



THE UNIVERSITY OF WESTERN AUSTRALIA

Achieving International Excellence

2nd February 2011

PODIATRIC MEDICINE UNIT

School of Surgery

M422
35 Stirling Highway
Crawley WA 6009

T 08 6488 4523
F 08 6488 4525
E alan.bryant@uwa.edu.au
www.meddent.uwa.edu.au/podiatry

CRICOS Provider Codes: 00126G, 064877F, 064876G, 064878E

Mr Jason Warnock
Chair, Podiatry Board of Australia
Health Practitioner Regulatory Agency
G.P.O. Box 9958
Melbourne VIC 3001

Dear Jason

Re: Blood Borne Consultation Paper – December 10, 2010

I would like to make a few personal comments regarding the above consultation paper, in particular to exposure prone procedures (EPPs) and the potential for the transmission of a blood borne virus (BBV) from a podiatrist/podiatric surgeon to a patient.

I note that the Board defers to the 2010 NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare recommendations. These recommendations, with respect to the practice of podiatry state:

"Routine procedures undertaken by podiatrists who are not trained in and do not perform surgical techniques are not exposure prone. Procedures undertaken by podiatric surgeons include surgery on nails, bones and soft tissue of the foot and lower leg, and joint replacements. In a proportion of these procedures, part of the operator's fingers will be inside the wound and out of view, making them EPPs" (pg 183).

The NHMRC categorise EPPs with increasing level of risk transmission from practitioner with a BBV infection to patient (pg 179):

Category 1 A procedure where the hands and fingertips of the healthcare worker are usually visible and outside the body most of the time and the possibility of injury to the worker's gloved hands from sharp instruments and/or tissues is slight. This means that the risk of the healthcare worker bleeding into a patient's open tissues should be remote, e.g. insertion of a chest drain.

Category 2 A procedure where the fingertips may not be visible at all times but injury to the healthcare worker's gloved hands from sharp instruments and/or tissues is unlikely. If injury occurs it is likely to be noticed and acted upon quickly to avoid the healthcare worker's blood contaminating a patient's open tissues, e.g. appendicectomy.

Category 3 A procedure where the fingertips are out of sight for a significant part of the procedure, or during certain critical stages and in which there is a distinct risk of injury to the healthcare worker's gloved hands from sharp instruments and/or tissues. In such circumstances it is possible that exposure of the patient's open tissues to the healthcare worker's blood may go unnoticed or would not be noticed immediately, e.g. hysterectomy.

In practice, the vast majority of routine elective podiatric surgery should be considered as non-exposure prone, given that the hands and fingers of the surgeon are *not* placed blindly within body cavities where sharp bony fragments or instruments are likely to be. A 'needle-stick' injury in podiatric surgery, although very uncommon, is most likely to be caused to the operator during suturing or to the surgeon, assistant or scrub nurse during the passage of instruments, distant to and highly unlikely to contaminate the wound and therefore the patient. 'Needle-stick' injuries in

podiatry are more likely to occur during the 'simple' act of debriding a moist foot ulcer or a hyperkeratotic pressure lesion in general podiatry practice.

While a podiatric surgeon could cause to upgrade non-EPP surgery to Category 1 or 2 EPP surgery by inserting their finger into an open wound where sharp bony fragments or instruments are, this is totally preventable and would be considered very poor surgical technique. The risk of transmission of a BBV from a practitioner to a patient, provided standard precautions, including double-gloving and sound surgical technique is practiced, is extremely unlikely to occur. While there have been a few reports in the literature of oral, orthopaedic and cardiovascular surgeons transmitting a BBV to a patient during an operation, there has never been a single recorded incident of transmission of a BBV from a podiatric surgeon to a patient. This is almost certainly related to the type of surgery being performed by the various surgical disciplines. Unlike the aforementioned surgical specialties, podiatric surgeons are not involved in the surgical management of traumatic fractures where spicules of bone are encountered and wire suturing is required rendering these procedures exposure prone.

With respect to the proposal that podiatric surgeons should be required to have annual blood checks I would offer the following comments. While the proposal is an attempt to protect the public, once acquired, BBVs can usually be demonstrated in blood tests after three months post-inoculation. For this proposal to be effective, the Board would need to require practitioners to subject themselves to on-going blood checks every three months! In reality, unless the practitioner has suffered a 'needle-stick' injury or engages in personal practices that place himself or herself at risk of contracting a BBV, then it should not be necessary for practitioners to undergo annual blood checks at all. The transmission of BBVs in the surgical setting is more likely to be from *patient to practitioner*, and I note that there is no proposal to routinely check the preoperative BBV status of patients. Ethically, any such proposal would of course be untenable.

Therefore, while it is quite appropriate to request podiatrists and podiatric surgeons to be cognizant of their health status, the onus should be on the practitioner to act responsibly and to monitor their health as necessary. Should a practitioner become infected with a BBV they should certainly seek appropriate medical management and counseling. However, they should not automatically be excluded from performing routine elective podiatric surgery. Adherence to standard universal precautions and sound surgical technique should be mandatory for all podiatric surgeons. In the unlikely event that there is epidemiological evidence that a practitioner is responsible for the transmission of a BBV to a patient, then that individual should naturally be excluded from practicing procedures of the type involved.

Yours sincerely



Alan Bryant
Head, Podiatric Medicine Unit