

CORRESPONDENCE

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Preoperative Testing for Human Immunodeficiency Virus Infection

To the Editor:—The review by Kunkel and Warner¹ states that patients with AIDS should not be treated differently, and that serologic screening for HIV (HTLV-III) in surgical patients is not warranted. I disagree.

Current information can be summarized as follows: AIDS is communicable by exposure to blood and secretions, and transmission to people providing health care has occurred. Screening, by use of ELISA *followed by Western blot when appropriate*, is perhaps 95% effective in identifying individuals whose blood may transmit the disease. Of patients thus identified, 65% have positive blood cultures for HIV on a single isolation attempt, and 25–50% will develop AIDS.² Proper testing will therefore show few false negatives, and a positive test is highly significant.

The CDC recommendations for health care workers treating seropositive patients include the use of eye coverings, gowns, and masks when blood splashes or aerosolization are likely to occur. I would add that the gowns should be impermeable, and that operating room surfaces and equipment touched by the gloved workers should subsequently be decontaminated. This is an unusual level of caution, but warranted during major surgery on patients with HIV infection, since exposure to the patients' blood can otherwise be extensive. ICU

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In Reply:—We disagree with Dr. Bazaral's contentions. Avoidance of blood splashes and aerosolization, and decontamination of equipment and operating room surfaces should be standard procedure regardless of a patient's serologic status. These precautions are practical for all patients. We would ask, "What other practices would Dr. Bazaral recommend?"

As noted, current screening procedures are highly sensitive and specific. However, there exists a period of weeks to months after exposure to HIV (human immunodeficiency virus) during which time a person may be viremic but seronegative. Are we to ignore this subgroup? Screening would also be impractical for emergency patients, as results would not be available prior to the procedure.

Hepatitis B virus is also transmitted by asymptomatic carriers. Since it is far more likely to be transmitted in the hospital environment than HIV, should we screen all patients for this virus as well? It is well known that

nurses should also maintain unusual caution when caring for seropositive patients.

Such precautions are practical only when we know a patient is seropositive. Most patients who are seropositive cannot be identified by symptoms, since the symptom-free incubation period is typically several years. Therefore, I believe routine screening of patients before elective major surgery is warranted. The laboratory cost for the initial ELISA screening is between \$4 and \$14. All medical information is routinely kept private, and testing for HIV infection should present no new confidentiality problem.

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hepatitis B acquisitions in health care personnel are usually from unrecognized sources.

We stand firm in our contention that all patients should be treated the same regardless of HIV serologic status. Avoidance of contact with blood and bodily secretions is always practical, and we recommend it. Screening, if instituted, would be valuable for counseling HIV carriers to avoid viral transmission to sexual contacts and possible offspring. It should not influence the way we care for our patients.

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