



Bulletin No. 1

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AIDS Policies

Recommendations for Providers of Pre-Hospital Emergency Care

The Department of Health and Social Services has adopted the following AIDS policies for providers of pre-hospital emergency care.

Precautions for Providers of Pre-Hospital Emergency Health Care

Providers of pre-hospital emergency health care include the following: paramedics, emergency medical technicians, law enforcement personnel, firefighters, lifeguards, and others whose job might require them to provide first-response medical care.

Acquired Immune Deficiency Syndrome (AIDS) is caused by infection with a virus known as human T-cell lymphotropic virus or HTLV-III. There is a wide spectrum of HTLV-III infections, ranging from infection in the absence of signs and symptoms at one end to infection with confirmed AIDS and a high degree of mortality at the other end. AIDS is a bloodborne, sexually transmitted disease that is not spread by casual contact.

HTLV-III infected individuals include those with AIDS; those diagnosed by their physician(s) as having other illnesses due to infection with HTLV-III; and those who have virologic or serologic evidence of infection with HTLV-III but who are not ill.

Persons at increased risk of acquiring infection with human T-lymphotropic virus type III HTLV-III, the virus that causes acquired immunodeficiency syndrome (AIDS), include homosexual and bisexual men, intravenous (IV) drug abusers, persons transfused with contaminated blood or blood products, heterosexual contacts of persons with HTLV-III infection, and children born to infected mothers.

HTLV-III is transmitted through sexual contact, parenteral exposure to infected blood or blood components, and perinatal transmission from mother to neonate. HTLV-III has been isolated from blood, semen, saliva, tears, breast milk, and urine and is likely to be isolated from some other body fluids, secretions, and excretions.

Epidemiologic evidence has implicated only blood and semen in transmission. Studies of nonsexual household contacts of AIDS patients indicate that casual contact with saliva and tears does not result in transmission of infection. Spread of infection to household contacts of infected persons has not been detected when the household contacts have not been sex partners or have not been infants of infected mothers. The kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III.

The risk to health care workers (HCWs) of acquiring HTLV-III infection in the workplace has been evaluated in several studies. In five separate studies, a total of 1,498 HCWs have been tested for antibody to HTLV-III. In these studies, 666 (44.5%) of the HCWs had direct parenteral (needlestick or cut) or mucous membrane exposure to patients with AIDS or HTLV-III infection. Most of these exposures were to blood rather than to other body fluids. None of the HCWs whose initial serologic tests were negative developed subsequent evidence of HTLV-III infection following their exposures.

In spite of the extremely low risk of transmission of HTLV-III infection, even when needle-stick injuries occur, more emphasis must be given to precautions targeted to prevent needle-stick injuries in HCWs caring for any patient, since such injuries continue to occur even during the care of patients who are known to be infected with HTLV-III.

Precautions to Prevent Acquisition of HTLV-III Infection by HCWS in the Workplace

These precautions represent prudent practices that apply to preventing transmission of HTLV-III and other bloodborne infections and should be used routinely.

1. Sharp items (needles, scalpel blades, and other sharp instruments) should be considered as potentially infective and be handled with extraordinary care to prevent accidental injuries.
2. Disposable syringes and needles, scalpel blades, and other sharp items should be placed into puncture-resistant containers located as close as practical to the area in which they were used. To prevent needlestick injuries, needles should not be recapped, purposefully bent, broken, removed from disposable syringes, or otherwise manipulated by hand.
3. When the possibility of exposure to blood or other body fluids exists, routinely recommended precautions should be followed. The anticipated exposure may require gloves alone, as in handling items soiled with blood or equipment contaminated with blood or other body fluids, or may also require gowns, masks, and eye-coverings when performing procedures involving more extensive contact with blood or potentially infective body fluids, as in some dental or endoscopic procedures or postmortem examinations. Hands should be washed thoroughly and immediately if they accidentally become contaminated with blood.
4. To minimize the need for emergency mouth-to-mouth resuscitation, mouth pieces, resuscitation bags, or other ventilation devices should be strategically located and available for use in areas where the need for resuscitation is predictable.

Because the hepatitis B virus is also bloodborne and is both harder and more infectious than HTLV-III, recommendations that would prevent transmission of hepatitis B will also prevent transmission of AIDS. No transmission of HBV infection during mouth-to-mouth resuscitation has been documented.

Because of the theoretical risk of salivary transmission of HTLV-III during mouth-to-mouth resuscitation, special attention should be given to the use of disposable airway equipment or resuscitation bags and the wearing of gloves when in contact with blood or

other body fluids. Resuscitation equipment and devices known or suspected to be contaminated with blood or other body fluids should be used once and disposed of or be thoroughly cleaned and disinfected after each use.

Management of Parenteral and Mucous Membrane Exposures of HCWS

If a HCW has a parenteral (e.g., needlestick or cut) or mucous membrane (e.g., splash to the eye or mouth) exposure to blood or other body fluids, the source patient should be assessed clinically and epidemiologically to determine the likelihood of HTLV-III infection.

If the assessment suggests that infection may exist, the patient should be informed of the incident and requested to consent to serologic testing for evidence of HTLV-III infection. If the source patient has AIDS or other evidence of HTLV-III infection, declines testing, or has a positive test, the HCW should be evaluated clinically and serologically for evidence of HTLV-III infection as soon as possible after the exposure, and, if seronegative, retested after 6 weeks and on a periodic basis thereafter (e.g., 3, 6, and 12 months following exposure) to determine if transmission has occurred.

During this follow-up period, especially the first 6-12 weeks, when most infected persons are expected to seroconvert, exposed HCWs should receive counseling about the risk of infection and follow U.S. Public Health Service (PHS) recommendations for preventing transmission of AIDS. If the source patient is seronegative and has no other evidence of HTLV-III infection, decisions regarding appropriate follow-up should be individualized based on the type of exposure and the likelihood that the source patient was infected.

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