

chance of becoming antibody positive for Hepatitis C virus (HCV), usually due to NSI or other penetrating injuries<sup>10</sup>. Given this undoubted risk, it is necessary that Chinese hospital managers consider introducing programmes to reduce NSI and other cutaneous injuries among their medical staff.

## Conclusion

In conclusion, our study suggests that, although infection control practices are variable between hospital departments, the overall rate among Chinese physicians clearly appears to be suboptimal. As such, an urgent priority should now be directed towards infection control practice during clinical procedures. Workplace training and education programmes may be useful in this regard, as well as more convenient access to protective gloves, hand washing stations and sharps disposal bins throughout all areas of the hospital. The direct involvement of infectious diseases physicians has also been shown to improve hand washing rates in other studies<sup>7</sup>, and may therefore be appropriate in China.

## Acknowledgments

We are grateful to all the hospital physicians who participated in our study and to Professor Yingze Zhang from Hebei Medical University, China, for his executive assistance. This project was conducted as part of the China Physicians' Occupational Health Research Group (CPOHRG).

## References

1. Gershon RRM, Vlahov D, Felknor SA *et al.* Compliance with universal precautions among health care workers at three regional hospitals. *Am J Infect Control* 1995; 23:225-36.
2. Stein AD, Makarawo TP & Ahmad MFR. A survey of doctors' and nurses' knowledge, attitudes and compliance with infection control guidelines in Birmingham teaching hospitals. *J Hosp Infect* 2003; 54:68-73.
3. Michalsen A, Delclos GL, Felknor SA *et al.* Compliance with universal precautions among physicians. *J Occup Environ Med* 1997; 39:130-7.
4. Nelsing S, Nielsen TL & Nielsen JO. Non-compliance with universal precautions and the associated risk of mucocutaneous blood exposure among Danish physicians. *Infect Control Hosp Epidemiol* 1997; 18:692-8.
5. Moret L, Tequi B & Lombrail P. Should self-assessment methods be used to measure compliance with handwashing recommendations? A study carried out in a French university hospital. *Am J Infect Control* 2004; 32:384-90.
6. Jeffe DB, Mutha S, L'Ecuyer PB *et al.* Healthcare workers' attitudes and compliance with universal precautions: gender, occupation, and specialty differences. *Infect Control Hosp Epidemiol* 1997; 18:710-2.
7. Salemi C, Canola MT & Eck EK. Hand washing and physicians: how to get them together. *Infect Control Hosp Epidemiol* 2002; 23:32-5.
8. Talaat M, Kandeel A, El-Shoubary W *et al.* Occupational exposure to needlestick injuries and hepatitis B vaccination coverage among health care workers in Egypt. *Am J Infect Control* 2003; 31:469-74.
9. de Vries B & Cossart YE. Needlestick injury in medical students. *Med J Aust* 1994; 160:398-400.
10. Watson KJR. Surgeon, test (and heal) thyself: sharps injuries and Hepatitis C risk. *Med J Aust* 2004; 181:366-7.

## Letters to the Editor

Recently an article in *Australian Infection Control* (Vol 10, Issue 3, September 2005, p103-109) displayed 'Pacer Release' as having a very poor efficacy result and no detectable protein digestion when compared to other products.

The batch number of the Pacer Release sample (780391) is a batch number for a very old batch of product (greater than five years old), and it also is for a superseded formulation that has much lower efficacy than the current 'Release Plus' that is on the market. The original 'Pacer Release' is no longer being manufactured.

Because this poor result has been recently published in a respected publication, the marketplace has assumed that the data is current and relevant, however it is in fact incorrect, misleading and very out of date.

The report states "All products were tested within their individual expiry periods and were diluted immediately before use" and thus if this statement is correct then the tests must have been conducted over three years ago. If the expiry period statement is actually incorrect then the batch in question would have been well out of date. Either way, the data published by your journal is being misconstrued by your readers.

Furthermore we are also disappointed that an obviously commercially funded article such as the one mentioned is put

forth as an independent publication by a University, as opposed to a 3M funded research project.

*Anthony Rayner, Technical Service Supervisor,  
Campbell Chemical, Tel 0418457808 or (07)3710 3239*

Thank you for your recent letter regarding the batch number of the Pacer Release product tested by Dr Cheetham in September 2003. We have checked the records and the batch number of the retained sample and it appears that the actual batch number tested was 348711 (date of manufacture 30/07/03), not 780391 as recorded in the article published. The Pacer Release product Batch number 780391 was the subject of a previous study and was inadvertently transcribed. I apologise for this error.

Regarding the last paragraph of the letter from Campbell Bros, the enzyme work was carried out by University Analytical Laboratory here at UNSW. The products were sourced by UNSW and the protocol used was that of Dr Cheetham who carried out all the work and wrote the article independently and submitted the article for publication. Funding was provided for carrying out the work as we operate as an independent commercial consulting laboratory however the provider of the funds had no influence over the study or any of the results emanating from the study.

*Terry Flynn, Manager, University Analytical Laboratory  
University of New South Wales, Tel: 02 9313 7908 / 0417 023 742*