CORRESPONDENCE

Glove puncture in the post mortem room

Weston and Locker document the high incidence of glove puncture in the post mortem room and advocate “frequent glove changes and hand washing throughout the post-mortem examination.” An alternative is to wear thicker gloves which are less easily punctured. I have used for some time now Long Nitrosolve gloves (Marigold Industrial), over a standard pair of nitrile surgical gloves. The heavy gloves are resistant to puncture and also afford protection against splashes almost up to the elbow. They feel clumsy at first but one soon becomes used to them. They can be washed and reused several times and are also economical.

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I read with interest the article by Weston and Locker regarding the frequency of glove puncture in the post mortem room. I am sure that few practising histopathologists could argue with their finding that glove punctures, both noticed and unnoticed, are extremely rare, and a similar observation was made by Babb et al in 1989, although actual wounds are, in my experience, comparatively rare in experienced staff. This has undoubtedly always been the case in post mortem work and consequently, we strive to make the procedure as safe as possible.

I have not rigorously tested my used gloves, but on the subjectively uncommon occasions when the outer glove was punctured, the inner glove appeared to have prevented any contamination of the skin. Given my prejudices, and the fact that most of my necropsy work is on infectious disease cases, I would now be unwilling to partake in a controlled comparative trial of single versus double gloving.

May I recommend discussion of the following proposals for necropsies: 1 Medicine and pathology have irrevocably changed since the HIV epidemic arrived: this one should assume that every cadaver is potentially infected. 2 Universal precautions, involving the use of double gloves, impermeable disposable gowns, masks, hats, and eye protection, should be used during all necropsies. This applies to both technicians and pathologists.

I would move to minimise the chance of glove puncture by adopting non-pointed instruments; round-ended scissors are obvious, and non-pointed scalpel blades are available. 4 We should re-evaluate dissection procedures in the light of the questions being asked; for example, in HIV seropositive cases removal of the prostate does not usually produce further relevant information and could be omitted.

I would suggest that a cover slip be used over any puncture. This is in accordance with the number of punctures that punctuates that punctuates the heart, arteries, veins, or other soft tissues.

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Diagnostic value of fibronectin determination in cerebrospinal fluid

Torre et al recently reported increased concentrations of fibronectin in the cerebrospinal fluid (CSF) of patients with bacterial meningitis, but not with viral meningitis, measured by a commercial turbidimetric and immunossay. Their results correspond to our study on the differential diagnostic value of CSF fibronectin determination using an enzyme-linked immunosorbent assay, although their mean (SEM) control concentrations were somewhat higher (6-7 (1-3) mg/l as opposed to 3-3 (0-3) mg/l) and their mean concentrations in bacterial meningitis were far lower (13-9 (6-1) mg/l compared with 64-0 (6-3) mg/l in our study. Their observation of decreased fibronectin concentration (2-2 (1-8) mg/l) in viral meningitis is very interesting as we did not find any decrease in various neurological disorders including lumbar disk disease, multiple sclerosis, acute demyelinating polyradiculoneuropathy, Guillain-Barré, neurologically asymptomatic HIV infection, tick-borne encephalitis, and diffuse leptomeningeal neoplasia. However, we detected very high concentrations of CSF fibronectin not only in bacterial meningitis but also in tick-borne encephalitis (26-7 (4-4) mg/l), neuroborreliosis (27-0 (3-6) mg/l), and notably in leptomeningeal neoplasia (58-4 (16-0) mg/l). Clinical data will help to distinguish infectious from neoplastic cerebrospinal disease in most patients but increased CSF

Dr Weston and Locker, comments:

We note that Lindsay and Lucas advocate wearing heavy duty gloves over surgical gloves for post mortem examinations. We have ordered some Long Nitrosolve gloves to try out. Dr Lucas suggests that his inner gloves protect him from skin contamination if his outer gloves are punctured. However, as we point out in our paper 31-8% of glove punctures go unnoticed and this is where the danger of prolonged skin contact with potentially infected material lies.

We do not mean to imply that changing gloves frequently and especially at the end of the evisceration prevents against hand contamination, but that it prevents prolonged skin contact with contaminated material via an unnoticed glove puncture.

Dr Dunn's opinion that the extra cost incurred by frequent glove changes during postmortem examinations is not justified concerns us. The paper cited reports that one case of tuberculosis and two of hepatitis B occurred in 76 mortuary technicians over 12 months. There were also 21 minor lacera
tions. While this may not cause much immediate morbidity, the constant risk of infection with HIV or indeed with hepatitis B or tuberculosis due to an unnoticed glove puncture would be calculable. We agree that to date the risk of infection via an unnoticed glove puncture has been slightly rather than real, but as the prevalence of HIV increases this trend could well reverse and is not a risk worth taking. All possible protective measures should be practised. This view also seems to be held by Dr Lucas.

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