIPLES OF EPIDEMIOLOGY (3030-6) SELF STUDY COURSE
(Richard Dicker, MD, MSc - CDC)

Epidemiologists at CDC have outlined substantial changes in this course, including updated information, newer samples, broader applications, and expanded content.

Under CSTE endorsement, state epidemiologists are being asked to review revised materials and mannuals. The Centers for Disease Control hopes to have a final product by September 1991.

NEW STATE EPIDEMIOLOGIST
NEVADA

Congratulations to Martin Atherton, MPH, who has just taken the position of State Epidemiologist for the State of Nevada.

1991 CSTE MEETING - SAN DIEGO, CALIFORNIA
MAY 20-23, 1991

This year's CSTE meeting will be one of many that week in San Diego. In addition to ASTHO's annual meeting, CDC will be holding its annual STD-HIV Prevention and Sensor conferences. We hope to take advantage of the overall meetings to enhance and expand participation at our meeting. See you there.

NOMINATION FOR CSTE "PUMP HANDLE" APPLIED EPIDEMIOLOGY AWARD
(Dale Morse - New York)

The Executive Committee is seeking nominations for the annual CSTE "Pump Handle" Award. The award is given to a person (current or former CSTE member) (Executive Committee members are not eligible) who has made an outstanding contribution to the field of applied epidemiology. The award is given at the annual meeting, which is to be held in San Diego, California, this year. Please forward nominations on the attached form to Dr. Dale Morse by April 1, 1991.

Send your articles or ideas for articles for the Newsletter to

Dale L. Morse, M.D., M.S.
State Epidemiologist
New York State Department of Health
E.S.P., Tower Building, Room 651
Albany, NY 12237-0627

NOMINATIONS FOR CSTE "PUMP HANDLE"

APPLIED EPIDEMIOLOGY AWARD

Nominees

Name: _____

Justification: _____

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Name: _____

Justification: _____

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DEADLINE April 1, 1991

Return to: Dale L. Morse, MD, MS
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