BC Centre for Disease Control

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ATTN: Medical Health Officers and Branch Offices
Public Health Nursing Administrators and Assistant Administrators
Holders of Communicable Disease Control Manuals

Re: Revised Blood and Body Fluid (BBF) Exposure Management

(1) **Page 3, Section 2.0 Policy:** Includes the statement that post-exposure treatment is required when all of the conditions, as listed, are present.

(2) **Page 4, Section 4.0 Definitions:** The definition for a skin exposure is broken into (i) non-intact skin exposure which includes blood or body fluid contact with skin having compromised integrity (e.g. dermatitis, abrasions, scratches, burns), and (ii) skin exposure in which a large amount of blood or body fluid comes into prolonged contact with skin.

(3) **Page 5, Subsection 5.1 Cleanse:** Includes the recommendation **no**t to apply bleach to the wound or to soak the wound in bleach.

(4) **Page 5, Subsection 5.2 Triage:**

(a) Bullet #1 lists the local HU as an alternate site in some communities for the supply of antiretroviral starter kits.

(b) Bullet #2 includes the recommendation that in the case of bites resulting in blood exposure to either person involved, both persons should go to the local hospital Emergency Department as soon as possible (or to an alternate site supplied with antiretroviral starter kits).

(c) Bullet #4 states that there is no absolute cut-off time for the initiation of therapy in significant risk exposures. While later use of antiretroviral therapy may not prevent transmission of HIV, it may favourably alter the subsequent disease in the exposed person, with later onset of advanced disease.

(5) Page 7, Table 1: <u>Fluids Capable of Transmitting Bloodborne Pathogens:</u>
Specifies that breast milk has a biologic plausibility of transmitting HBV and HCV, particularly if nipples are cracked or bleeding. The 1998 policy specified breast milk as being unlikely to transmit HBV and that there was no evidence that breastfeeding transmits HCV from mother to baby.

(6) Page 7, Subsection 5.3.2 <u>Assess the risk of transmission from the source:</u>
(a) Bullet #2 is new. Testing may be done under pseudonym or using non-nominal identifiers as long as these can be traced appropriately.

(7) Page 8, Subsection 5.3.2 <u>Assess the risk of transmission from the source:</u>
(a) Bullet #1: The following statement has been added to this bullet: "Explain to the source that while the exposed person and their follow-up physician will be informed of the source's test results, they will not be informed of the source's identity."
(b) Bullet #2: Specifies that when the source is unknown, each individual exposure should be carefully evaluated for the risk of each specific pathogen in the source in that community and in that particular setting. Examples of high-risk settings are given. It further states that except for exposures in a high risk setting, HIV prophylaxis will not be given for an unknown source. However, hepatitis B prophylaxis should be given for an unknown source. The 1998 policy advised to respond as if the source is HIV+, HBV+, and HCV+ when the source was unknown.
(c) Bullet #3: The following statement has been added to this bullet: "If all tests on the source are negative, and if the source is not in a high risk group within the window period, no follow-up testing of the exposed person is indicated."
(d) Bullet #4: States that it is not appropriate to consider all source persons who refuse testing as being positive. In the situation of a source person refusing testing, the 1998 policy advised to respond as if the source was positive for HIV, HBV, and HCV.

(8) Page 9, Subsection 5.3.2: <u>Assess the risk of transmission from the source:</u>
(a) Bullet #2: Information has been deleted pertaining to P24 antigen testing as negative tests are inconclusive.

(9) Page 10, Table 2: <u>Indicators for Increased Risk of Transmission From the Source to the Exposed Person.</u>
For all of the indicators, it states "The source is a person **who has ever had…**" The 1998 policy had specified "within the past 3 months" for some of the indicators. Another indicator for increased risk of transmission of HIV from the source has been added: "history of receipt of blood-derived coagluation products before July 1988." A history of dialysis has been added as an indicator for increased risk of transmission of HIV and HBV from the source to the exposed

person. The 1998 policy listed a history of dialysis as an indicator for increased risk of transmission of HCV only. Pertaining to HCV, if the source is a person who has ever had a sexual partner who has a history of multiple transfusion of blood or blood products: the date of "prior to June 1990" has been changed to "prior to May 1992." First generation anti-HCV testing came into use June 1990, while second generation anti-HCV testing came into use May 1992. Second generation anti-HCV testing was much more sensitive than first generation.

(10) Page 11, Section 5.4 <u>Determine the HIV, HBV, and HCV status of the exposed person:</u>

(a) Bullet #1: Stresses the importance of baseline testing for occupational exposures and possible compensation by the WCB.

(b) Bullet #3: Where the exposure is work-related, consent must also be obtained for the release of the blood testing results of the exposed person to the exposed person's worksite Occupational Health Department and/or WCB as needed for follow-up. The exposed person should also be informed that positive results for reportable diseases will be forwarded to public health.

(11) Page 12, Section 7.0: <u>Arrange clinical and laboratory follow-up:</u>

(a) Bullet #2: Added the instruction that, when sending a specimen for HIV testing, identify the specimen as a possible HIV exposure and phone the lab to notify staff so that rapid turn around can be achieved.

(12) Page 13, Table 3: Testing of the Exposed Person:

Anti-HBc has been added. Testing for HBsAg 3 months after exposure is no longer recommended. Testing for anti-HBs is recommended at 6 months after exposure. These changes were made to be consistent with the revised Hepatitis B Control Policy, dated July 2001. Testing at 12 months is now recommended for anti-HIV, HBsAg, anti-HBs, anti-HBc, and anti-HCV. This testing is primarily for the purposes of reassurance. Also, with administration of HBIG and antiretrovirals, the incubation periods may be prolonged. A footnote has also been added stating that if the exposed person is a pregnant woman, do HBV testing as close to delivery as possible.

(13) Page 14, Section 8.0 <u>Record:</u>

Bullets #1and #4 are new.

(a) Bullet #1: emphasizes that the white copy (copy 1) of the HLTH 2339 "Management of Percutaneous or Permucosal Exposure to Blood or Body Fluid/Laboratory Requisition" contains information pertaining to the source person. For reasons of confidentiality, the white copy should be forwarded **ONLY** to the laboratory that will be doing testing for the exposed person (and/or the source person).

(b) Bullet #4 specifies that for occupational exposures, copy 4 (goldenrod) of the HLTH 2339 should be forwarded to the WCB. The HLTH 2339 is

replacing the WCB Form 8. The WCB will pay the physician/health care facility for the completion of the HLTH 2339 for occupational exposures.

(14) Page 15, Table 4 Stratification of HIV Exposures:
There are only two exposure risk categories. One is "significant risk," for which an antiretroviral starter kit is recommended. The other is "negligible risk," for which no antiretrovirals are recommended. Previously, there were three exposure risk categories (higher risk, moderate risk, and negligible risk). Antiretrovirals were recommended for two of these categories (higher risk and moderate risk). No antiretrovirals were recommended for the third category of "negligible risk."

(15) Page 16, Subsection 9.1.1 Antiretroviral therapy:
(a) Bullet #1 is new.
(b) Bullet #6: Antiretrovirals are **NOT** recommended for needlesticks from an abandoned needle in a community setting when there is no history of the origin of the needle or the time of its abandonment. There are several reasons for this:

- There has never been a seroconversion anywhere from a community exposure
- There are real risks from the antiretrovirals
- Risks from the antiretrovirals outweigh the theoretical risk of seroconversion from a community exposure

Hepatitis B immunoprophylaxis is still recommended for needlesticks from an abandoned needle in any community setting.

(16) Page 18, Subsection 9.1.3 Post-exposure HIV antiretroviral therapy in children: This is a new subsection.

(17) Page 18, Subsection 9.1.4 Post-exposure HIV antiretroviral therapy in pregnant women: This is a new subsection.

(18) Page 18, Subsection 9.2 HBV exposure:
(a) Bullet #1: Deleted the conditional phrase, "**if there is blood in the mouth of the biter or in the wound of the person bitten."** Anti-HBc has been added to the tests to be done on the exposed person.

(19) Page 20, Table 5: Post-exposure prophylaxis for percutaneous and mucosal exposures:

Information is this table is consistent with the revised Hepatitis B Control Policy, dated July 2001, with the following exceptions:

- if the exposed person has a documented anti-HBs level ≥ 10 IU/ml at any prior time, baseline testing for all 3 markers is indicated for medical-legal reasons;
- given the new 2 dose schedule for Recombivax vaccine for individuals aged ≥ 11 years but ≤ 15 years, two of the categories pertaining to the previous history of the exposed person have been re-named. The two renamed categories are "2 doses of a 3 dose series of HBV," and "complete HBV vaccination (2 or 3 dose series)."
- recommendation for a 3 dose, rather than 4 dose, HBV series if the source tests HBsAg negative within 48 hours of exposure and the exposed person is unvaccinated or a known non-responder to one course of HBV. The July 2001 Hepatitis B Control policy will be changed to reflect these revised recommendations. A footnote has also been added defining a non-responder to hepatitis B vaccine.

(20) Page 21, Subsection 9.2 HBV exposure:

(a) Bullet #5: Test for HBsAg, anti-HBc, and anti-HBs at 6 and 12 months post-exposure. This recommendation is consistent with the revised Hepatitis B Control Policy, dated July 2001. The 1998 policy recommended testing for only HBsAg at 3 and 6 months.
(b) Bullet #6: Is new.

(21) Page 22, Subsection 9.3 HCV Exposure:

The exposed person should be tested for anti-HCV at 6 weeks, and 3, 6 and 12 months post-exposure. Recent studies have found that early treatment following seroconversion is beneficial.

(22) Page 25, Subsection 10.2 Testing:

Addition of the statement that if a woman of childbearing age is exposed, consider pregnancy testing when warranted.

(23) Page 25, Subsection 10.4 Follow-up of Source Person:

Bullet #2 is new.

(24) Page 26, Subsection 10.5 Reducing transmission to others:

Modification of recommendation: "Dispose of bloody sharp items into a hard-sided container. Dispose in regular garbage, do not place in container for recycling."

(25) Page 27, Subsection 10.5 Reducing transmission to others:
Addition of the recommendation that if a breastfeeding mother is on antiretrovirals, any pumped breast milk must be discarded.

(26) Page 27, Subsection 10.5 Reducing transmission to others:
(a) Bullet #3: There is additional information pertaining to an anti-HCV mother breastfeeding. The mother should be advised to consult her physician to discuss the risks and benefits of breastfeeding if she was exposed to an anti-HCV+ source.
(b) Addition of recommendation: "If a breastfeeding mother is exposed to a HBV positive source, or an unknown source, immunize both the mother and her infant against hepatitis B, using both hepatitis B vaccine and HBIG. The mother can then continue to breastfeed."

(27) Page 28, Subsection 10.5 Reducing transmission to others:

Addition of practice guidelines for exposed health care workers.

The revised BBF Exposure Management policy has also been sent to the following groups:

- Infection Control Practitioners and Occupational Health Nurses in acute care hospitals across the province
- Government Employee Health Services Occupational Health Nurses
- Emergency Departments of all hospitals in the province and all sites that supply antiretroviral starter kits.

As the HLTH 2339: "Management of Percutaneous or Permucosal Exposure to Blood and Body Fluid/Laboratory Requisition" is replacing the WCB Form 8 for occupational exposures, it is anticipated there will be more widespread use of the form. With this increased usage, there is the possibility of using the information in the future development of a provincial database for BBF exposures.

To ensure the most effective implementation of the revised BBF policy, it is hoped that Health Service Delivery Areas will discuss the guidelines with their local hospital emergency departments and/or local hospital Infection Control Practitioners/Occupational Health Departments.

Stock of the HLTH 2339 and HLTH 2340 can be ordered from Warehousing Services, 742 Vanalman Avenue, Victoria BC, V8Z 3B5; phone (250) 952-4439.

Please remove and destroy the following pages from the Communicable Disease Control Manual:

Blood and Body Fluid Exposure Management Policy Pages 1 to 24	Dated June 1998
HLTH 2339 “Management of Percutaneous or Permucosal Exposure to Blood and Body Fluid”	Dated May 1998
HLTH 2340 “Letter for Follow-up Physician”	Dated May 1998

Insert the following pages in the Communicable Disease Control Manual:

Blood and Body Fluid Exposure Management Policy Pages 1 to 30	Dated April 2002
HLTH 2339 “Management of Percutaneous or Permucosal Exposure to Blood and Body Fluid”	Dated April 2002
HLTH 2340 “Letter for Follow-up Physician”	Dated April 2002

If you have any questions or concerns, please contact Karen Pielak, Nurse Epidemiologist, BCCDC Epidemiology Services at karen.pielak@bccdc.ca or phone (604) 660-6061.

Sincerely,

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