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COMMENT ON

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Needlestick injury management – what's the solution?

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The management of needlestick injury is a troublesome problem for surgeons for a variety of reasons. As Thomas and Murray highlight, it is a combined failure of systems reporting and surgical attitudes that place surgeons at risk.

It has previously been shown that surgeons possess little insight into the risks of needlestick injury.¹ In a survey of 45 consultants and trainees, we found that the estimated transmission rates for HIV, hepatitis B and hepatitis C were inaccurately perceived to be 40%, 16% and 24%, respectively. *Ad hoc* risk assessment was performed by 42% of respondents as opposed to following local reporting protocols. To examine why concordance was so low, a second survey was completed examining the reasons influencing such decisions.² The chief reasons cited were disruption to the operating list and a perception that the risk of transmission was insignificant. This reluctance was reflected again in the low numbers of surgeons following local reporting protocols (19%). Despite this, we found that 35% of participants had at least one injury that caused significant anxiety.

Orthopaedic surgeons may be more prone to needlestick injury due to the prevalence of bone spikes in the operative field and the use of sharp orthopaedic instruments such as drills, saws and wires. There is also increased risk of contamination due to aerosolisation of body fluids secondary to

air-driven power tool use. The advent of needlestick or sharps injury is always unpleasant and, on occasion, deeply worrying. Given that blood-borne viral diseases are becoming increasingly prevalent,^{3,4} all patients should be regarded as high-risk, regardless of known viral status.

Thomas and Murray rightfully concluded that occupational health processes need to be streamlined so as avoid deterrence of incident reporting. We must also strive to remove the culture of self risk assessment to promote safer working practices within the environment.

With constant time pressure on operating lists, consultants and trainees will be reluctant to forfeit time going through rigorous machinations of needlestick injury reporting. Perhaps a national protocol is needed to ensure familiarity and compliance with the necessary steps.

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AUTHORS' RESPONSE

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I thank Mr McCann for his comments and congratulate him on his work in this important area. The *ad hoc* risk assessment one makes following a contamination event is risky. I concur with Mr McCann's findings^{1,2} that disruption to operating lists and an inaccurate perception of risk of transmission of a blood-borne virus (BBV) are key factors influencing the post event action. I would also add that an assessment made rapidly and with little consideration, on the basis of an 'educated' guess regarding the BBV status of the patient compounds the unsafe nature of this decision.

The transmission of a BBV to an operating surgeon in this country would be a tragedy. To reduce the risk of this