

THE AIDS HEALTH PROJECT

The AIDS HEALTH PROJECT has worked with hundreds of people as they confront such sensitive issues as health, drug and alcohol use, and sexuality. We are devoted to supporting people "at risk" for AIDS, people with AIDS, and those with AIDS-Related Conditions as they explore their needs and feelings, and to help them make choices about their health behaviors.

We know change isn't easy.
That's why we're here.

How to participate in our programs:

If you're interested in participating in our programs or finding out more about our services, call

626-6637

People with AIDS may call Judy Macks or Calú Lester at 821-8830 for more information on our free services available to them.

If you have concerns about drug and alcohol use and AIDS, call Barbara Faltz or Scott Madover at 821-8764.

WE CAN CHALLENGE AIDS NOW!

"The AIDS Health Project groups help people to make positive responses to difficult challenges in their lives. They offer a safe environment to learn about risk reduction and to find support during this time of crisis."

Jackson Peyton, Education Director
San Francisco AIDS Foundation

NEW ADDRESS:

THE UCSF AIDS HEALTH PROJECT

333 Valencia Street
San Francisco, CA 94103
(415) 626-6637

Graphics: Buzz Bense Design
Typesetting: En Character Typography
Printing: Printmasters

THE AIDS HEALTH PROJECT

A HEALTH PROMOTIONAL EFFORT

Educational Support Groups

"I joined a stress reduction group with both curiosity and skepticism. The weekly meetings soon became a unique place to receive support different from what friends provide. The stress didn't magically disappear, but the groups helped me learn how to cope with it better. The groups also convinced me that my peers both support and encourage personal health behavior changes."

Michael Helquist, Journalist

Making changes doesn't have to be lonely.

What we do:

The **AIDS HEALTH PROJECT** is a supportive health promotion program for people at risk for AIDS, and those with AIDS and AIDS Related Conditions. Our Project is sponsored by the University of California, San Francisco, and funded by the City of San Francisco, Department of Public Health.

Who we are:

We provide low-cost educational support groups. No one will be turned away for lack of funds. These short-term groups are focused on various aspects of creating a healthier lifestyle, including AIDS prevention. The groups meet once a week for two hours and are led by mental health professionals who are knowledgeable and sensitive to persons at risk.

"The Project's educational and stress reduction groups have been exactly the help needed by friends and clients I've referred to the Project. In combatting AIDS, the groups have been crucial."

Tim Wolfred, Coordinator of Men's Services, Operation Concern

Groups for People at Risk for AIDS

The Integrated Health Group

This group assists participants to review their health and sexual behaviors, and to express their feelings related to the AIDS crisis. Participants are encouraged to develop goals for health and sexual behaviors, and are supported in making those changes. Feelings of hopelessness and helplessness are redirected to make positive lifestyle changes in a sex-positive manner.

The Stress Management Group

This group assists participants to assess the level and types of stress in their lives, to understand the physiological and psychological effects of stress, and to learn techniques to help modify these effects. Various approaches are presented, including progressive muscle relaxation, meditation, guided imagery and visualization, problem solving and social support as ways to reduce stress. Participants are encouraged to practice the exercises and develop an ongoing stress management program.

Hot and Healthy Sex

Participants explore ways to find greater satisfaction in their sex lives, while remaining within the guidelines for healthy sex. Sexual alternatives, sex play, communication, and sexual self-esteem are discussed in a non-threatening, supportive atmosphere.

Groups for people with AIDS Related Conditions

Available for people with "serious" or "mild to moderate" AIDS Related Conditions, these groups combine aspects of stress management, healthy sex, and integrated health. The groups focus on the development of coping skills and the psychological aspects of living with ill health.

Groups for People with AIDS

The Stress Management Group provides training in stress reduction, relaxation and visualization.

The Couples Group assists couples in which at least one partner has AIDS to share their feelings and explore their experiences in a group setting. The group focuses on communication between partners and how decisions are made by the couple.

STARTING NOW: STRATEGIES FOR COPING

By taking the AIDS Antibody blood test, you have expressed an important interest and concern about your current state of health. While you are awaiting the results of your test, it would not be unusual to experience some feelings of anxiety or worry about the possible outcome. Remember, you cannot change your past life events or behavior. However, you can change your ongoing behavior one day at a time. Assume an active role in maintaining your mental and physical health.

Use the following strategies to cope with any stress you may experience during this two week waiting period and to promote and maintain your health into the future.

- * Maintain a lowfat, low salt, balanced diet; get plenty of rest, and sleep; avoid stressful situations.
- * Decrease or eliminate alcohol and recreational drug use. Contrary to popular myth, use of drugs actually increases your overall stress.
- * Keep active! Structure your time with interests and activities you enjoy.
- * Engage in some form of physical exercise which you enjoy.
- * Talk about your feelings and concerns with a loved one, friend or medical/mental health professional whom you trust. Spiritual growth can also be helpful.
- * Maintain a sense of humor. There is a whole lot of silliness in the world to be appreciated.
- * Remind yourself: A positive test does not mean that you are certain to get AIDS or an AIDS related condition.
- * Continue to follow the AIDS safe sex and needle cleaning guidelines.

Should you need or desire additional assistance in coping with feelings and concerns here is a short list of community resources:

AIDS Hotline (San Francisco AIDS Foundation).....	863-AIDS (2437)
UCSF AIDS Health Project:	
Information, crisis intervention.....	476-6430
substance abuse program.....	821-8764
mental health programs.....	821-8830
City of San Francisco, Mission Crisis.....	558-2071
Mt. Zion Crisis Clinic.....	885-7290
Suicide Prevention Crisis Line.....	221 1423
Mental Health Information and referral.....	387-5100

Your result will be given to you, individually and in private, by a counselor from the UCSF AIDS Health Project. Should you be unable to keep your appointment please call 621-4858 to reschedule your appointment.

AIDS FEDERAL FUNDING TESTIMONY

Before the House Labor, Health and Human Services, Education
Appropriations Subcommittee

May 12, 1983

David G. Ostrow, MD, PhD

Chairperson, Chicago AIDS Task Force

Director of Research, Howard Brown Memorial
Clinic, Chicago

Special Assistant to Chicago Department of
Health for AIDS Program Development

Associate Professor, Northwestern University
Medical School Department of Psychiatry and
Department of Community Health and Preventive
Medicine

I am extremely honored to join my colleagues in addressing this Congressional hearing on the problem of Acquired Immunodeficiency Syndrome (AIDS) and federal funding aimed at combatting this devastating disease. No doubt you are already aware of the rapidly increasing number of AIDS cases, approximately 1400 at this time according to the CDC AIDS Task Force, and the clinical manifestations. Nor is it necessary for me to discuss the major groups currently affected and the fact that additional groups, such as infants, will undoubtedly be added as the disease spreads. Rather, I want to address four specific problems in the federal government's attempts to understand and prevent this disease and to suggest several ways in which those efforts can be hastened. The major problems which I will briefly discuss relate to the traditional governmental approaches to medical investigations and the non-traditional aspects of the disease under investigation. The major point which I wish to make is that only through a major crash program of research that goes outside of the standard formats can we hope to make major progress in the immediate future. And each year, month, or even day that our ignorance of the cause(s) and prevention of AIDS continues means that additional US citizens' lives are endangered or ended.

Problem #1: The medical research grant cycle has a turn around time of one to two years. AIDS currently has a doubling time of six to eight months, meaning that the numbers of AIDS cases will quadruple or increase eight-fold during the normal grant award cycle.

We first learned of the emergence of AIDS in early 1981; my own awareness of the problem as it affected the gay male community came during the June, 1981 CDC National STD Training Conference in San Diego. At that conference I presented a keynote address on sexually transmitted disease problems affecting gay men, and a subsequent workshop on these problems revealed an alarming number of reports regarding this newly described outbreak of opportunistic infections and neoplasms. Upon returning to Chicago, I immediately contacted the heads of infectious disease departments at the major medical institutions in the Chicago area. None reported obvious AIDS cases, but several patients were being studied for unusual infections. By the fall of 1981, with the national AIDS tally at about two hundred cases, the first confirmed Chicago-area cases and two deaths were reported. At that time, I joined with Dr. John Phair, Chief of Infectious Diseases at Northwestern University Medical School (NUMS) and other colleagues to begin an organized study both of AIDS cases and persons at risk for the development of AIDS. Those early efforts were helped by the willingness of both patients and healthy gay men participating in our hepatitis B vaccine studies to undergo immunological testing and were supported by the research programs of both the Howard Brown Memorial Clinic (HBMC) and NUMS. But it was spurred on by the growing awareness that AIDS was not just a problem isolated to several cities and one or two groups. With each new case admitted to the intensive care unit or with each person with unexplained lymphadenopathy referred for more intensive testing, the reality of AIDS and the threat it posed to everyone's health grew.

By early 1982, our studies had confirmed that the dozen or so AIDS cases in Chicago were similar in epidemiological and immunological characteristics to the cases in New York City and California. Work began on the preparation of a major grant proposal to the National Cancer Institute, which issued the first RFP for AIDS research proposals. Utilizing our experience in the hepatitis B research area, we developed an open-ended prospective risk factor identification strategy which would allow us to address simultaneously several major questions concerning the etiology and clinical spectrum of AIDS.

Work progressed simultaneously during the summer of 1982 on the preparation of our grant proposal and the continued acquisition of AIDS patients and control subjects for the prospective study. By the fall of 1982 we had completed both the grant proposal and the initial studies. These studies confirmed some of our initial findings and were presented at a variety of clinical research meetings. Along the way we have extended our knowledge of hepatitis B and its possible use as a model for immunosuppressive viral infection. The final grant proposal--consisting of two hundred pages of data, methodology, and supporting information--represented hundreds of hours of work by researchers, clinicians, and volunteers, and an investment of at least \$50,000 in laboratory support by NUMS and HBMC. It was submitted to NCI on October 22, 1982. In February of this year, approximately eighteen months after beginning our work for this proposal, we received the response from NCI. Our grant proposal was one of 22 approved studies but was not one of the four studies to be funded during this grant cycle. To date, we have received no further feedback from NCI concerning the reasons why this study was not

funded, nor have we received any suggestions for improving the grant proposal design for resubmission.

The course of events outlined above is not unusual for federal research programs, nor would it be so inappropriate if we were dealing with a long-standing or less disastrous disease condition. My colleagues and I are used to having first or second grant applications denied funding and we use these opportunities to improve and sharpen the focus of research proposals. But we are dealing here with a "new" disease that has claimed seven hundred lives in the last 2 years alone and threatens to kill thousands more. Therefore, I am here today to ask not only for increased funding of AIDS research programs but also for modifications in the manner in which research proposals are solicited and reviewed for funding. Much can be learned from the manner in which the hepatitis B studies were collaboratively developed by the Centers for Disease Control, several major medical research institutions, and gay community-oriented STD clinics. Those studies, which progressed from the identification of a major disease epidemic to the establishment of the causes of that epidemic to the development of an effective preventive vaccine in the course of five years, were developed through active on-going collaboration among the participants. It did require legislative action to enable the CDC with the collaborative research award mechanism to fund those studies (Title 318B), and it may require similar legislative action to enable NCI, NIAID, and other public health institutions to respond most effectively to this new health crisis.

Problem #2: Epidemiological studies cannot unequivocally prove causality but do provide essential information regarding interrelated risk factors. Conversely, investigations aimed at proving/disproving the role of individual causative agents have turned up a number of promising leads, but each one is at odds with one or more of the epidemiological findings.

The list of putative AIDS agents keeps growing almost as fast as the number of cases. Volatile nitrites, cytomegalovirus (CMV), the hepatitis B virus or the vaccine made from it, amoebas, Mycobacterium avium-intracellulare and, most recently, human adult T-cell leukemia virus (ATLV) have all been suggested as the cause of AIDS; each has failed one or more of the tests for a single causative agent. In addition, since studies to date have focused on patients meeting the stringent CDC-criteria for AIDS--namely, a life-threatening (terminal) opportunistic infection or neoplasm--it is quite possible that the causative agent(s) is no longer present in a significant proportion of patients by the time they reach the terminal stage of the disease. In fact, the current estimated incubation period of 8-36 months makes it quite likely that the initiating factor(s) is altered by the time clinically apparent AIDS is present.

By limiting the definition of AIDS to a very narrow spectrum of patients, there is an additional problem beyond that of hindering our efforts at studying etiology. The actual size of the AIDS epidemic in the US may be grossly underestimated by the CDC Task Force's tabulations. There may already be tens of thousands of individuals with AIDS-related symptoms such as the unexplained lymphadenopathy

syndrome. While I agree that we should not prematurely label persons with AIDS until we are absolutely sure that their disease fits this syndrome in order not to unduly alarm them, there needs to be a systematic effort to collect information on such individuals in order that we may understand the full extent of the problem and work to solve it. Again, my attempts to enlist CDC support towards developing such a system have fallen on deaf ears. Perhaps, as the numbers of AIDS cases and related syndromes increases, the CDC is truly overwhelmed and cannot mount the effort necessary to interview or even keep track of all the cases. But then shouldn't they be willing to turn over to a national community-based network this task and provide the funding and consultative assistance necessary to perform this crucial work?

The only solution to these problems inherent in the AIDS disease process and our ignorance of its causes is the establishment of large-scale prospective studies involving populations at varied risk for the disease. Such studies are expensive, inherently slow and need to be quite intensive in order to have a high likelihood for finding the actual cause. In order to accelerate the possible pace of such studies, I recommended to the CDC AIDS Task Force, in September of last year, the establishment of a national network which would capitalize on the different stages of the epidemic progress of the disease in different geographical areas around the US. While initially enthusiastic about the proposal, there has been no response by the CDC to further enquiries and letters detailing progress made on establishing the network. Even a request for limited monies for secretarial support to continue the increasing correspondence required

to communicate among the ever-growing number of groups and individuals interested in participating in the network (currently 25 in 18 major cities or areas) has been met by responses "we have no money for studies of this kind" from the CDC. There appears to be a two-sided response from CDC officials to requests for support for the establishment of the network necessary both to monitor the spread of AIDS and provide the basis for extensive prospective studies: to persons such as myself, desperately in need of funds to continue our work, the response is "great idea, but no money." To Congress and others interested in supplying the funds for such studies, the response has apparently been "we have enough funds for these efforts" (Clinical Labs/Blood Banks Newsletter, April 26, 1983, page 3). This is unfortunate because it was, in large part, the CDC's enthusiastic support of grass-roots research on hepatitis B in homosexually active men which led to the networking which would make a coordinated national response to AIDS possible. It is not my role nor area of expertise to speculate on the reasons for this change in the CDC's role from one of actively encouraging a community response to infectious disease problems to their current "passive" role in AIDS research. However, I will again point to the example of the hepatitis B research programs and suggest that coordinated, multi-centered, prospective research studies which involve the communities most affected by the AIDS problem be established. I feel that I am speaking for communities at risk not only in Chicago, but nationwide, when I say that studies of this sort would have their enthusiastic support and cooperation.

Problem #3: Communication of ideas and knowledge from the research laboratory to clinical practice and vice versa is a slow and difficult process. Yet this is precisely the final barrier to converting any knowledge we may gain on the research front to other fronts in the battle against AIDS.

What are we doing now to educate clinicians about AIDS? To educate researchers in laboratories about the role they could be playing in this area? Of educating public health workers to the problem of counseling potential AIDS patients about ways to decrease their disease risks or to allay their irrational fears? Virtually nothing. In fact, to return to the analogy with our hepatitis B experience, we can see that the application of valuable information resulting from problem-solving research can be severely limited by factors beyond the control of the scientists and administrators involved in that research. Our efforts to utilize the hepatitis B vaccine to decrease the spread of this serious infection have been stymied by a variety of factors, none of which were foreseen during the vaccine development. Not the least has been AIDS itself, which has both cast an irrational cloud over considerations of the hepatitis B vaccine's safety, and called for a necessary diversion of our efforts and resources.

I cannot say that I have any simple remedies for the perennial problems of education and translation of information into change. I am sure that the members of the education subcommittee are well aware of these problems. More money for research alone will not ensure a timely curtailment of the spread of AIDS. Even if we could follow the

successful example of our hepatitis B research, it would be at least 5 years before an "AIDS vaccine" or other preventive measure is developed and ready for clinical application. And by then, given even the current rate of transmission of AIDS, we could expect to have 5,000 to 10,000 cases and at least half that many fatalities. Public health and educational efforts must be developed now to curtail the spread of AIDS while we are awaiting scientific answers and preventive measures. At least as much money as will be appropriated for AIDS research needs to be appropriated for educational and public health efforts.

Problem #4: The treatment of AIDS at this time must be considered as therapeutic research, incorporating all of the necessary laboratory, consent and invasive procedures which such research entails. For the AIDS patient and his/her family and intimates, already suffering under the psychological strain of this devastating illness, the rigors of intensive treatment in a setting of precautionary isolation can be traumatizing.

As already discussed, the diagnosis of AIDS can only be definitively made at a point where the patient is suffering from a life-threatening condition. In addition, even if the presenting primary infection or neoplasm is successfully treated, the patient knows that his immune system is permanently damaged and that he is at very high risk for a recurrence or new life-threatening condition. Of the 26 AIDS patients identified in Chicago during the past three years, 17 are deceased, including all those diagnosed in 1980 and

1981. For the lucky survivors, life is an endless battle against seen and unseen threats to their existence. Contacts with the healthcare system invariably lead to increased anxiety over such questions as: What new disease am I developing? Will the doctors and nurses understand what I am going through? Will my insurance cover the costs of "experimental" treatments? Will I be told to stop shaking hands with others? I have seen the development of at least two major psychiatric syndromes in these patients--severe depression and phobic avoidance of contact with any other human being. Undoubtedly, suicides have occurred among AIDS patients and persons at risk.

The strains resulting from working with a potentially fatal infectious disease can be equally severe for the healthcare workers assigned to the care of AIDS patients. In addition, there are relatively few persons trained to treat the severe and unusual infections seen in AIDS patients. Overloaded by patients desperately seeking their services, disheartened by the frequent failures of even their most heroic treatment efforts, and aware that they may be working with a deadly agent, these healthcare workers are themselves suffering from psychological problems which include depression and "burnout."

Therefore, any research programs in the therapy of AIDS must be performed with the utmost sensitivity to the psychological problems of patients, their families and the persons caring for them. The primary relationship between the patient and his/her personal physician must be respected and resources for psychological support must be provided side-by side with medical technologies. I am proud to say that community organizations in several of the major cities, namely New

York City, San Francisco and Chicago, have all established such coordinated medical-psychological support programs for AIDS patients. But the dearth of federal funding for AIDS programs at the local level has stressed those organizations and the individuals working in them to the breaking point. All of the persons who have communicated with me regarding the proposed national case-finding network have responded with similar pleas for financial help so that they can continue the fine work they are already doing, let alone further intensify their case-finding and research efforts. The results of these stresses can be seen at all levels of government and the public and private healthcare sectors.

In summary, I am here to urge both increased funding for AIDS research and specific measures to increase the effectiveness of those outlays and their ultimate impact on the persons suffering most directly from this disease. These persons are young (average age of AIDS patients in Chicago is 36 years old), well educated (average educational level is two to three years of college), and many had already made significant contributions to our country's culture and industry prior to developing AIDS. The waste in terms of human lives and energy is enormous and needs to be matched by Congressional funding efforts. Members of my own district are wondering if the inertia they see in both federal appropriation efforts and CDC/NIH efforts on AIDS is an example of discrimination against the populations at highest risk for AIDS. I hope that the response of this committee to today's testimony will strongly repudiate those fears.

Attachments:

1. Ostrow DG, Altman NL: Sexually Transmitted Diseases and Homosexuality, January 15, 1983.
2. Clinical Labs/BloodBankc Newsletter, April 26, 1983, page 3.



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 consensus 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-resistant 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 consensus 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 evaluation 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 review and refine these guidelines as necessary in light of additional scientific findings concerning AIDS.



SCHOOL OF MEDICINE
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SAN FRANCISCO, CALIFORNIA 94143

June 2, 1983

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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-resistant 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 consensus 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 evaluation 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 review and refine these guidelines as necessary in light of additional scientific findings concerning AIDS.



MORBIDITY AND MORTALITY WEEKLY REPORT

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Current Trends

**Acquired Immune Deficiency Syndrome (AIDS):
Precautions for Clinical and Laboratory Staffs**

The etiology of the underlying immune deficiencies seen in AIDS cases is unknown. One hypothesis consistent with current observations is that a transmissible agent may be involved. If so, transmission of the agent would appear most commonly to require intimate, direct contact involving mucosal surfaces, such as sexual contact among homosexual males, or through parenteral spread, such as occurs among intravenous drug abusers and possibly hemophilia patients using Factor VIII products. Airborne spread and interpersonal spread through casual contact do not seem likely. These patterns resemble the distribution of disease and modes of spread of hepatitis B virus, and hepatitis B virus infections occur very frequently among AIDS cases.

There is presently no evidence of AIDS transmission to hospital personnel from contact with affected patients or clinical specimens. Because of concern about a possible transmissible agent, however, interim suggestions are appropriate to guide patient-care and laboratory personnel, including those whose work involves experimental animals. At present, it appears prudent for hospital personnel to use the same precautions when caring for patients with AIDS as those used for patients with hepatitis B virus infection, in which blood and body fluids likely to have been contaminated with blood are considered infective. Specifically, patient-care and laboratory personnel should take precautions to avoid direct contact of skin and mucous membranes with blood, blood products, excretions, secretions, and tissues of persons judged likely to have AIDS. The following precautions do not specifically address outpatient care, dental care, surgery, necropsy, or hemodialysis of AIDS patients. In general, procedures appropriate for patients known to be infected with hepatitis B virus are advised, and blood and organs of AIDS patients should not be donated.

The precautions that follow are advised for persons and specimens from persons with opportunistic infections that are not associated with underlying immunosuppressive disease or therapy; Kaposi's sarcoma (patients under 60 years of age); chronic generalized lymphadenopathy, unexplained weight loss and/or prolonged unexplained fever in persons who belong to groups with apparently increased risks of AIDS (homosexual males, intravenous drug abusers, Haitian entrants, hemophiliacs); and possible AIDS (hospitalized for evaluation). Hospitals and laboratories should adapt the following suggested precautions to their individual circumstances; these recommendations are not meant to restrict hospitals from implementing additional precautions.

A. The following precautions are advised in providing care to AIDS patients:

1. Extraordinary care must be taken to avoid accidental wounds from sharp instruments contaminated with potentially infectious material and to avoid contact of open skin lesions with material from AIDS patients.

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Acquired Immune Deficiency Syndrome — Continued

2. Gloves should be worn when handling blood specimens, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.
3. Gowns should be worn when clothing may be soiled with body fluids, blood, secretions, or excretions.
4. Hands should be washed after removing gowns and gloves and before leaving the rooms of known or suspected AIDS patients. Hands should also be washed thoroughly and immediately if they become contaminated with blood.
5. Blood and other specimens should be labeled prominently with a special warning, such as "Blood Precautions" or "AIDS Precautions." If the outside of the specimen container is visibly contaminated with blood, it should be cleaned with a disinfectant (such as a 1:10 dilution of 5.25% sodium hypochlorite [household bleach] with water). All blood specimens should be placed in a second container, such as an impervious bag, for transport. The container or bag should be examined carefully for leaks or cracks.
6. Blood spills should be cleaned up promptly with a disinfectant solution, such as sodium hypochlorite (see above).
7. Articles soiled with blood should be placed in an impervious bag prominently labeled "AIDS Precautions" or "Blood Precautions" before being sent for reprocessing or disposal. Alternatively, such contaminated items may be placed in plastic bags of a particular color designated solely for disposal of infectious wastes by the hospital. Disposable items should be incinerated or disposed of in accord with the hospital's policies for disposal of infectious wastes. Reusable items should be reprocessed in accord with hospital policies for hepatitis B virus-contaminated items. Lensed instruments should be sterilized after use on AIDS patients.
8. Needles should not be bent after use, but should be promptly placed in a puncture-resistant container used solely for such disposal. Needles should not be reinserted into their original sheaths before being discarded into the container, since this is a common cause of needle injury.
9. Disposable syringes and needles are preferred. Only needle-locking syringes or one-piece needle-syringe units should be used to aspirate fluids from patients, so that collected fluid can be safely discharged through the needle, if desired. If reusable syringes are employed, they should be decontaminated before reprocessing.
10. A private room is indicated for patients who are too ill to use good hygiene, such as those with profuse diarrhea, fecal incontinence, or altered behavior secondary to central nervous system infections.

Precautions appropriate for particular infections that concurrently occur in AIDS patients should be added to the above, if needed.

B. The following precautions are advised for persons performing laboratory tests or studies on clinical specimens or other potentially infectious materials (such as inoculated tissue cultures, embryonated eggs, animal tissues, etc.) from known or suspected AIDS cases:

1. Mechanical pipetting devices should be used for the manipulation of all liquids in the laboratory. Mouth pipetting should not be allowed.
2. Needles and syringes should be handled as stipulated in Section A (above).
3. Laboratory coats, gowns, or uniforms should be worn while working with potentially infectious materials and should be discarded appropriately before leaving the laboratory.
4. Gloves should be worn to avoid skin contact with blood, specimens containing blood, blood-soiled items, body fluids, excretions, and secretions, as well as surfaces, materials, and objects exposed to them.

Acquired Immune Deficiency Syndrome - Continued

5. All procedures and manipulations of potentially infectious material should be performed carefully to minimize the creation of droplets and aerosols.
 6. Biological safety cabinets (Class I or II) and other primary containment devices (e.g., centrifuge safety cups) are advised whenever procedures are conducted that have a high potential for creating aerosols or infectious droplets. These include centrifuging, blending, sonicating, vigorous mixing, and harvesting infected tissues from animals or embryonated eggs. Fluorescent activated cell sorters generate droplets that could potentially result in infectious aerosols. Translucent plastic shielding between the droplet-collecting area and the equipment operator should be used to reduce the presently uncertain magnitude of this risk. Primary containment devices are also used in handling materials that might contain concentrated infectious agents or organisms in greater quantities than expected in clinical specimens.
 7. Laboratory work surfaces should be decontaminated with a disinfectant, such as sodium hypochlorite solution (see A5 above), following any spill of potentially infectious material and at the completion of work activities.
 8. All potentially contaminated materials used in laboratory tests should be decontaminated, preferably by autoclaving, before disposal or reprocessing.
 9. All personnel should wash their hands following completion of laboratory activities, removal of protective clothing, and before leaving the laboratory.
- C. The following additional precautions are advised for studies involving experimental animals inoculated with tissues or other potentially infectious materials from individuals with known or suspected AIDS.
1. Laboratory coats, gowns, or uniforms should be worn by personnel entering rooms housing inoculated animals. Certain nonhuman primates, such as chimpanzees, are prone to throw excreta and to spit at attendants; personnel attending inoculated animals should wear molded surgical masks and goggles or other equipment sufficient to prevent potentially infective droplets from reaching the mucosal surfaces of their mouths, nares, and eyes. In addition, when handled, other animals may disturb excreta in their bedding. Therefore, the above precautions should be taken when handling them.
 2. Personnel should wear gloves for all activities involving direct contact with experimental animals and their bedding and cages. Such manipulations should be performed carefully to minimize the creation of aerosols and droplets.
 3. Necropsy of experimental animals should be conducted by personnel wearing gowns and gloves. If procedures generating aerosols are performed, masks and goggles should be worn.
 4. Extraordinary care must be taken to avoid accidental sticks or cuts with sharp instruments contaminated with body fluids or tissues of experimental animals inoculated with material from AIDS patients.
 5. Animal cages should be decontaminated, preferably by autoclaving, before they are cleaned and washed.
 6. Only needle-locking syringes or one-piece needle-syringe units should be used to inject potentially infectious fluids into experimental animals.

The above precautions are intended to apply to both clinical and research laboratories. Biological safety cabinets and other safety equipment may not be generally available in clinical laboratories. Assistance should be sought from a microbiology laboratory, as needed, to assure containment facilities are adequate to permit laboratory tests to be conducted safely.

Reported by Hospital Infections Program, Div of Viral Diseases, Div of Host Factors, Div of Hepatitis and

Acquired Immune Deficiency Syndrome — Continued

Viral Enteritis, AIDS Activity, Center for Infectious Diseases, Office of Biosafety, CDC, Div of Safety, National Institutes of Health.

Epidemiologic Notes and Reports

Isolation of *E. coli* 0157:H7 from Sporadic Cases of Hemorrhagic Colitis — United States

Since the beginning of August 1982, stool isolates of *Escherichia coli* serotype 0157:H7 have been identified at CDC from specimens obtained from four patients in two states. Three of four patients had an unusual bloody diarrheal illness; each illness began suddenly with severe crampy abdominal pain followed within 24 hours by watery diarrhea, which subsequently became markedly bloody. One patient underwent a laparotomy to rule out appendicitis. All patients recovered within 7 days without complications or specific therapy. In one instance, *E. coli* 0157:H7 was isolated from the stool of a patient's spouse. This fourth patient had abdominal cramps and non-bloody diarrhea. Since early August, 25 additional sporadic cases of this unusual illness have been reported to CDC, but appropriately collected stool specimens were available in only two of these. *E. coli* 0157:H7 was not isolated from either specimen. The four patients with sporadic cases in which *E. coli* was isolated from

(Continued on page 585)

TABLE I. Summary—cases of specified notifiable diseases, United States

Disease	43rd Week Ending			Cumulative, First 43 Weeks		
	October 30, 1982	October 31, 1981	Median 1977-1981	October 30, 1982	October 31, 1981	Median 1977-1981
Aseptic meningitis	307	216	216	7,307	8,032	6,288
Brucellosis	7	4	4	137	141	147
Encephalitis: Primary (arthropod-borne & unsp.)	41	31	30	1,149	1,238	980
Post-infectious	1	-	3	50	79	181
Gonorrhea: Civilian	14,141	19,008	21,991	787,973	831,987	829,232
Military	276	520	511	21,897	23,237	22,824
Hepatitis: Type A	425	531	567	18,521	20,772	24,118
Type B	402	484	308	17,572	16,877	13,606
Non A, Non B	40	N	N	1,879	N	N
Unspecified	154	213	207	7,402	8,944	8,516
Legionellosis	4	N	N	428	N	N
Leprosy	3	4	3	165	214	147
Malaria	16	15	17	883	1,184	633
Measles (rubeola)	44	28	61	1,491	2,739	13,074
Meningococcal infections: Total	42	58	35	2,420	2,926	2,179
Civilian	42	58	35	2,407	2,915	2,159
Military	-	-	-	13	11	16
Mumps	46	59	105	4,492	3,655	11,824
Pertussis	137	24	24	1,383	1,039	1,422
Rubella (German measles)	16	9	51	2,109	1,865	11,007
Syphilis (Primary & Secondary): Civilian	604	590	590	27,127	25,464	20,615
Military	11	9	8	366	325	258
Tuberculosis	440	641	557	21,139	22,381	22,745
Tularemia	12	3	3	220	231	171
Typhoid fever	5	16	9	333	495	432
Typhus fever, tick-borne (RMSF)	4	8	12	945	1,134	1,075
Rabies, animal	112	108	96	5,203	6,236	4,281

TABLE II. Notifiable diseases of low frequency, United States

	Cum 1982		Cum 1982
Anthrax	-	Polio myelitis, Total	4
Botulism (Md 1, Utah 1, Calif 1)	70	Paralytic	4
Cholera	-	Psittacosis (S.C. 1)	101
Congenital rubella syndrome	5	Rabies, human	-
Diphtheria	2	Tetanus	67
Leptospirosis	55	Trichinosis (Ohio 1, Mo. 1)	77
Plague	18	Typhus fever, flea-borne (endemic, murine) (Hawaii 2)	38

E. coli 0157:H7 - Continued

stools and 24 of the remaining 25 patients with sporadic cases had eaten hamburgers from a variety of sources (including homes and/or local or national-chain restaurants) within the week before they became ill.

Examination of stool samples from sporadic cases of this recently recognized diarrheal illness, currently designated "hemorrhagic colitis," began at CDC after *E. coli* 0157:H7 was isolated from patients in two separate outbreaks of this illness earlier this year in Oregon and Michigan. Illness was associated with eating hamburgers at restaurants of one national chain.

Hemorrhagic colitis appears to be a distinct clinical entity, characterized by severe crampy abdominal pain, grossly bloody diarrhea, little or no fever, a characteristic barium-enema finding of marked edema involving the cecum, ascending and/or transverse colon, and the absence of usual pathogens in stool.

Reported by RR Uyeyama, MD, Good Samaritan Hospital, San Jose, SB Werner, MD, S Chin, MD, State Epidemiologist, California Dept of Health Svcs; SF Pearce, MD, CL Kollip, MD, Portland Adventist Medical Center, Portland, LP Williams, DVM, JA Googins, MD, State Epidemiologist, Oregon State Health Div; Enteric Diseases Br, Div of Bacterial Diseases, Center for Infectious Diseases, CDC.

Editorial Note: The diagnoses of hemorrhagic colitis are based on the typical clinical presentation and isolation of *E. coli* 0157:H7 from the stool specimens. Early stool collection (within 4 days after onset of illness and before any antibiotic exposure) is crucial for detecting the *E. coli*, so physicians encountering typical cases need to ensure that stool samples are obtained and a portion held frozen (preferably at -70 C [-94 F] or on dry ice) while their laboratories perform routine examinations for *Salmonella*, *Shigella*, *Campylobacter*, *Yersinia*, and parasites. If these test results are negative, arrangements can be made through the state epidemiologist and state laboratory director to look for *E. coli* 0157:H7 in the frozen specimen. Those state laboratories that do not have the antisera to identify *E. coli* 0157:H7 may wish to send either the whole frozen stool or 10 picks (if possible) of *E. coli* colonies to CDC. This strain of *E. coli* 0157:H7 does not ferment sorbitol, and this biochemical property may facilitate screening for this serotype. Further studies are under way at CDC to better characterize the epidemiology of hemorrhagic colitis, the reservoir of *E. coli* 0157:H7, and serologic methods to confirm infection.

Epidemiologic investigation of the outbreaks showed that one source of *E. coli* 0157:H7 is hamburger. Other enteric diseases, such as salmonellosis, have been reported following consumption of hamburger (1). Careful handling and adequate cooking of raw meat products should minimize or eliminate the risk of contracting infectious diseases from this source.

Reference

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Current Trends

Subacute Sclerosing Panencephalitis Surveillance — United States

Subacute sclerosing panencephalitis (SSPE) is a slow-virus infection of the central nervous system associated with prior measles infection. Onset generally occurs in late childhood or adolescence and is usually characterized by the insidious onset of mental deterioration and myoclonia. Although spontaneous improvement or stabilization can occur, the vast majority of patients proceed over a period of months to years to generalized convulsions, dementia, coma, and death.

To collect demographic and clinical information on SSPE cases, a national SSPE registry

Subacute sclerosing panencephalitis — Continued

was initiated in 1969 at the University of Tennessee. Since October 1980, responsibility for the registry has resided with the Medical College of Georgia.* The registry is supported by the Office of Biologics, Food and Drug Administration, and maintained in collaboration with CDC.

A case of SSPE is defined by CDC as an illness with a compatible clinical course plus one of the following items of supporting laboratory evidence: 1) measles antibody detected in the cerebrospinal fluid (CSF), 2) a characteristic pattern on electroencephalography, or 3) typical histologic findings in brain biopsy material or tissue obtained on postmortem examination.

As of July 1982, 634 individuals suspected of having SSPE, with onset from 1956-1981, had been reported to the registry; of these, 368 were U.S. citizens who met the case definition of SSPE and had onset of symptoms between 1969 and 1981 (Figure 1). Fifty-five percent (202) of the 368 confirmed cases had a history of only measles infection; 14% (51) had a history of only measles vaccination; and 17% (63) had a history of both, with the natural illness most frequently preceding the vaccination. The remaining 14% (52) gave no positive history of having natural measles infection or measles vaccination.

The reported incidence rate among U.S. citizens under 20 years of age has been estimated for selected years (by year of onset of SSPE). The rate for 1970 is estimated at 0.61 per million population, decreasing to 0.35 in 1975 and 0.06 in 1980.

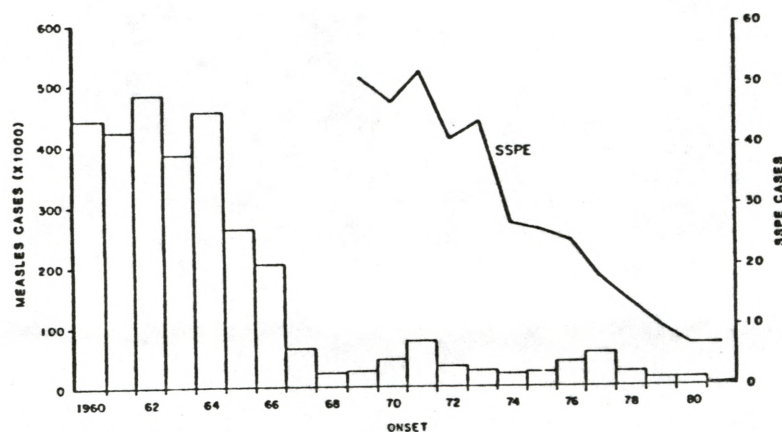
A crude estimate can be made of the risk of SSPE following natural measles infection by determining the year in which a given person who developed SSPE contracted measles and the number of measles cases that occurred in that year.[†] Similarly, the risk, if any, associated with measles vaccine can be estimated by determining the year of vaccination of patients with SSPE and the net number of doses of live-virus measles vaccine distributed during that year. The estimated risk of SSPE following natural measles infection averaged 8.5 cases per million measles cases occurring in 1960-1974.[§] The estimated rate of SSPE following mea-

*Inquiries and suspected case reports can be directed to Dr. Paul R. Dyken, Professor and Chief, Section of Pediatric Neurology, Medical College of Georgia, 1459 Lancy-Walker Boulevard, Augusta GA 30912.

[†]Assuming a 10% reporting efficiency, estimated case numbers were determined by multiplying reported cases for those years by 10.

[§]The average interval between onset of measles and onset of SSPE is approximately 7 years. Thus, SSPE risk estimates for persons who developed measles beyond 1974 are less likely to be accurate.

FIGURE 1. Confirmed subacute sclerosing panencephalitis (SSPE) and reported measles cases by year of onset — United States



Subacute sclerosing panencephalitis -- Continued

sles vaccination averaged 0.7 reported SSPE cases per million doses of live-virus measles vaccine distributed from 1963 (the year of vaccine licensure) through 1974.

Reported by P Dyken, MD, R DuRant, P Shimunes, Medical College of Georgia, Augusta, GA; Surveillance, Investigations, and Research Br, Immunization Div, Center for Prevention Svcs, CDC.

Editorial Note: Reported SSPE cases with onset since 1973 have declined substantially paralleling the substantial decline in reported measles cases after 1964-1966 (Figure 1). The lag period between the decline in reported measles cases and the decline in reported SSPE cases is similar to the mean latent period of 7 years noted previously between natural measles infection and subsequent onset of SSPE (7). Recently reported cases have a mean latent period of approximately 10 years, indicating that many of these cases may reflect sequelae due to measles incidence from the 1960s and early 1970s.

There is often a several-year lag period between onset of SSPE and registry notification (median = 3 years). Reporting is probably not complete, in part because diagnosing the illness requires a high index of suspicion. However, surveillance efforts have increased during the past 2 years from the immediately preceeding years (e.g. by continually soliciting reports from pediatric neurologists). Therefore, the apparent decrease in case reports since 1973 is probably an accurate trend, but the apparent annual case report level since approximately 1980 must also be viewed with consideration of these factors. Because of the lag time between natural measles illness and SSPE onset and the current lag time between onset and reporting, the impact on SSPE incidence of the dramatic decline in measles incidence as a result of the measles elimination effort will not be seen for nearly another decade.

Four lines of evidence indicate that measles vaccine protects against SSPE: 1) the decrease in reported SSPE cases in recent years as measles incidence has declined; 2) two case-control studies performed in the United States which indicated that measles vaccine, by protecting against measles, reduces the chance of developing SSPE (2,3); 3) a cohort analysis of children born from 1953 to 1973 indicating that, for cohorts born since 1966, one of the first years of widespread use of measles vaccine, the incidence rate of SSPE occurring at all ages has progressively decreased (4); 4) estimates of the ratios of SSPE cases to measles cases and of SSPE cases to measles vaccinees suggest that if there is any risk of SSPE following measles vaccination, it is $\leq$ one-twelfth the risk of SSPE following measles infection. Although some cases of SSPE have developed among children who had no history of natural measles infection but who received measles vaccine, these patients may have had unrecognized measles illness (e.g., during the first year of life). Studies performed before measles vaccine licensure indicated that 15%-30% of persons without a history of measles illness had evidence of measles antibody (5). A better picture of the etiologic role of live-measles vaccine in SSPE occurrence will only be seen several years after interruption of measles transmission in this country. Based on current imperfect estimates, however, the risk, if any, of SSPE from vaccination seems extremely low.

SSPE is only one of a number of degenerative neurologic diseases. In such illnesses, testing for measles antibody in the CSF will allow the diagnosis of SSPE when applicable. In order to obtain as complete reporting as possible, health-care providers and public health personnel are encouraged to report all suspected cases to the registry.

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Epidemiologic Notes and Reports**Influenza — Alaska**

Nine influenza viruses, which, in preliminary hemagglutination-inhibition testing, appear antigenically related to A/Bangkok/1/79(H3N2), were isolated in Alaska between September 25 and October 25, 1982. These isolations are the first reported in the United States for the 1982-1983 season. One virus was isolated in Anchorage, the rest in Fairbanks; several isolates were from children <1 year old. School absenteeism in Fairbanks has not increased, but increases in influenza-like illness have been reported in nursery schools and kindergartens.

Reported by D Ritter, Northern Region Laboratories, Section of Laboratories, J Middaugh, MD, State Epidemiologist, Alaska State Dept of Health and Social Svcs; Influenza Br, Center for Infectious Diseases, CDC.

Erratum, Vol. 31, No. 42

p. 565. In the article, "Valproic Acid and Spina Bifida: A Preliminary Report—France," the p-value in Table 2 on p. 266 should read: 0.00098.

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ATLANTA, GEORGIA 30333
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William H. Foege, M.D.
Director, Epidemiology Program Office
Philip S. Brachman, M.D.

Editor
Michael B. Gregg, MD 94102DJR 52 7900
Mathematical Statistician
Keewhan Choi, Ph.D. DIRECTOR
Assistant Editor SAN FRANCISCO HEALTH DEPT
Karen L. Foster, M 101 GROVE ST
SAN FRANCISCO, CA 94102

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Vol. 3, #2

July, 1983

ACQUIRED IMMUNODEFICIENCY SYNDROME: EPIDEMIOLOGY AND INFECTION CONTROL

In June 1981 the Centers for Disease Control (CDC) first received reports about unusual diseases occurring in gay men in New York City and California. The diseases, Kaposi's Sarcoma (KS) and *Pneumocystis carinii* pneumonia (PCP), as well as other life-threatening opportunistic infections (OI) appeared to be linked by a severe disorder of the immune system. Because of the underlying immune dysfunction, this disease entity has been termed Acquired Immunodeficiency Syndrome (AIDS).

SURVEILLANCE OF AIDS

Retrospectively, AIDS may have occurred in the United States since late 1978. Table 1 indicates the total number of cases recognized nationally to date. The number of cases has been doubling every 5-6 months. Half the patients are in New York City with San Francisco having the second highest incidence, but cases have now been reported from 35 states. Seventy-one percent of the cases have occurred in homosexual or bisexual men, 17% in intravenous drug abusers, 5% in Haitians, 1% in hemophiliacs, and 6% in individuals with no known risk factors. Included in the latter group are sexual partners of drug abusers, possible transfusion related cases, and others from whom insufficient information could be obtained or no risk group could be determined, (personal communication, Centers for Disease Control). There have also been reports of AIDS in infants of Haitian and drug-user mothers (J Oleske et al., JAMA 249:2345, 1983; A Rubinstein et al., JAMA, 249:2350, 1983).

Cases have occurred in the San Francisco Bay Area since 1980 (Table 2). Almost all of the Bay Area cases have occurred in gay men (personal communication, San Francisco Public Health Department).

Initially, no special precautions or isolation measures were used at the University of California, San Francisco (UCSF), because the cause of the underlying immune disorder was not suspected to be communicable. Early reports from the CDC indicated that patients had little or no contact with each other; however, in June

Table 1. Disease and Mortality, United States, 1978-1983, As of June 7, 1983

	Cases	Percent of total	Deaths (percent)
KS without PCP	415	26.7	88 (21.2)
PCP without KS	783	50.5	339 (43.3)
Both KS and PCP	120	7.7	67 (55.8)
OI without KS or PCP	234	15.1	103 (44.0)
Total	1552	100.0	597 (38.5)

1982 clusters of cases began to be reported. In July 1982 the Infection Control Committee at UCSF (Moffitt Hospital) established that Blood and Enteric Precautions would be used for AIDS patients. Specific guidelines were published in the ID/IC Bulletin (Vol 2, No 3, October 1982). The CDC published guidelines in November 1982 emphasizing that AIDS patients should be placed on Hepatitis B virus-like precautions (CDC, MMWR, 31:577, 1982).

Table 2. Disease and Mortality, San Francisco Bay Area 1980-1983, As of June 15, 1983

	Cases	Percent of total	Deaths (percent)
KS without PCP	110	43.5	16 (14.5)
PCP without KS	91	36.0	36 (40.0)
Both KS and PCP	34	13.4	20 (58.8)
OI without KS or PCP	18	7.1	8 (44.4)
Total	253	100.0	80 (32.6)

Infection control concerns have increased concomitant with increasing numbers of patients and escalating press coverage. At Moffitt Hospital an Ad Hoc Subcommittee of the Infection Control Committee was established to review present guidelines and to determine procedures in areas not previously considered. Subsequently, a Task Force comprised of representatives of Moffitt, San Francisco General, and the Veterans Administration Hospitals was formed to develop infection control policies and procedures that were consistent among the three institutions.

ETIOLOGY AND EPIDEMIOLOGY: AIDS

Although the cause of AIDS is unknown, epidemiologic evidence suggests that there is a transmissible agent, possibly a virus, which is responsible for the disease. The incubation period appears to be 6-24 months or longer. It is hypothesized that the agent affects the immune system and particularly the T-lymphocytes in some still undetermined manner. Patients then become susceptible to a variety of infections, malignancies, and possibly other diseases. There may also be asymptomatic carriers or conceivably individuals who have been infected and recovered, although no one with recognized disease has yet been shown to recover normal immune function. In the absence of a known agent and a test to determine who has been infected, the epidemiology remains somewhat obscure. Nevertheless, it is important to recognize that considerable epidemiologic data have accumulated which implicate AIDS infection through sexual transmission, infusion of blood or blood products, and vertical transmission from infected mothers *in utero* or during delivery. Despite misleading information in some of the lay press, there has been no evidence to date which indicates that AIDS can be spread by any other method.

Medical workers may conceivably be at risk of acquiring AIDS through occupational exposure because of frequent handling of blood and other body fluids. Although medical personnel have been treating patients in New York since 1979 and in California since 1980, there have been no documented cases among health care or laboratory personnel caring for AIDS patients or processing laboratory specimens (CDC, MMWR, 31:101, 1983). Infection Control guidelines which are based on current knowledge should be respected and followed because of the theoretical possibility of nosocomial transmission to personnel. There is, however, no evidence to support airborne or casual contact transmission of an AIDS agent or spread through fomites which are not contaminated with blood or excreta. Placement of patients on strict isolation or employing restrictive measures which would prevent a patient from receiving optimal medical care should not be practiced.

EPIDEMIOLOGY: INFECTIONS ASSOCIATED WITH AIDS

Patients with AIDS frequently harbor a number of infectious agents, either through asymptomatic colonization or overt infection. Appropriate infection control

procedures should be followed if patients are known or suspected to be infected with a transmissible agent. The following organisms have been recognized in AIDS patients and the epidemiology in terms of nosocomial transmission is discussed for each.

Cytomegalovirus (CMV): Almost all AIDS patients have been found to be infected with CMV. The organism is usually present in urine, semen and saliva but may also be isolated from blood and tissues. CMV is a common infection worldwide with positive antibody titers found in 30-100% of the populations studied. Most infections in immune competent individuals are asymptomatic or produce a mononucleosis-like syndrome. Infection with CMV has particular significance for pregnant women since *in utero* transmission can cause congenital infection in the neonate. Two recent papers review the current literature on nosocomial spread of CMV (AB Young et al., Lancet, 1:975, 1983; Dept of Health Services, State of California, Calif Morbidity Suppl #7, Feb 25, 1983). Studies of personnel in hospital areas with many potential shedders, such as dialysis units and nurseries, indicate insignificant or minimal occupational risk to employees. Transmission occurs via direct contact with urine, saliva, blood, etc. and can be prevented by thorough handwashing following contact with body fluids. It is prudent, however, to recommend that pregnant women not provide direct patient care to patients with CMV or AIDS.

Pneumocystis carinii: *P. carinii* is a protozoan also found ubiquitously worldwide. By the age of 4, approximately 80% of immunocompetent children have serological evidence for past infection. Disease is believed to occur when an individual's own latent organisms become reactivated in the presence of immunosuppression. Outbreaks have occurred in immunosuppressed children and infection probably occurs through the respiratory route (TK Ruebush II et al., Am J Dis Child, 132:143, 1978). Experts have not recommended isolation or special precautions for patients with pneumocystis pneumonia (CDC: Isolation Techniques for use in Hospitals, 2nd ed., 1978); however, the policy at UCSF is to separate them from immunosuppressed patients.

Mycobacteria: Both *M. tuberculosis* and "atypical" mycobacteria, e.g. *M. avium-intracellulare* have caused pulmonary and disseminated infection in AIDS patients. Tuberculosis (TB) has been less common in the San Francisco experience but is highly communicable in patients who are coughing. Patients with known or suspected TB must be placed in Respiratory Isolation. (UCSF Infection Control Manual — Section 3.5, page 11). The epidemiology of the non-tuberculous mycobacteria is less well understood. The organisms are found widely in nature, especially in water and soil. Colonization and asymptomatic infection are much more common than actual disease. Pulmonary infection is most likely to occur in individuals with predisposing factors, but may occur in otherwise healthy persons. Organisms are probably acquired through exposure to natural sources in the environment but person to person transmission has been reported, albeit very rarely (E

Wolinsky, Am Rev Resp Dis, 119:107, 1979).

Herpes Simplex Virus (HSV): Herpetic lesions are not uncommon in AIDS patients and occasionally develop into severe peri-rectal or peri-oral ulcers. HSV is transmitted by direct contact with virus containing lesions or saliva; gloves should be worn for contact with lesions or for mouth care.

Cryptococcosis: *Cryptococcus neoformans* is a fungus which can cause meningitis or disseminated disease. It is usually an opportunistic infection but can occur in individuals with no apparent risk factors. Infection occurs by inhaling dust containing the organism. Soil contaminated with pigeon droppings contains high concentrations of the yeast. There are no reports of man to man transmission and special infection control procedures are not necessary.

Toxoplasmosis: *Toxoplasma gondii* is a protozoan which can cause a variety of diseases in man including a congenital syndrome, but most infections are asymptomatic. Immunosuppressed patients are more likely to exhibit clinical disease. Many animal species are infected and infection can occur through ingestion of raw meat. Only cats and other felines can excrete infectious oocysts. Person to person transmission does not occur except *in utero*. No special precautions are necessary for patient care.

Cryptosporidiosis and Other Intestinal Parasites: AIDS patients are often infected with intestinal parasites as well as enteric bacterial pathogens. Routine Enteric Precautions which include special handling of fecally contaminated articles and gloves for contact with feces will prevent nosocomial transmission. Most of these organisms are acquired through the fecal-oral route and thorough handwashing is essential.

INFECTION CONTROL POLICIES AND PROCEDURES

The following guidelines for care of AIDS patients have been approved by the Infection Control Committee and Medical Executive Board at UCSF (Moffitt-Long) Hospitals and Clinics. These recommendations are based on current knowledge and may be refined as additional scientific findings become available.

Identification of Patients: The definition of an AIDS patient is as outlined by the CDC in their category A designation; that is, "a disease at least moderately predictive of a defect in cell mediated immunity, occurring in a person with no known cause of diminished resistance to that disease. Such diseases include *Pneumocystis carinii* pneumonia, Kaposi's sarcoma and other serious opportunistic infections." It is recommended that patients with the generalized lymphadenopathy syndrome or those being evaluated for the possibility of AIDS should be included in the definition for infection control purposes. The responsibility for identification of the patient in the above categories should rest with the attending physician. The attending physician must report the diagnosis to the Public Health Department since category A AIDS is now a reportable disease. The attending physician should also have the responsibility,

in consultation with the Infection Control Unit, of determining when appropriate precautions and/or isolation measures can be discontinued.

Isolation Procedures: Patients should be placed on Blood and Excretion Precautions (blue sign). Private rooms are not necessary for the care of patients with AIDS unless they have an additional illness which would normally require a private room. A patient with AIDS should not be placed in a room with another immunocompromised or infected patient. Individuals may want or need private rooms for reasons other than infection control, however, and these may also be considered during patient placement. Gloves should be worn when personnel have contact with blood, secretions, or excretions. Gowns should be worn if clothing may become contaminated with blood or excretions but are otherwise not routinely necessary. Masks are necessary for personnel or visitors if the patient has tuberculosis. They may be worn for direct sustained contact with other patients who are actively coughing although there are no data to support respiratory transmission of PCP or CMV to visitors or staff. Masks should not be worn if an AIDS patient has no respiratory disease. The same guidelines apply for the wearing of masks by AIDS patients when they are outside of their rooms; it is not recommended that patients wear masks when in their own rooms. Handwashing is mandatory for everyone who has patient contact. Disposable dietary trays are not necessary. Linen needs to be double bagged only if it is visibly contaminated with blood or excreta. Rooms do not routinely need to be high cleaned; questions concerning exceptions should be directed to Infection Control.

Equipment: Disposable items which are contaminated with blood or excreta should be red bagged. Contaminated reusable items should be rinsed under running water and sent to Materiel Services in a plastic bag labelled "contaminated". Any instrument which comes in contact with blood, secretions or excretions must be sterilized before reuse. This includes all lensed instruments, laryngoscopes and endotracheal tubes. Respiratory therapy tubing may be pasteurized. Because of the extreme difficulty in cleaning "Clinitron" beds, they should not be used for AIDS patients. Environmental surfaces contaminated with blood or other body fluids should be immediately cleansed with a disinfectant such as bleach diluted 1:10.

Out-Patient Clinics and Emergency Room: AIDS outpatients may use common waiting areas and bathroom facilities unless they have an infection that would otherwise require isolation. Patients who are actively coughing should be asked to cough or sneeze into a tissue and efforts should be made to minimize close contact with other immunocompromised patients. The general guidelines for handling equipment should also be applied in these settings.

Laboratory Specimens: Specimens from patients will be labelled, "H/A Precautions", and placed in an impervious bag or container for transport. It is important to remember, however, that blood, other body fluids and tissues from anyone may be infectious and appropriate

infection control measures should always be followed during specimen processing.

Departmental Procedures: Questions concerning special infection control procedures in each hospital department should be addressed to the Infection Control Department (x 5793).

PSYCHO-SOCIAL ISSUES

Patients with suspected or proven AIDS frequently are very frightened and/or confused by their illness. They have a need for a trusting, non-rejecting relationship with their health care providers. Over-isolation can be traumatic to a person who is already faced with a multitude of concerns about his chances for survival, his relationship with family and friends, and his lifestyle after diagnosis.

The Infection Control guidelines described in this Bulletin are designed to protect personnel from possible infectious diseases and yet provide a humane approach to patient care. Personnel who have concerns about the transmissibility of AIDS or its associated infections may contact the Infection Control Department (x 5793) to discuss these issues or to set up inservice programs for their staff.

Infectious Diseases and Infection Control Unit: John E. Conte, Jr., M.D.; Linda L. Rosendorf, M.S.; Jacqueline Octavio, R.N.

Note: An excellent bibliography of all publications concerning AIDS through May 1983 can be obtained by calling the AIDS/KS Foundation at (415) 864-4376.



University of California San Francisco
Division of Infectious Diseases and
Hospital Infection Control
San Francisco, California 94143

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THE AIDS HEALTH PROJECT

Address Correspondence To:

UCSF AIDS Health Project
Box 0884
San Francisco, CA 94143-0884

Administrative Offices:

1855 Folsom Street
Suite 506
San Francisco, California
(415) 476-6430

Programs:

- AIDS Mental Health Program
- AIDS Prevention Program
- AIDS Health Professional Training Program
- AIDS & Substance Abuse Program
- AIDS Antibody Counseling Program
- FOCUS: A Guide to AIDS Research
- Youth & AIDS Education & Training

LUBRICANTS AND CONTRACEPTIVES WITH NONOXYNOL-9

Lubricants:

Astroglide	none
Forplay	1%
H-R	none
KY Jelly	none
Lubrasetic	none
Ortho	none
Probe	none

Contraceptives:

Conceptrol Disposable Unscented Gel	4%
*Conceptrol Scented Cream	5%
*Delfen Foam	12.5%
Encare Suppository	2.27%
Gynol II Unscented Jelly	2%
Koromex Crystal Clear Gel (unscented)	2%
Koromex Cream	none
*Koromex Foam	12.5%
Koromex Jelly	3%
Ortho-Creme	2%
Ortho-Gynol	none
Prepair Contraceptive Gel	1%
*Ramses Jelly	5%
Semicid Suppository	none
Shur-Seal Gel	2%

*Under laboratory conditions, a 5% concentration of nonoxynol-9 kills free-floating AIDS virus. We recommend the use of nonoxynol-9 only with a condom. Condoms provide the barrier to the AIDS virus and prevent the virus from passing from person to person. Nonoxynol-9 without a condom does not provide a significant amount of protection against the AIDS virus.

Note: Some people are allergic to nonoxynol-9 and may develop a skin rash. Also, nonoxynol-9 may cause some numbing sensation of the lips if ingested orally.



INFORMATION SHEET FOR EVALUATION RESEARCH PARTICIPANTS
AT THE ALTERNATIVE TEST SITE

Address Correspondence To:

UCSF AIDS Health Project
Box 0884
San Francisco, CA 94143-0884

Administrative Offices:

1855 Folsom Street
Suite 506
San Francisco, California
(415) 476-6430

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Barbara Havassy, Ph.D., Jeffrey Moulton, Ph.D., Neil Seymour, MFCC, and James Dilley, M.D. are conducting an evaluation of the Alternative Test Site. This evaluation will be used to understand the needs of the clients seen here and whether the services offered meet those needs.

While the evaluation is being performed at the Alternative Test Site, it is separate from the operations of this facility. Participation in the evaluation is completely voluntary. You may refuse to participate or withdraw from the evaluation at any time without jeopardy to your receiving any or all of the services provided by the Alternative Test Site now or in the future. You just have to say so.

If you agree to participate in this evaluation project, you will be asked to fill out five short questionnaires; one at each different point in the testing process. The questionnaires will include specific questions concerning your current feelings, your reasons for wanting to take the HIV antibody test, knowledge about AIDS, questions about high risk sexual and drug use behavior and your overall satisfaction with the services offered at the Alternative Test Site. Each of the five questionnaires will take approximately five to fifteen minutes to complete.

The possible risks of your filling out the questionnaires are that you may feel uncomfortable revealing psychological or behavioral information about yourself. Some of the questions are concerned with explicit sexual practices. You have the right not to answer any of the questions which might cause psychological discomfort.

Your name or any other identifying information will not be recorded in any way. Your questionnaires will have a code number on them that will be the same code number used to identify your blood when you come to get your results. This number will be assigned to you at random. This number can not be traced to you in any way. Your individual responses recorded on the questionnaires will not be available to the staff of the Alternative Test Site.

There will be no benefit to you from participation. The information gathered will be used to improve the quality of the services offered here.

A health educator will be available to answer any of your questions. If you have other questions, you may call Dr. Jeffrey Moulton at 476-6430. In addition, you may contact the Committee on Human Research, which is concerned with the protection of volunteers in research projects. You may reach the committee office by calling: (415)476-1814 from 8:00 A.M. to 5:00 P.M., Monday to Friday, or by writing the Committee on Human Research, University of California, San Francisco, CA 94143.

A list of mental health referrals will also be available to you from the counselor who gives you your results. These referrals are intended to be of help if you experience distress related to the counseling process itself or the evaluation questions asked.