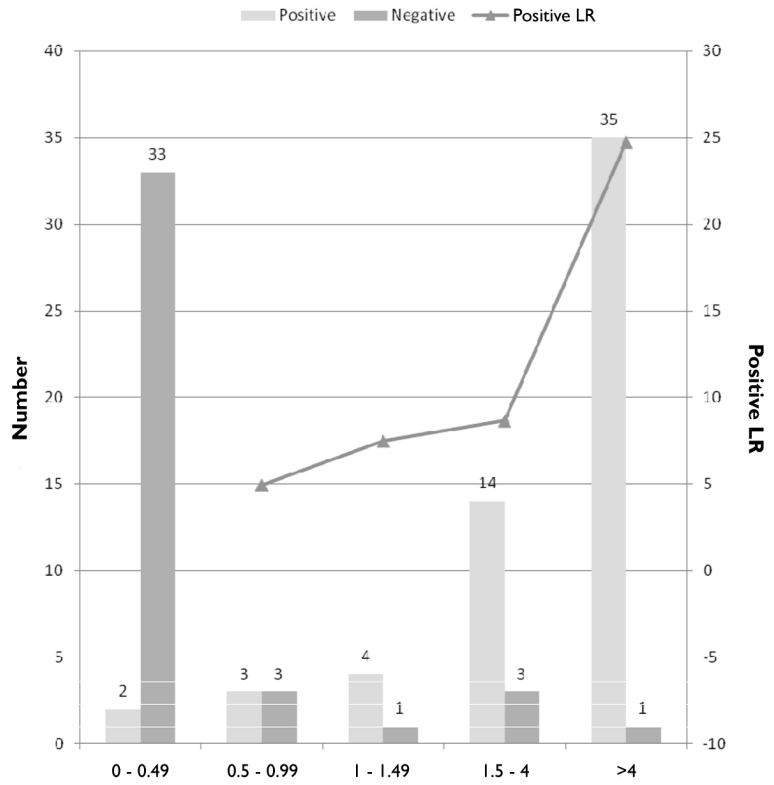

Figure 1. Positive likelihood ratio (LR), according to bronchoalveolar lavage galactomannan test results.

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The Endangered White Coat

To the Editor—In June of 2009, the American Medical Association (AMA) House of Delegates passed a resolution to encourage the "adoption of hospital guidelines for dress codes that minimize transmission of nosocomial infections (NI)" [1, p. 15]. So began publication of editorials and news stories questioning whether white coats cause harm to patients [2]. This debate is not new—for example, changes in dress codes for hospital personnel have been implemented in the United Kingdom [3–5]—but renewed interest has again brought this issue to the forefront [2, 6, 7]. Hospital personnel in the United Kingdom now abide by a "bare below the elbows" policy when in patient care areas, in hopes that this will decrease the incidence of NI. Although the United Kingdom has implemented these changes, no studies have looked at the effect of physician's white coats or the bare below the elbows policy on NI rates.

The British Department of Health issued guidelines to help prevent NI [8]. They cite Wilson et al [9] and Loveday et al [10] as the evidence base for their recommendations. They acknowledge that the study by Wilson and colleagues offers "no conclusive evidence that uniforms (or other work clothes) pose a significant hazard in terms of spreading infection" [8, p. 6]. However, they still recommend a bare below the elbows policy [8]. Loveday and colleagues attempted to gauge the public's perception of health care worker uniforms in relationship to infections and concluded that "the general public's perception is that uniforms pose an infection risk when worn inside and outside clinical settings" [10]. In addition, *EPIC2: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England* also concluded that "none of these studies established an association between contaminated uniforms and HCAI (healthcare associated infections)" [11].

Although little clinical evidence exists regarding the impact of these potential fomites on NI, some data seem to give credence to the thought that clothing may play a role in transferring pathogens. Several studies have shown that physicians' white coat sleeves and pockets are frequently colonized with bacteria associated with NI [12–15]. Mackintosh et al [16] also showed that several pathogens transferred well from fabrics to hands. Scott et al [17] showed that several types of pathogens can be transferred from contaminated soiled cloth and surfaces to fingertips in detectable numbers. In a cost-benefit analysis, Puzniak et al [18] showed that gown and glove use together lowered

the incidence of vancomycin-resistant enterococci infection in a medical intensive care unit, which would seem to support the claim that clothes are a potential fomite for NI.

NI accounted for 1.7 million infections in 2002, which resulted in 99,000 deaths in the United States, and it is estimated to cost $6.7 billion per year [19, 20]. With such a significant impact from NIs, it is understandable that preventing them is a desirable outcome; however, the AMA took the appropriate position in recommending more research before implementing resolutions or guidelines on the removal of white coats or implementing a bare below the elbows policy in the United States.

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Mixed Cryoglobulinemia: A Role for Parvovirus B19 Infection

To the Editor—The association of parvovirus B19 with autoimmune conditions has been reported with increasing frequency, including in patients with vasculitis (mainly polyarteritis nodosa). Here, we describe a patient with mixed cryoglobulinemia that followed acute B19 infection.

A 37-year-old white woman was admitted to our hospital because of new-onset symmetrical and febrile polyarthralgia, which affected her wrists, elbows, knees, and ankles, without joint swelling. She had no notable medical history and was taking no medications. The onset of symptoms occurred just after she had visited the mountains, 2 weeks before admission. Although these symptoms resolved rapidly and spontaneously, she presented with severe myalgia and weakness of lower limbs.

Physical examination revealed a painful infiltration of the calves that predominated on the right. There was no associated cutaneous manifestation, and neurological examination and muscular strength were normal. Laboratory data at hospital admission included a mild increase in the C-reactive protein level (to 0.34 mg/dL) and normocytic aregenerative anemia (hemoglobin level, 109 g/L). The serum level of creatine phosphokinase was normal. Magnetic resonance imaging revealed hypersignal (T2STIR) related to an inflammatory diffuse muscular infiltration of lower limbs (Figure 1). Immunological analysis revealed no antinuclear or antineutrophil cytoplasmic antibodies but did reveal rheumatoid factor (320 UI/mL; normal level, <15 UI/mL), complement consumption of the C4 fraction (0.05 g/L; normal range, 0.2–0.4 g/L), and abundant mixed cryoglobulin (type II with monoclonal immunoglobulin [Ig] Mκ component). Serologic tests for hepatitis viruses A–C, human immunodeficiency virus, cyto-