

Editorial

Walter Popp
Assistant Editor, IJIC

doi: 10.3396/IJIC.v10i2.009.14

This issue of IJIC has a wide variety of papers ranging from highly developed countries to countries with low resources, from high level of infection prevention to very basic level and covering dentistry, surgery, water safety and sepsis prevention.

The paper from Farias *et al.* from India is describing some programs in Dental Clinics in India and making proposals how to improve the situation there. You may find recommendations regarding gloves, face and eye protection, sterilisation, water supply and medical waste; also the hint that staff should be vaccinated against hepatitis B which is not usual in every low income country. I would not agree with every idea, e.g. proposed disinfectants for dental unit water systems, but anyhow this paper is a good start for ongoing discussions about improving hygiene in a big country with big problems in health care sector.

Mafi *et al.* from UK give a review of the literature about negative pressure wound therapy (NPWT) dressing applications. The method was introduced in clinical setting in 1997 and the review is a nice overview about the history of the method and the various applications of vacuum assisted closure dressings. If someone is not common with this therapy he or she will find helpful information in this paper.

Ramcharan *et al.* from the Netherlands describe surveillance of surgical site infections after gastrointestinal surgery. In the light of the bundle hype everywhere they report that the effect of their bundle (peri-operative antibiotic prophylaxis, no hair removal before surgery, normothermia, and discipline in the operating room) had very few effect on the infection rate. This is an experience a lot of us have: If you use bundles in your own hospital the results are by far not as tremendous as always is reported in the famous papers. Additionally, you can get some doubts about the interventions used in a lot of the bundles: is no hair removal before surgery really a new intervention or even (like in many bundles) hand hygiene? Or should it be basic standard, not necessary to mention at all in a bundle? Also the authors frankly report that the compliance with their bundle was not sufficient – also an experience a lot of us will have. An important finding of the study is that a lot of the infections are detected after hospitalisation so that the overall surgical site infection rate should usually include also the post hospital period.

SenGupta *et al.* from India describe an in-vitro investigation about the influence of triclosan coated sutures on typical bacteria from surgical site infections. They could show a good zone of inhibition around the

sutures in comparison to sutures without any coating. Whether this is a way to go on in order to prevent surgical site infections has to be proven in further investigations.

Hell *et al.* from Austria present an investigation about disinfection of *C. difficile* with an oxygen-releasing sporocide. They compare the usual daily use of a quaternary ammonia compound with additional oxygen-releasing sporocide for targeted disinfection with a daily service decontamination of all services with an oxygen-releasing sporocide. They could reduce the *C. difficile* prevalence, especially in patients over 70 years old. The explanation is that the continuous disinfection might lower the environmental contamination by *C. difficile*.

Rivera *et al.* from Spain assess two systems for disinfection of *Legionella* in water systems. The Pastormaster system for potable water was very effective. This is not surprising because it is heating the water on a special point within the system up to 70°C for at least 2 minutes. A photo-catalyst method was used for the cooling system resulting in some reduction of *Legionella pneumophila* serogroup 1 but also an increase of other serogroups. So in my opinion,

for cooling systems biocides might be the best solution because usually there are no humans exposed and, therefore, toxic effects of biocides are not of main concern.

Ramli *et al.* from Malaysia made a 6-month study in a tertiary hospital in order to reduce the blood culture contamination rate. They changed from alcohol plus povidone-iodine solution to alcohol plus chlorhexidine and they described a dramatic reduction of the contamination rate. I have some problems about their decision what is the contamination because this seems to have been made by doctors, more or less from a clinical point of view. Also for me it is not really clear why an additional application of chlorhexidine for few seconds might really have an impact on blood culture contamination rate. Anyhow, we need these studies and we need their publication and also the critical discussion about the methods and conclusions because this is the basis of scientific work and not everywhere scientific work can be done in the same manner as in high income countries.

So this issue is a good mixture of different topics and gives a lot of occasions for critical and fruitful discussions.