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Occupationally Acquired Human Immunodeficiency Virus Infections in Laboratories Producing Virus Concentrates in Large Quantities: Conclusions and Recommendations of an Expert Team Convened by the Director of the National Institutes of Health (NIH) Reported by Division of Safety, National Institutes of Health*

INTRODUCTION

The recommendations of the expert team are directed to industrial-scale facilities for the production of large quantities of highly concentrated HIV. Their recommendations are similar to and complement those in the preceding "1988 Agent Summary Statement for Human Immunodeficiency Virus," which updates the one published in 1986 (1). Laboratory directors and others responsible for the health and safety of laboratory employees working with HIV and HIV-containing material should carefully consider these relevant recommendations and guidelines in developing an appropriate safety program. COMMITTEE REPORT

Two workers in different laboratories producing large quantities of highly concentrated HIV have been reported to have laboratory-acquired HIV infections (1). One worker's infection was presumed to be caused by "undetected skin contact with virus culture supernatant" (2). The other worker's infection followed "an injury with a potentially contaminated needle" (2). After the first case was identified, the Director of NIH convened a team of experts to investigate the incidents and to visit seven different laboratories that produced large volumes of HIV. After facilities inspections and separate, confidential interviews with the workers, the team prepared a report of their findings. The conclusions and recommendations from that report follow.

The most probable cause for the first laboratory-acquired infection was inapparent parenteral exposure. Frequent opportunities for unrecognized direct contact with contaminated materials and surfaces were reported to be present. Gloves of questionable integrity, skin cuts and abrasions, and one episode of a dermatitis-like condition represented portals for possible exposure and routes of infection. The inexperience of the first infected worker in microbiologic procedures and Biosafety Level (BSL) 3 practices, coupled with the reliance on obtaining necessary skills through on-the-job training in a setting in which episodes of contamination may have occurred

frequently, suggests that the worker might not have possessed an appropriate level of proficiency when the infection may have occurred.

The most probable cause for the second worker's infection was parenteral inoculation. This worker recalled incurring an injury with a blunt cannula approximately 6 months before the first seropositive sample. Incidents of contamination, such as those reported by the first worker, occurred infrequently in the second worker's laboratory.

Aerosol transmission is considered to be the least likely cause of infection in both cases. Operations in which aerosols may have been generated were carried out in biological safety cabinets to reduce the potential for inhalation exposure. Although some aerosols may have been released during the few reported rotor-seal failures involving the continuous-flow zonal centrifuge, the potential for contact exposure was greater. Aerosol transmission was unlikely because: a) in situations in which overt aerosol exposure has occurred in laboratory and production operations involving HIV, no exposed workers have seroconverted; b) no evidence exists that suggests aerosols may be a natural mode of HIV transmission; c) the probable cause identified above is consistent with documented modes of transmission of bloodborne pathogens in the laboratory.

The occurrence of these two infections emphasizes the finite risk that exists for laboratory workers who handle concentrated preparations of HIV. The conclusions of a National Cancer Institute prospective cohort study (2) indicate that this risk is low and may be similar to the risk for infection of health-care workers who have experienced a needlestick injury.

The occupational risk for infection by parenteral exposure is substantially reduced or eliminated by strict adherence to BSL 2 practices. The recommended use of BSL 3 practices for highly concentrated preparations of HIV is appropriate. The review of these two infected laboratory workers does not suggest the need to alter current CDC/NIH biosafety recommendations for HIV or for patient care (3), research (1), or virus production. There is a need, however, for more proficiency and discipline in laboratory safety practices.

The following recommendations will help assure maintenance of a safe and healthy environment for laboratory and production-facility workers who handle concentrated preparations of HIV:

A. Strictly adhere to standard microbiologic practices and techniques

The most important recommendation is to adhere strictly to standard microbiologic practices and techniques. Persons working with HIV must be aware of potential hazards and must be trained and proficient in practice and techniques necessary for self-protection. Employees must be informed that parenteral exposure is the most serious potential hazard for causing a laboratory-acquired infection. They must be able to recognize how such exposures occur and how they can be prevented. Although on-the-job training is an acceptable approach for learning techniques and practices, it is imperative that proficiency be obtained BEFORE virus is actually handled.

B. Assure that workers are proficient in virus-handling techniques

Selection criteria for employees who will work in production operations or with concentrated preparations of HIV should require experience in the handling of human pathogens or tissue cultures. If an employee has not had such experience, s/he should participate in carefully structured, well-supervised on-the-job training programs.

The director or person in charge of the laboratory or production facility must ensure that personnel are appropriately trained and are proficient in practices and techniques necessary for self-protection. Initial work activities should not include the handling of virus. A progression of work activities should be assigned as techniques are learned and proficiency is developed. Virus should only be introduced into the work activities after the supervisor is confident it can be handled safely.

C. Monitor work practices

Periodically, the biosafety officer or a person with expertise in biosafety should closely observe practices and techniques used in handling HIV. This can be helpful in identifying activities or behavior that may increase the potential for contact with contaminated material or for inapparent parenteral exposures. If deficiencies are noticed, corrective measures should be specified and implemented.

D. Continuously reinforce safe practices

Practices that reduce the potential for direct contact and inapparent parenteral exposure should be continuously reinforced:

- Gloves should always be worn when concentrated preparations of HIV are handled and when contact with a contaminated surface or material may be unavoidable. If a gloved hand accidentally touches a contaminated surface or material, the glove should be removed immediately and the hands washed.
- Work surfaces should be decontaminated at the end of each day and any time contamination is recognized.
- Workers must develop the habit of keeping hands away from the eyes, nose, and mouth in order to avoid potential exposure of mucous membranes. Wearing filter masks and eye goggles or face shields may assist in accomplishing this objective.
- Needles and sharp implements must not be used when HIV is handled unless no acceptable alternative is available. When possible, unbreakable containers should be substituted for glassware, in order to avoid accidental cuts from broken pieces.
- In the absence of advice and consent of an occupational physician or nurse, no worker should handle any virus-containing material when s/he has cuts or skin abrasions on the hands or wrists.

E. Establish a medical surveillance serology program

Each medical facility should have a medical-surveillance serology program. Serum samples should be obtained at least once a year and analyzed for seroconversion. Results should be reported to individual workers in a timely manner. Counseling services should be available for workers who have positive serologic results. Procedures that maintain strict confidentiality should be adopted.

F. Revalidate integrity of process, transport, and containment equipment

The operational integrity of all equipment used to process, transport, and contain fluids containing HIV should be revalidated at least once a year. The integrity of such equipment should be revalidated after any system failure that releases contaminated fluids into the work environment.

G. Develop production processes that enhance biosafety

Efforts should be made to explore and use production systems and strategies that reduce operational complexity and manual manipulations.

H. Validate efficacy of decontamination methods

Special attention should be given to demonstrating the adequacy of decontamination methods when high organic content, such as cellular debris, is present.

- I. Sponsor and conduct biosafety training initiatives Responsible institutions should orient such programs toward the application of biosafety practices to work involving HIV. Presentation strategies and materials to make the training widely available should be encouraged.

References

1. CDC. Human T-lymphotropic virus type III/lymphadenopathy-associated virus: agent summary statement. MMWR 1986;35:540-2, 547-9.
2. Weiss SH, Goedert JJ, Gartner S, et al. Risk of human immunodeficiency virus (HIV-1) infection among laboratory workers. Science 1988;239:68-71.

3. CDC. Recommendations for prevention of HIV transmission in health-care settings. MMWR 1987;36(suppl 2S):3S-18S. *Expert Team: W. Emmett Barkley, PhD, Director, Division of Engineering Services, National Institutes of Health; Robert McKinney, PhD, Director, Division of Safety, National Institutes of Health; John Richardson, DVM, MPH, Biosafety Officer, Emory University; Gerald Schochetman, PhD, Chief, Laboratory Investigations Branch, AIDS Program, Center for Infectious Diseases, Centers for Disease Control; David Henderson, MD, Hospital Epidemiologist, Warren Grant Magnuson Clinical Center, National Institutes of Health.

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This page last reviewed 5/2/01