

ticularly in *S. agalactiae* infections. In the early postpartum period, fever in the mothers was significantly less likely in the patients offered vaginal disinfection, a reduction from 7% in those douched using saline compared with 3% in those disinfected using chlorhexidine. A lower occurrence of urinary tract infections also was observed: 6% in the saline group as compared with 3% in the chlorhexidine group ($P < .01$).

This prospective controlled trial demonstrated that vaginal douching with 0.2% chlorhexidine during labor can significantly reduce both maternal and early neonatal infectious morbidity. The squeeze bottle procedure was simple, quick, and well-tolerated.

FROM: Stray-Pedersen B, Bergan T, Hafstad A, Normann E, Grogaard J, Vangdal M. Vaginal disinfection with chlorhexidine during childbirth. *Int J Antimicrob Agents* 1999;12:245-251.

Effectiveness of Live, Attenuated Intranasal Influenza Virus Vaccine

A recent study by Nichol and colleagues concluded that, among healthy adults, a live, attenuated influenza vaccine delivered intranasally not only helps prevent serious illness but also saves money.

In a randomized, double-blinded, placebo-controlled trial of 4,561 healthy adults aged 18 to 64, investigators found that recipients of intranasally administered trivalent, live, attenuated influenza virus (LAIV) vaccine were as likely to experience one or more febrile illnesses as placebo recipients during peak outbreak periods (13.2% for vaccine vs 14.6% for placebo). However, vaccination significantly reduced the numbers of severe febrile illnesses (18.8% reduction) and febrile upper respiratory tract illnesses (23.6% reduction). Vaccination also led to fewer days of illness across all illness syndromes (22.9% reduction for febrile illnesses; 27.3% reduction for severe febrile illnesses), fewer days of work lost (17.9% reduction for severe febrile illnesses; 28.4% reduction for febrile upper respiratory tract illnesses), and fewer days with healthcare-provider visits (24.8% reduction for severe febrile illnesses; 40.9% reduction for febrile upper respiratory tract illnesses). Use of prescription antibiotics and over-the-counter medications was also reduced across all illness syndromes. Vaccine recipients were more likely to experience runny nose or sore throat during the first 7 days after vaccination, but serious adverse events between the groups were not significantly different.

The match between the type A(H3N2) vaccine strain and the predominant circulating virus strain (A/Sydney/05/97[H3N2]) for the 1997/98 season was poor, suggesting that LAIV provided substantial cross-protection against this variant influenza A virus strain. The authors concluded that intranasal trivalent LAIV vaccine

was safe and effective in healthy, working adults in a year in which a drifted influenza A virus predominated.

FROM: Nichol KL, Mendelman PM, Mallon KP, Jackson LA, Gorse GJ, Belshe RB, et al. Effectiveness of live, attenuated intranasal influenza virus vaccine in healthy, working adults: a randomized controlled trial. *JAMA* 1999;282:137-144.

Gastrointestinal Endoscopic Reprocessing Practices in the United States

Patient infection from contaminated gastrointestinal (GI) endoscopes generally can be attributed to failure to follow appropriate reprocessing guidelines. Recently, the Food and Drug Administration recommended a 45-minute exposure of GI endoscopes to 2.4% glutaraldehyde solutions heated to 25°C. Simultaneously, the American Society for Gastrointestinal Endoscopy (ASGE), the American Gastroenterological Association, and the Society of Gastroenterology Nurses and Associates endorsed a reprocessing guideline that emphasized manual precleaning and recommended a 20-minute exposure to a 2.4% glutaraldehyde solution at room temperature. Since then, little information has become available regarding actual reprocessing practices in the United States.

Cheung and colleagues mailed a questionnaire regarding endoscopic disinfection practices to 730 randomly selected members of the ASGE; 294 (40%) responded. Appropriate manual cleaning (suctioning detergent through the accessory channel and brushing the channel and valves) was reported by 91% of respondents; 70% then used automated reproprocessors for disinfection or sterilization. Glutaraldehyde was the most widely used chemical disinfectant; 85% used glutaraldehyde as one of their primary disinfectants. The most commonly used disinfection time with 2.4% glutaraldehyde was 20 minutes (83.9%) followed by 45 minutes (11.4%). Only 24% of users of 2.4% glutaraldehyde heated their solution; 60% of centers tested disinfectant concentration daily or more frequently; 74% sterilized nondisposable forceps before use; 29% of centers reused disposable endoscopic accessories (which are more frequently disinfected rather than sterilized). Twelve respondents reported cases of endoscopic cross-infection.

The authors note that a significant minority of endoscopy centers still do not completely conform to recent ASGE, American Gastroenterological Association, and the Society of Gastroenterology Nurses and Associates guidelines on disinfection, and they may not be appropriately disinfecting GI endoscopes. Rigid adherence to recommended guidelines is strongly encouraged to ensure patient safety.

FROM: Cheung RJ, Ortiz D, DiMarino AJ Jr. GI endoscopic reprocessing practices in the United States. *Gastrointest Endosc* 1999;50:362-368.

The School of Medicine at the University of Washington

is recruiting a full-time faculty member at the Assistant or Associate Professor level to lead the program in Infection Control at the University of Washington Medical Center. The closing date for applications is December 10, 1999.

Although the School and Medical Center are seeking a person at the Assistant or Associate Professor rank, under unusual circumstances and commensurate with the qualifications of the individual, appointment may be made at the rank of Professor.

Desirable credentials include national board certification in the candidate's specialty and ABIM eligibility in infectious diseases or advanced training in epidemiology, microbiology or related fields. Must have a strong clinical background with training in hospital epidemiology with emphasis on infection control. The selected individual will direct infection control activities of both ambulatory and inpatient care at the University of Washington Medical Center (including aspects of the new Seattle Cancer Care Alliance) and will participate in the clinical and teaching activities of their academic department. Development or continuation of an infection control or hospital epidemiology research program is desirable.

Send C.V. to:

Henry Rosen, M.D., Associate Chair
Department of Medicine, Box 356420
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Statement of Ownership, Management, and Circulation

(Required by 39 USC 3685)

1. Publication Title Infection Control and Hospital Epidemiology	2. Publication Number 0899-823X	3. Filing Date October 1, 1999
4. Issue Frequency Monthly	5. Number of Issues Published Annually 12	6. Annual Subscription Price \$105.00
7. Complete Mailing Address of Known Office of Publication (Not Printer) (Street, city, county, state, and ZIP+4) 800 Grove Road Thorofare, Gloucester County, New Jersey 08068-9447		
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer) Black, Incorporated, 6800 Grove Road, Thorofare, New Jersey 08068-9447		
9. Full Name and Complete Mailing Address of Publisher, Editor, and Managing Editor (Do not leave blank) Publisher (Name and complete mailing address) Richard N. Roach, Black Incorporated, 6800 Grove Road, Thorofare, New Jersey 08068-9447		
Editor (Name and complete mailing address) Michael D. Decker, MD, MPH Same as above		
Managing Editor (Name and complete mailing address) Betsy Strick Same as above		
10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.) Full Name PMB & WBS, Incorporated dba Black, Incorporated 6800 Grove Road, Thorofare, New Jersey 08068-9447		
Full Name Peter H. Black Same as Above		
Full Name W. Samuel Black Same as Above		
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box ☒ None Full Name Complete Mailing Address		
12. Tax Status For completion by nonprofit organizations authorized to mail at special rates (Check one) The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes: ☐ Has Not Changed During Preceding 12 Months ☐ Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement) Form 3526, September 1995 (See instructions on Reverse)		

13. Publication Title Infection Control and Hospital Epidemiology	14. Issue Date for Circulation Data Below September 1999	
15. Extent and Nature of Circulation	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net Print Run)	6,487	6,533
b. Paid and/or Requested Circulation (1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales (Not Mailed)	0	0
(2) Paid or Requested Mail Subscriptions (Include advertiser's proof copies and exchange copies)	5,312	5,362
c. Total Paid and/or Requested Circulation (Sum of 15b(1) and 15b(2))	5,312	5,362
d. Free Distribution by Mail (Samples, complimentary, and other free)	433	442
e. Free Distribution Outside the Mail (Carriers or other means)	272	352
f. Total Free Distribution (Sum of 15d and 15e)	705	794
g. Total Distribution (Sum of 15c and 15f)	6,017	6,156
h. Copies not Distributed (1) Office Use, Leftovers, Spoiled	470	477
(2) Returns from News Agents	0	0
i. Total (Sum of 15g, 15h(1), and 15h(2))	6,487	6,633
Percent Paid and/or Requested Circulation (15c/15g x 100)	86%	87%
16. Publication Statement of Ownership ☒ Publication required. Will be printed in the November 1999 issue of this publication. ☐ Publication not required.		
17. Signature and Title of Editor, Publisher, Business Manager, or Owner Richard N. Roach, VP/Group Publisher		Date October 1, 1999
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