recovery, convalescent patients continue to pose a risk of disease transmission. Therefore, patients convalescing from a filoviral or an arenaviral infection should refrain from sexual activity for 3 months after clinical recovery.

POSTEXPOSURE PROPHYLAXIS

Effective prophylaxis following exposure to an HFV is hampered by the absence of effective vaccines and antiviral medications. The working group does not recommend preemptive administration of ribavirin in the absence of signs of infection to persons with known or suspected exposures to the HFVs. Ribavirin has no utility against filoviruses or flaviviruses. For arenaviruses, there is limited experimental evidence that postexposure prophylaxis with ribavirin will delay onset of disease but not prevent it. Furthermore, the effectiveness of ribavirin as postexposure prophylaxis for arenaviruses or Rift Valley fever virus has never been studied in humans. While 1995 CDC guidelines recommend ribavirin to high-risk contacts of patients with Lassa fever, a review and possible revision of these recommendations is to be shortly undertaken (James Hughes, MD, oral communication, January 10, 2002). However, public health professionals suggest that stratification of risk groups into high-risk and close contacts may facilitate counseling and outbreak investigation. High-risk contacts are those who have had mucous membrane contact with a patient (such as during kissing or sexual intercourse) or have had a percutaneous injury involving contact with the patient's secretions, excretions, or blood. Close contacts are those who live with, shake hands with, hug, process laboratory specimens from, or care for a patient with clinical evidence of VHF prior to initiation of appropriate precautions. Persons considered potentially exposed to HFVs in a bioterrorist attack and all known high-risk and close contacts of patients diagnosed with VHF should be placed under medical surveillance. All such individuals should be instructed to record their temperatures twice daily and report any temperature of 101° F (38.3° C) or higher (or any symptom noted in Table 3) to a clinician, hospital epidemiologist, or public health authority designated with surveillance. Surveillance should be continued for 21 days after the person's deemed potential exposure or last contact with the ill patient. If a temperature of 101° F (38.3° C) or higher develops, ribavirin therapy should be initiated promptly as presumptive treatment of VHF, as described in Table 4, unless an alternative diagnosis is established or the etiologic agent is known to be a filovirus or a flavivirus. In the case of close and high-risk contacts of patients diagnosed with Rift Valley fever or a flavivirus, only those who process laboratory specimens from a patient prior to initiation of appropriate precautions require medical surveillance, as these specific viruses are not transmitted from person to person but may be transmitted in the laboratory setting.

Table 4. Recommendations for Ribavirin Therapy in Patients With Clinically Evident Viral Hemorrhagic Fever of Unknown Etiology or Secondary to Arenaviruses or Bunyaviruses*

	Contained Casualty Setting	Mass Casualty Setting†
Adults	Loading dose of 30 mg/kg intravenously (IV) (maximum, 2 g) once, followed by 16 mg/kg IV (maximum, 1 g per dose) every 6 hours for 4 days, followed by 8 mg/kg IV (maximum, 500 mg per dose) every 8 hours for 6 days	Loading dose of 2000 mg orally once, followed by 1200 mg/d orally in 2 divided doses (if weight _75 kg), or 1000 mg/d orally in 2 doses (400 mg in AM and 600 mg in PM) (if weight_75 kg) for 10 days‡
Pregnant women §	Same as for adults	Same as for adults
Children	Same as for adults, dosed according to weight	Loading dose of 30 mg/kg orally once, followed by 15 mg/kg per day orally in 2 divided doses for 10 days

*Recommendations are not approved by the US Food and Drug Administration for any of these indications and should always be administered under an investigational new drug protocol. However, in a mass casualty setting, these requirements may need to be modified to permit timely administration of the drug.

†The threshold number of cases at which parenteral therapy becomes impossible depends on a variety of factors, including local health care resources.

‡Although a similar dosage (1000 mg/d in 3 divided doses) has been used in a small number of patients with Lassa fever, this regimen would be impractical because the current formulation of oral ribavirin in the United States consists of 200-mg capsules, and ribavirin capsules may not be broken open.

§ Refer to the section in text on treatment of pregnant women for details.

9.「各医療施設が決定すべき事項」の例について

限られた資源の中で、全く一類感染症を疑わない段階から、想定される段階、確定した段階と、対応が必要になる。現実は刻々と変化しうる。

重要なことは以下の事項を明確化することである。

「決定方法」を明確化すること
「何を決定したか」を明確化すること
「その決定内容の有効期限はいつまでか」を明確化すること
「新たな決定事項が必要となった場合の決定方法」の明確化すること

以下の事例が重要な決定事項の例と考える。
「一類感染症(想定)患者」に対する医療として、個人防護具(PPE)として何を選択するのか？
「一類感染症(想定)患者」に対する医療として、医療のレベルをどこまで実施するのか？
「一類感染症(想定)患者」に対する医療として、看護のレベルをどこまで実施するのか？
「一類感染症(想定)患者」に対する医療として、検査のレベルをどこまで実施するのか？
「一類感染症(想定)患者」に対する医療として、画像診断の範囲をどこまでにするか？
「一類感染症(想定)患者」に対する医療として、人工呼吸器の使用を含めるのか？
「一類感染症(想定)患者」に対する医療として、内視鏡の使用を含めるのか？
「一類感染症(想定)患者」に対する医療として、ICU の使用を含めるのか？
「一類感染症(想定)患者」に対する医療として、人工透析機器の使用を含めるのか？
「一類感染症(想定)患者」に対する医療として、外科的処置(主に手術)を含めるのか？
「一類感染症(想定)患者」をいつまで、発見された医療施設で対応するか？

以上の事項を決定する上で、病院全体の能力に基づいて判断しなければならない。担当医師が疾患を充分理解し診療に熱心であったとしても、看護部門、検査部門等他部門に「疾患に対する理解」が乏しい場合には、医療スタッフは危険に曝されることになる。