UCSF Task Force on AIDS and University Wide Task Force on AIDS, 1983/84

University of California, San Francisco
AIDS Task Froce
March 21, 1983

Present: Drs. Hopewell, Jensen, Toy, Hadley, Grossman, Wofsy, Conte, Follansbee, Brody, Sande, Volberding; Jackie Octovio, Linda Rosendorf, Infection Control nurses from Moffitt Hospital; Leslie Lingaas, News and Public Information Services; and Diana Twesten, Department of Medicine, SFGH.

Meeting was called to order by Dr. Merle Sande, Chairman, at 5:15 PM.

1. Review of minutes of 2/28.

   Dr. Conte suggested that the report included in the last meeting's minutes be clearly marked as a SFGH Infection Control Committee report and not as a concensus from this Task Force.

2. Progress Report.

   Following discussions from the last meeting, certain changes in the focus of the proposed unit have occurred.

   a. The so-called "physical barrier" for the "AIDS" unit will be minimal or nonexistent.

   b. The use of this unit for other kinds of patients remains an open issue.

   c. This unit will not be referred to as an "AIDS Unit" but a unit where AIDS patients are.

   Dr. Hadley reported on the Infection Control Committee meeting at SFGH. There is mounting concern among the various hospital personnel who deal with AIDS patients for their own safety. Several educational programs have been initiated:

   a. A coordinator will be hired for teaching and educating the hospital personnel on AIDS. Dr. Hadley met with Mr. Tom Griffin to set up a job description. This person will report to the Infection Control Committee but actually be placed in Employee Health. The coordinator will work closely with physicians, nurses, and ancillary help and will coordinate teaching with other hospitals. This position will be established initially for six months and the person will be hired as a "Clinical Specialist."

   b. Drs. Hadley, Volberding, Wofsy, Sande, and others, have been conducting ongoing educational conferences with staff members to increase awareness of the disease and what is known to date. A group of nurse specialists have been assigned to various parts of the hospital to organize inservice teaching about AIDS. Drs. Wofsy and Volberding have been working with this group.

Mary Ann McGuire, Director of Nursing at SFGH, announced today at the Executive Committee meeting that a head nurse for the AIDS unit has been identified and she will proceed with the staffing of this unit--the number of nurses to be hired is presently undetermined. It is hoped that the staffing of this unit will be voluntary. It will, however, be mandatory for nurses on other wards to treat AIDS patients. The target date for nurse recruitment is mid-May.

Dr. Conte reported on his first meeting of the ad hoc committee at Moffitt Hospital. It was reaffirmed for infection control purposes that AIDS patients should be handled the same as those with Hepatitis B. They will meet again to discuss the handling of AIDS patients who have contracted a specific disease associated with AIDS (i.e., pneumocystis) versus AIDS patients without a specific disease entity. Dr. Conte will submit copies of the minutes from this meeting to Dr. Sande so they can be distributed to the Task Force members. A separate bronchoscope for AIDS patients will be purchased.

Dr. Jensen reported on the Medical Service Conference held at the V.A. The discussion of the AIDS topic at this meeting will be entered into the minutes for distribution to the members of the Medical Service at the V.A. Dr. Grossman asked how the other services were being informed, i.e., the Surgical Serivce. Dr. Jensen said that the other services were represented by the Infection Control Committee. The V.A. was also able to expedite the acquisition of a second bronchoscope.

Dr. Hadley will be putting together a general guideline based on the CDC recommendation to disseminate to all clinical staff at SFGH. Copies will also be sent to Drs. Conte and Jensen for distribution at Moffitt and the V.A.

Dr. Toy reported on the Blood Bank Policy. Histories are taken on all blood donors and asked if they have symptoms or have been exposed to anyone with AIDS. Those volunteers who are apt to be high risk are asked not to donate. The results of this volunteer screening are not yet known. Data on the effectiveness of anticore antibody screening for identifying potential AIDS-carrying blood is being collected at the blood bank. No action is currently being taken on positive units.

Drs. Volberding and Wofsy last week attended a national meeting at New York University on AIDS. They discussed points of interest.

- There are more AIDS patients than the CDC reports (>1200).
- The infection control measures in New York are also those being used for Hepatitis B.

- NYU is presently putting together a labeling system for blood and other specimens from AIDS patients similar to ours. It was suggested that labeling should not consist of the word "AIDS" but be generic or possibly use "Biohazard." Dr. Hadley suggested "H/A."

- The potential diagnostic marker alpha-thymosin (levels >100 units) looks disappointing although high circulating levels are present in 75% of AIDS patients. Specificity has not yet been defined.

- Neurologic complications (encephalitis, dementia) are more common than generally accepted.

- The significance of the primate outbreak is not known but could represent a good model.

- The general concensus at the conference at NYU was that the cause of AIDS is a virus.

- It was predominantly agreed that AIDS can be transferred by whole-blood transfusions but only several cases are convincing.

- UC precautions in handling AIDS patients are stronger than most elsewhere, especially those in New York (i.e., masks, single rooms).

Dr. Hopewell discussed the sensitivity of transbronchial biopsy. There have been two cases of patients with pneumocystis in which the transbronchial biopsy and touch pap were negative but had proven disease on open biopsy. Therefore, in both cases the transbronchial biopsy was inadequate.

Use of monoclonal antibodies for diagnosis of pneumocystis is promising.

Drs. Volberding and Sande met with Mr. Roger Boas last week. Mr. Boas is putting considerable effort into generating support for AIDS research both at local and national levels. He is meeting with Dean Schmid today. Dr. Sande will meet with Mayor Dianne Feinstein this Wednesday (3/23) to brief her on the AIDS problem.

Dr. Merv Silverman has appointed a city-wide committee on AIDS (through the Health Department).

John Jacobs, science writer for the Examiner, has interviewed many of the SFGH staff involved in AIDS. It was agreed that his articles were sensitive and informative and effectively walked the fine line in keeping the community informed and yet not producing hysteria.

Dr. Volberding noted that Newsweek and Time magazines will both have stories on AIDS next week.

3. New Business

It was suggested that this Task Force maintain a registry on AIDS patients in the UC system. A form will be developed and filled out on each patient and data entered into a computer. Dr. Follansbee brought up the concern about who has access to such records or registry and indicated a need for confidentiality. Dr. Hopewell commented that when collecting information, it must be in a systematic way so that the data can be used later to make decisions.

The safety of the Hepatitis B vaccine was discussed and felt it was not a risk factor for AIDS. Members of the committee felt that they no longer have any lingering doubts that they would not give the vaccine because of AIDS.

HBIG is another concern but no change in procedures were recommended.

4. Agenda for the next meeting.

a. Housestaff and staff concerns.

b. An anesthetist may want to sit in on this meeting.

c. Should we allow patients with AIDS to work?

Meeting adjourned at 6:30 PM.

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DECEMBER 12, 1983 UNIVERSITYWIDE TASK FORCE ON AIDS WORKSHOP

The meeting began at 9:15 AM with Merle A. Sande, M.D., Chairman of the Universitywide Task Force on AIDS, welcoming everyone to the Workshop. The members of the Task Force who were present were introduced. Dr. Sande then briefly outlined some important future dates:

1. **MAY 31, 1984**
   Progress reports are due from all individuals who have received monies from the Task Force. Details on format will be sent to all investigators at a later date.

2. **EARLY JUNE, 1984**
   The next meeting of all of the awardees is tentatively scheduled for early June. This meeting will be on a larger scale than the December 12 Workshop, with members of the legislature invited. Details will be sent out as they are finalized.

3. **SEPTEMBER 1, 1984**
   This is the deadline for applications for the next award cycle. This cycle will be from 11/1/84 to 6/30/85, in order to return to a normal fiscal year.

Dr. Sande then clarified the dates of the current award cycle. For those investigators who received monies November 1, 1983, the award cycle is from 11/1/83 to 10/31/84. For those investigators who received monies July 1, 1983, the award cycle is from 7/1/83 to 6/30/84.

Dr. Sande then introduced C.L. Hopper, M.D., Vice President, Office of Health Affairs, University of California. Vice President Hopper welcomed all of the investigators and passed along President Gardner's sincere greetings, and explained that the president office's role is strictly to expedite matters. The history of the AIDS monies, from May 1982 up to the present were briefly outlined by Vice President Hopper, to illustrate the speed with which matters have been handled. A copy of this chronology is attached.

Vice President Hopper announced that another $2.9 million has been put into the govenor's budget for the 1984-1985 fiscal year. In addition, the importance of returning to a July 1 to June 30 award cycle was emphasized.

In addition, Vice President Hopper reiterated that those investigators who received funding November 1, 1983, have funding for an entire year, through 10/31/84. The specifics of how this is to be handled can be obtained from the individual campuses. Investigators whose funding started in July 1983 will have a four month gap between when their award cycle ends and the next cycle begins; mechanisms for handling this will be investigated.

Dr. Sande then introduced Lawrence R. Freedman, M.D., a member of the Task Force. Dr. Freedman, pointing out that the AIDS Clinical Research Centers represent a new and exciting concept in Universitywide research in the face of a major public health challenge, outlined the goals of the Centers (see attached). In addition, he mentioned that there will be a site visit to each of the Centers by the Task Force in approximately four months. The Centers will be notified at a later date of the exact date. The Directors of the UCSF and UCLA AIDS Clinical Research Centers, Marcus Conant, M.D, San Francisco, and Michael Gottlieb, M.D., Los Angeles, were then introduced.

Dr. Conant spoke to the group first, and emphasized the University of California's commitment to solving this major public problem. As an example he mentioned the already existing cooperation between the San Francisco and Los Angeles Centers. The following individuals, who will be directly involved in the working of the San Francisco AIDS Clinical Research Center, were then introduced by Dr. Conant:
Paul Volberding, M.D., Frank Baumgartner, R.N., N.P., and Frank Jacobson, Assistant Director, Hospital and Clinics.

The main components of the San Francisco Center, as outlined by Dr. Conant, are 1) the computer system that will provide a central storage area for all data collected and 2) the tissue and serum banks. The same data access form will be used by all of the hospitals connected to UCSF. A Tissue Committee of 10 individuals from UCSF has been formed to evaluate requests for samples from the tissue bank. If the request is denied the individual can appeal the decision to the Appellate Committee (which is equivalent to the Dean's Committee responsible for overseeing the San Francisco AIDS Clinical Research Center). Dr. Conant asked for proposals requesting tissue and serum samples at this time. To apply, an individual should send a one page proposal outlining how the tissue samples are to be utilized to Dr. Volberding. In turn, the Center has stipulated the following conditions and/or restrictions on the use of materials from the tissue and serum banks:

1. If the research is already being done it should be done as a collaborative effort.

2. The materials requested are to be used only by the investigator(s) named in the proposal.

3. The investigator can only use the samples for the purpose outlined in the proposal.

Dr. Volberding spoke briefly about the VAX computer system to be used and its function. Data will be input into the system from a uniform tissue form and uniform clinical data base form that will have the patient's history and laboratory tests. The patient's confidentiality will be maintained since no names or hospital ID#s will be used.

John Greenspan, D.D.S., is in charge of the tissue/serum bank. He mentioned that requests for samples will be taken one by one as they are submitted.

Dr. Gottlieb outlined the AIDS situation in Los Angeles, the goals of the Los Angeles AIDS Clinical Research Center, and the mechanisms for achieving those goals:

1. Establish a mechanism for a comprehensive and active surveillance of AIDS/Identify the full spectrum of the illness to determine the incidence and prevalence of AIDS.

2. Facilitate research of AIDS at the University of California through a standarized data base and tissue and serum banks.

3. Provide special education programs on AIDS for health care workers.

At a later date, case control studies need to be done. Dr. Gottlieb pointed out that at the present time the Los Angeles Center is at a disadvantage, not having pre-existing tissue and serum banks like the San Francisco Center, thus inhibiting the major goal of the Los Angeles Center for the time being.

Dr. Gottlieb introduced Peter Wolff, M.D., who will supervise the nursing staff in the data and tissue collection process and will design and implement education programs in the Center. In addition, the main staff will consist of a nurse epidemiologist to visit high yield areas, and nurse educators.

Following questions, the concensus was to establish a tissue sub-committee that will meet to determine what tissues are to be collected by the Centers. This group, to be chaired by Dr. Greenspan, will meet within the next 6 weeks. The committee will be composed of a representative from each campus and from each Center (Dr. John Greenspan, San Francisco Center; Dr. Robert Cardiff, Davis and the Task Force; Dr. J. Allen McCutchan, San Diego, Dr. Thomas Cesario, Irvine; plus several as yet unnamed individuals). Following the meeting of this sub-committee, the results will be sent to all awardees.

In addition, a sub-committee was established, to be chaired by Dr. Freedman, to define (standardize) case and lab tests. This group will also meet within the next 6 weeks to establish the aforementioned criteria, that in turn will be disseminated to all the awardees.

Following a coffee break presentations by each of the awardees began at 10:45 PM. After the last presentation by an awardee, Dr. Sande thanked everyone for their participation in this successful Workshop. He solicitated suggestions from the awardees for the Task Force, now or in the future.

The meeting concluded at 3:30 PM.

UNIVERSITYWIDE TASK FROCE ON AIDS
CLINICAL CASE STUDIES COMMITTEE
1:00 PM LOS ANGELES AIRPORT HOLIDAY INN
FEBRUARY 1, 1984
MINUTES

Present: Donald Abrams, M.D., Marcus Conant, M.D., Lawrence Freedman, M.D., Michael Gottlieb, M.D., Harry Hollander, M.D., Allen McCutchan, M.D., Peter Wolfe, M.D.

Chairman Lawrence Freedman outlined the points that the Clinical Case Studies Committee (CCSC) needs to turn its attention to:

1. Criteria for case selection
2. Techniques which permit the establishment of surveillance systems in the largest number of hospitals and out-patient facilities both within and outside of the UC system
3. The definition of laboratory studies which are part of routine patient care (for which center funds would not be appropriate) and those laboratory studies - not part of routine care - which would be purchased by center funds
4. The determination of how to obtain laboratory studies to be paid for by center funds in the most inexpensive way and in a way so as to insure comparability of results from the centers
5. Mode of functioning of the scientific advisory committees to insure access to the resources of the Clinical Research Centers and at the same time to provide maximal patient protection so as to insure confidentiality and minimize patient discomfort.

1. The differences between the UCSF and UCLA AIDS Clinical Research Centers were mentioned. At the UCSF Center the patient population seeks out the Center. Those individuals are then entered into the data pool via one of 3 categories: 1) normal gay males; 2) assymptomatic gay males; 3) gay males with AIDS. On the other hand, the UCLA Center actively seeks out its patient population and then enters them into their data pool provided the patient has one and/or more symptoms found on a pre-determined list compiled by the UCLA Center for this study. Dr. Gottlieb is to standarize the definitions of the symptoms on the list and distribute them to this committee for final approval so that they can be used by all of the centers. This will insure a standarization of terminology used by the Centers for symptom definition. In addition, the CCSC felt there should be an indication of how a case got into the file (i.e. self-referred, by a physician, via a project). It was considered important for the computer people at the UCSF and UCLA Centers to get together to assure compatability of data storage.

Dr. Gottlieb is also to construct the clinical data base form, with a core of information, that will be utilized by the Centers. For example, in order to eliminate the need for recording the data from a chest x-ray, a space for diagnoses should be available on the core information sheet. Any additional information that a center wishes to collect will be put on its own data form.

2. It was felt that in the first year of operation the Centers should focus on setting up a data collection system and a uniform language. In addition, it was decided that one surveillance system at the UCLA Center is sufficient. In addition it was decided that though the Committee favors reaching as large a group of facilities and patients as possible, for the time being the clinical case study process should not be obligated to extend beyond the UC system.

3. The CCSC decided the following laboratory tests should be the obligatory core tests run on all patients:

Total T cells, T_H/T_S, and absolute nos. of T_H and T_S
CBC (to include differential and platelet count)
Hepatitis core antibody
Banked serum

The following tests were considered to be non-obligatory:

Skin test
Urinalysis
Sedimentation rate
Liver function tests
Stool cultures

Dr. Allen McCutchan is to finalize this list of obligatory and non-obligatory laboratory tests and submit it to the committee for final approval.

The CCSC discussed the issue of who should be responsible for the costs of the T_H/T_S ratios, and came to the following conclusions: if an individual visits a physician on his own initiative then the Insurance Co./individual is responsible for the cost of this test because it is desirable to have this information. However, this can be charged to the Insurance Co./individual only once. If, however, the individual is sought out by the physician (i.e. detected in a screening program) then the Centers will cover the cost of this test, provided the individual meets the criteria as defined by the UCLA Center. In addition, all core tests are billable to the insurance companies. Studies subsequently run on banked serum must, of course, be paid for by Center funds (or other research funds).

4. Two situations that need to be investigated are: 1). the possibility of negotiating a contract with a UC lab(s) to run the CBC and T_H/T_S tests at a reduced cost. This possibility needs to be raised with Vice President Hopper, and 2). in reference to the on-going NIH-NIAID study, explore the possibility of have the individuals in charge inform their subjects about the UC AIDS Clinical Research Centers in hopes some of the subjects might be willing to contribute to the UC data collection system also.

5. The CCSC discussed a possible procedure for access to data/specimens/patients. The following points were made:

1. Each AIDS Clinical Research Center will have a local review/tissue committee to evaluate requests for access to information, patients, or specimens (tissue, serum).
2. Concensus of authorship, and ownership of specimens will be agreed upon between the individual(s) requesting and the local tissue committee (who will initially negotiate with the owner).
3. If a request is denied, the individual may appeal to the Dean's Committee at that institution.
4. The Clinical Case Studies Committee and the Specimen Banking Committee will keep track of what data is available at each Center and refer any requests to the Tissue Committee at the appropriate institution.
5. Requests to the Universitywide Task Force on AIDS for research funds to support studies utlizing patients or data from the research centers should be accompanied by a letter of cooperation from the local review/tissue committee. Consequently the CCSC recommended that for the next round of requests for grants, the Universitywide Task Force on AIDS ask for a letter of collaboration to be included in the application, thus clairfying ahead of time where an investigator will be obtaining his specimens and that he will have access to them.
6. It was pointed out that the above proposals relegate the Dean's Committees at UCSF and UCLA to position of appeals boards. It is not clear that this was the original intention of the Universityside Task Force on AIDS.

It was discussed that several of the points agreed upon by the participants at the meeting were potential subjects of controversy. One of the major issues related to the process by which individuals outside the Centers could have access to the Centers' data. Dr. Freedman stated that the view of the Task Force was that the Centers were collecting data on <u>contract</u> from the University of California. The participants in the CCSC did not realize that this was the view of the Unversitywide Task Force on AIDS.

There was general agreement on the potential usefulness of the forthcoming site visits of the Centers.

The next meeting of the CCSC was not scheduled at this time.

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PROGRESS REPORT TO THE UNIVERSITYWIDE TASK FORCE ON AIDS

Title: Nuclear Magnetic Resonance Studies of Lymphadenopathy in Patients with AIDS.

Investigators: Susan D. Wall, M.D.
Hedvig Hricak, M.D.
Paul Volberding, M.D.
Thomas L. James, Ph.D.

Award amount: $9,000

Award Cycle: 7/1/83 to 6/30/84 (with proposed extension to 10/31/84)

1. Current Status of the Project:

This study is still in progress. Data collection is, as yet, incomplete due to some logistical difficulties which have been or are being addressed. The patient referral system is being extended to include the community physicians who frequently have contact with AIDS patients before they are seen at San Francisco General Hospital or the University of California, San Francisco. This will increase the number of potential subjects for magnetic resonance imaging. Additionally, the scheduling system for the magnetic resonance scanner has been altered and now is more feasible in regard to the completion of this project. Difficulty with coordinating the appointment time of the MRI scan, the date and time of the patient's lymph node biopsy, and the availability of the 5.6 Tesla magnet for ex-vivo tissue analysis of T_1 and T_2 relaxation times may preclude the latter data accumulation. This would not compromise the outcome of the study; it would ease some logistical obstacles which have been encountered; and it is being considered at this time.

2. Summary of Results to Date Relevant to the Initial Question:

To date, the data accumulation has been limited. It is not yet sufficient to allow for a statement regarding results in reference to the initial question, namely, can magnetic resonance imaging provide a non-invasive in-vivo differentiation of malignant from benign lymphadenopathy in patients with AIDS. However, progress has been made in regard to selection of the optimal imaging parameters for the detection of deep (non-palpable) lymphadenopathy by MRI.

3. Summary of Expenditures To Date:

Not applicable.

N.B.: No billing for MRI scans prior to May 21, 1984.

Susan D. Wall

Susan D. Wall, M.D.
Assistant Professor

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SCHOOL OF MEDICINE
DEPARTMENT OF MEDICINE

SAN FRANCISCO, CALIFORNIA 94143

June 2, 1983

REPORT FROM THE UCSF TASK FORCE ON AIDS

In March 1983 a task force was established by Acting Dean Robert Crede under the chairmanship of Dr. Merle Sande to coordinate and enhance communication between the three UCSF hospitals--Moffitt, VAMC, and San Francisco General--regarding issues dealing with the problems of AIDS. The task force's responsibilities have expanded and include 1) producing a concensus document outlining agreed upon infection control procedures, 2) coordinating efforts aimed at acquiring additional resources and investigations in the area dealing with AIDS, and 3) coordinating educational activities dealing with AIDS. This report deals specifically with the infection issues and represents our best judgement based on current knowledge and it is hoped that this will offer general guidelines from which each individual hospital can formulate its own specific requirements.

Definition of AIDS and Identification of the Problem

AIDS is an acquired immunodeficiency syndrome first recognized in San Francisco in 1981. It appears that the disease did not exist worldwide prior to 1979 but has been increasing at an alarming rate. At the present time approximately 1300 to 1400 cases have been reported in the United States. The disease appears to concentrate in specific high risk epidemiological groups that include gay males (approximately 90% of cases in San Francisco), intravenous drug abusers, hemophiliacs, Haitians, and in some patients receiving transfusions. An estimated 5-6% of all cases have occurred outside of these high risk groups. The disease is characterized by a severe suppression of the cellular immune system and a marked reduction in helper T-cell function, resulting in a predominance of suppressor cell function. Patients are particularly susceptible to the development of Kaposi's sarcoma and opportunistic infections, particularly Pneumocystis carinii pneumonia, disseminated Mycobacterium avium-intracellulare infections, cytomegalovirus infections, chronic herpes simplex ulcerations, pulmonary and disseminated Cryptococcus neoformans infections, disseminated histoplasmosis, Candida albicans infections of the mucous membranes, and certain immunological manifestations including immune thrombocytopenic purpura. The etiology of the disease to date is unknown but epidemiological data suggest a transmissible agent. Several agents including cytomegalovirus, Epstein-Barr virus, or herpes simplex virus have been suggested but no agent has been identified. Transmission of the disease appears to have an epidemiological pattern similar to hepatitis B, and for this reason, the Centers for Disease Control has suggested that hepatitis B precautions be utilized as a

guideline in implementing infection control procedures. This implies that the disease may be transmitted by blood and secretions which might contain blood such as semen, urine, stool, and possibly saliva, and that precautions should be aimed at reducing exposure to these body fluids. The incubation period of the disease appears to be as long as 12 to 24 months. To date, there have been no documented cases of health workers involved in the care of AIDS patients having contracted the disease unless the health care worker was in a high risk group.

Recommended Procedures--Hospitalized Patients

Purpose: To prevent spread of presumably transmissible agents to others and to protect AIDS patients from acquisition of potential opportunistic infections.

1. Isolation procedures should be consistent with hepatitis B guidelines as proposed by the Centers for Disease Control (attached). This should include the use of gloves and hand-washing when in contact with patient's blood or secretions. Gowns are recommended for those likely to have direct contact with patient secretions and blood.

2. Strict isolation rooms per se are not necessary for AIDS patients. However, it may be prudent to admit AIDS patients to private rooms. This is not essential if the patient is not coughing, is cooperative, and can be adequately instructed on blood, secretion, and enteric precautions. It is, however, recommended that when a double room is used that the additional patient not be an impaired host who might be susceptible to the potential opportunistic infections harbored by the patient with AIDS nor should the roommate be a patient who might harbor potential opportunistic infections.

3. Masks are not essential for all AIDS patients, but it is recommended that they be worn by the patient who is actively coughing when out of hospital room. Masks are advisable for visitors or health care personnel who are in direct, sustained contact with these actively coughing patients. The purpose of this recommendation is to prevent the potential aerosolization of a large inoculum and spread of opportunistic infections (Pneumocystis carinii) to other immunosuppressed patients. This recommendation is based on theoretical considerations supported by animal studies since this mode of transmission has not been proven in humans. Masks should also be worn by patients in whom Mycobacterium tuberculosis or other agents known to be spread by the droplet or respiratory route have not been ruled out.

4. AIDS patients should be placed on precautions to include blood, needle, secretion and excretion. Specimens from patients should be labelled "H/A precautions" or another similar designation, without mention of a specific disease and placed in an impervious bag or container for transport.

5. Procedures for equipment use for AIDS patients should be as follows: lensed instruments should be sterilized as recommended by the CDC (attached). Respiratory therapy tubing should at least be pasteurized. Any instrument which comes in contact with blood, secretions or excretions must be sterilized before reuse; this includes anesthesia instruments such as laryngoscopes and tracheal tubes. All such reusable items should be transported in an appropriately labelled impervious bag or container.

6. All contaminated (visibly soiled with potential infectious material) disposable items are to be considered infectious wastes and must be red-bagged. Needles and syringes should be disposed in rigid wall, puncture-resistent containers as specified by the hospital. Needles must not be resheathed after use. Contaminated linen is to be double-bagged.

7. Environmental surfaces contaminated with blood or other body fluids should be immediately cleansed with a disinfectant such as sodium hypochlorite.

Recommended Procedures--Outpatients

The general guidelines for hospitalized patients used for hepatitis B precautions should also be applied to the outpatient and emergency settings. Efforts should be made, however, to minimize direct contact to other severely immunocompromised patients. Specimen-labelling, equipment sterilization, and disposition of equipment will be handled as for hospitalized patients. AIDS outpatients may use common waiting areas and bathroom facilities.

Recommended Procedures--Hospital Employees

1. The following protective apparel for hospital workers is recommended:

   Gloves when personnel are in direct contact with blood or secretions and excretions of AIDS patients.

   Gowns when clothing may become contaminated with blood, excretions or secretions. Water-protective barrier gowns are recommended when there will be exposure to large volumes of secretions.

   Masks when in direct sustained contact with actively coughing patients with AIDS as detailed on page 2, item 3.

   Eye protection in situations where splatter with blood or bloody secretions is expected.

   These protective devices are only necessary when hospital personnel are directly exposed to blood and/or excretions. Such apparel is not necessary if there will only be casual contact while in patient's room.

2. Employees who have needle-stick injuries associated with the care of AIDS patients should be reported to the employee health service in their hospital and ongoing records maintained. The injured employee should then be treated according to the protocol for needle-stick exposure for potential hepatitis at their hospital. At the present time the task force does not recommend follow-up lymphocyte studies since numerous intercurrent illnesses have been shown to reverse the helper-suppressor ratio. Thus, information so derived has a potential for producing untoward anxiety, while not accurately predicting or identifying the disease--AIDS.

3. It is the recommendation of the task force that personnel should not be excused on their own request from delivering care to AIDS patients. Employees who believe they are at high risk for infection because of their own immune status should be encouraged to discuss their work responsibilities with their personal physician. If the physician determines that there are certain assignments the employee should not accept, this should be communicated in writing to the employing department for appropriate action, according to the institution's policies and procedures. Pregnant employees should not engage in the direct care of patients with AIDS because of the possible risk of acquiring cytomegalovirus.

4. Hospital employees who have AIDS and are directly involved in patient care require special consideration. Their continued contact with patients raises concern about the potential spread of infectious diseases to them from infected patients and vice versa; we do not consider the direct transmission of AIDS itself to patients to be likely as there is to date no evidence supporting casual contagion. We are concerned, however, that the employees with AIDS may have an undiagnosed transmissible infection such as CMV or pneumocystis and may thus represent a small but real risk to patients who might themselves be immunosuppressed. An equally important problem is the potential for transmission of unsuspected and undiagnosed infections from patients to the employee with AIDS.

   The task force has had particular difficulty developing a concensus position on this issue. All agreed that when an AIDS employee is symptomatic he should not be directly involved in patient care. It was agreed that asymptomatic AIDS employees could be approached in two different ways.

   A. A hospital could decide to make an effort to reassign asymptomatic AIDS employees to nonpatient care positions in order to protect the employee from nosocomial pathogens and protect high risk patients from pathogens possibly carried by the employee.

B. A hospital could consider each asymptomatic AIDS employee on a case by case basis, through their employee health service in conjunction with recommendations from the employee's private physician, to determine that 1) the employee is free from transmissible infection, 2) the employee is not unduly susceptible to infections he might come in contact with in the line of performing his patient care duties. Patient care responsibilities could then be assigned according to an ongoing clinical evalutation of the AIDS employee's status.

These guidelines should be applied to employees with AIDS as defined by the CDC, including biopsy-proven Kaposi's sarcoma, opportunistic infections, and unexplained wasting febrile illnesses in members of AIDS risk groups.

This document represents a working statement. In light of the unknown nature of this disease, the task force will reveiw and refine these guidelines as necessary in light of additional scientific findings concerning AIDS.