

Screening Criteria for Communicable Diseases

Tuberculosis Screening

1. Specified healthcare workers shall have a 2-step tuberculin skin test applied at the time of employment. [see HR/EHC database]
2. Employees who are initially skin test positive at the time of employment, or who subsequently convert their skin test, should be counseled regarding signs and symptoms of tuberculosis such as cough, fever, night sweats, and weight loss and instructed to report promptly to the EHC if such symptoms develop.
3. Tuberculosis screening shall be repeated annually for employees who have direct patient care.
4. All full-time and part-time employees who work in the Mycobacteriology Section of the Clinical Microbiology Laboratory and have no history of a positive tuberculin skin test will have an annual tuberculin skin test.
5. Employees of the UTMB Community Based Clinics (CBC) will be allowed to have their PPD skin tests placed at their work site instead of the PPD skin test being placed at the Employee Health Clinic. One employee of each CBC clinic will be trained by the employee health clinic to place and read skin tests. All results of the tests will be sent to the Employee Health Clinic and documented in the employees chart.
6. PPD skin testing will be available for all employees even if they are not required to have skin tests.
7. Employees who have a documented positive skin test will not receive further skin testing. Employees will be counseled regarding signs and symptoms of tuberculosis. Routine chest x-rays are not necessary.
8. After exposure to tuberculosis, employees who have no previously documented positive skin test should be tested immediately after exposure. If the skin test done immediately post exposure is negative, it will be repeated in three months. A chest x-ray should be done on all new converters. All converters will be counseled and offered management through the EHC.
9. In cases of multiple exposures, employees should not be skin tested more than four times in one year. Individual cases shall be referred to the EHC physician.

Employees with Exudative Lesions or Weeping Dermatitis

These employees must refrain from all direct patient care and from handling patient care equipment until the condition resolves. Evaluation of such employees will be conducted by the EHC.

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Pregnant Healthcare Workers

Pregnant healthcare workers are not at greater risk of contracting infectious diseases than are other healthcare workers who are not pregnant; however, if a healthcare worker develops an infection such as HIV, Varicella, Hepatitis B, CMV, or Rubella during pregnancy, the infant may be at risk of becoming infected. Because of this risk, pregnant healthcare workers should be especially familiar with and strictly adhere to precautions to minimize the risk of transmission of infectious diseases. Work reassignment is generally not necessary. Pregnant women should not work with patients who have Varicella infection without serologically documented immunity to Varicella Zoster virus. Pregnant healthcare workers who have questions regarding exposure in the hospital should contact HCE.

Hepatitis A Exposures

Direct contacts (parenteral or enteral) of patients with Hepatitis A who are \leq 40 years of age should be administered the first dose of monovalent Hepatitis A vaccine or 0.02 ml/kg of gamma globulin IM as soon as possible after exposure.

Those who receive the first dose of monovalent Hepatitis A vaccine should receive the second dose on schedule.

Persons who are $>$ 40 years of age or $<$ 12 months of age, have chronic liver disease, who are immune-compromised or for whom Hepatitis A vaccine is contraindicated should be given gamma globulin IM 0.02 ml/kg as soon as possible after exposure.

Prophylaxis with Hepatitis A vaccine or gamma globulin should be given as soon as possible after exposure but within 2 weeks after exposure. No information exists regarding the efficacy of gamma globulin or vaccine if administered \geq 2 weeks after exposure,

See Policy 01.02 Blood borne Pathogens (BBP) – Occupational Post-Exposure Prophylaxis.

Hepatitis B, C and HIV Exposures

Meningococcal Disease

1. Any individual who has been in the room of a patient with meningococcal disease while not wearing a surgical mask is a candidate for prophylaxis. “Intimate” contact with a patient defined as extremely close exposure to the patient’s respiratory secretions (i.e. mouth-to-mouth resuscitation) is an even stronger indication for prophylaxis.
2. The EHC, as well as HCE, should be notified immediately of possible exposure to meningococcal infection so that prophylaxis may be initiated as soon as possible if it is determined by HCE that exposure has occurred.
3. The following regimens are recommended for chemoprophylaxis and should be given as soon as possible after exposure (within 24-48 hours):

<i>CHILDREN</i>	<i>Rifampin</i>	
	<i><1 month</i>	<i>5 mg/kg PO q 12h x 2 days</i>
	<i>≥1 month</i>	<i>10 mg/kg PO q 12h x 2 days (600 mg maximum)</i>
<i>ADULTS</i>	<i>Ciprofloxacin</i>	<i>500 mg PO x 1</i>
<i>PREGNANT WOMEN</i>	<i>Ceftriaxone</i>	
	<i><15 years</i>	<i>125mg IM x 1</i>
	<i>≥15 years</i>	<i>250mg IM x 1</i>

Screening Criteria for Communicable Diseases

Meningococcal Disease, continued

4. Persons receiving chemoprophylaxis for exposure should be cautioned to seek immediate medical attention if fever, headache or stiff neck or any other signs or symptoms consistent with meningococcal disease develop.
5. Medical Technologists and Medical Technicians who work in the Bacteriology Section of the Clinical Microbiology Laboratory will be offered meningococcal vaccine at employment and during employment as indicated.
6. Persons aged ≤ 55 years will receive meningococcal conjugate vaccine with a booster dose every 5 years.
7. Persons aged ≥ 56 years will receive meningococcal polysaccharide vaccine with a booster every 5 years
8. Persons who were vaccinated with the meningococcal conjugate vaccine prior to reaching age 56 will receive a booster with meningococcal polysaccharide vaccine when their 5 year booster comes due at ≥ 56 years.
9. Since the meningococcal vaccines do not provide protection against serogroup B meningococcal infection and the serogroup will not be known at the time of exposure, all exposees will need to be offered antibiotic prophylaxis as soon as possible after exposure but no later than 24 hours after exposure.

Syphilis Exposure

1. Any employee, who has had direct contact (due to cuts or other breaks in his/her skin) with skin or mucous membrane lesions or the blood of a patient who has primary or secondary syphilis, should have a VDRL drawn and be given the following prophylaxis: 2.4 million units of benzathine penicillin G (Bicillin) IM.
2. Employees who are penicillin sensitive should be treated with tetracycline 500 mg, po qid for 15 days or Azithromycin 2.0g po x1. (*Pregnant women should not receive tetracycline.*)

Varicella Exposure

See policy: 01.34 Varicella-Zoster Virus Infection Control Program.

Pertussis Exposure

See policy: 01.44 Pertussis Infection Control Program