classified as clean procedures, and should have an infection rate of less than 2%. Graft infections are difficult to estimate because cases may not become clinically evident for several years. In general, bypass operations involving groin incisions, prosthetic material, recent arterial puncture, and distal limb infection have a higher risk of graft infection.

Lower-extremity amputations following vascular reconstruction vary with type of procedure and indications for surgery. Overall, early limb amputation should be less than 5%. Amputations following operation for intermittent claudication should be essentially zero, but may be as high as 10% to 15% in cases of severe ischemia or gangrene. Further material on these subjects is available.[1,2]

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Scrubbing Between Cases in Nursery

To the Editor:

The Editorial in your March 1984 issue contained the statement "Conditions in nurseries frequently make it difficult for staff to wash hands between infant contacts, fostering spread of infection."[1] I take exception to this statement, since I cannot conceive of any condition, other than a life-threatening emergency, which would justify neglecting to wash one's hands between infant contacts. One might as well say the following: "Conditions in operating rooms frequently make it difficult for staff to scrub between cases."

The reference given by Dr. Rein in support of this statement makes no such implication.[2] It states that it is not uncommon for personnel to fail to perform this all important function. It in no way implies that such behavior is acceptable.

It is important that a journal devoted to the control of infection examine carefully such editorial statements to avoid the appearance of condoning such negligence.

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Dr. Michael F. Rein, author of the Editorial, replies to Ms. Keelan's comments.

I wholeheartedly agree with Ms. Keelan's view that scrupulous handwashing is crucial to infection control in the nursery and other areas of the hospital. My statement regarding conditions in nurseries should be regarded as an explanation rather than as an excuse or a justification for lax handwashing technique. In fact, motivating personnel to wash their hands is often difficult. The problem is compounded by the layout of some facilities in which, for example, a single, small, inconveniently located sink serves an entire nursery room. Fortunately, hospital planners are now taking such considerations into account and are designing facilities with multiple, conveniently located sinks. Newer technology, including, for example, electric eye triggered faucets, may also make handwashing easier and therefore more likely to be practiced regularly. An appropriate physical plant is one important element of a program to control nosocomial infection. I apologize for giving the impression that I condone lax handwashing practices.

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