

tuberculosis is not under control and case numbers continue to increase, though not at the levels reported from Latvia. Particular problems are identified with tuberculosis in the homeless, drug users and alcoholics. The authors call for greater adaptation of treatment and care services in London to cater for the special needs of those at greatest risk of tuberculosis in the capital including greater use of DOT (especially in the intensive phase) and greater support for patients during treatment.

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EDITORIAL

TATTOOING AND PIERCING – THE NEED FOR GUIDELINES IN EU

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As in Amsterdam [1], the impetus for UK guidelines for hygienic tattooing came from an outbreak of hepatitis B caused in 1978 by a tattooist. The outbreak resulted in 30 primary and 3 secondary cases [2]. Guidelines for hygienic tattooing followed soon after, and were taken up, fairly enthusiastically on the whole, by the tattooists. These were expanded in 1982 to include acupuncture, ear-piercing and hair electrolysis. Laws to control the hygiene of these practitioners were introduced at the same time [Local Government Miscellaneous Provisions Act 1982 [amended 2003] and the Greater London Council [General Powers] Act 1982]. Body piercing was hardly heard of at the time: although it was undoubtedly and somewhat furtively practised, it was not as popular or as open as it is now. Guidelines for beauty therapy, hygienic hairdressing and micropigmentation followed.

The main, and most urgent, problem with non-medical skin penetration is hygiene – in particular the transmission of bloodborne viruses, and especially hepatitis B. This virus is arguably the most infectious organism known to man and can survive for long periods in the environment. Fortunately, the guidelines formulated in 1978 and 1982 in the UK were for hepatitis B, so that when the other two main bloodborne viruses, hepatitis C and HIV, became known a little later, being much less resistant, they were adequately covered by the guidelines.

HCV may be asymptomatic for years, and HIV may also be asymptomatic, though usually for a shorter period. HBV infection in adults is less commonly asymptomatic, but all three infections eventually cause serious symptoms. The incubation periods for these three infections can be long, which can make outbreaks difficult to recognise. Bacterial infection must also be considered – in my experience, these usually arise from poor aftercare or poor aftercare advice. Infection introduced at the time of the piercing may lead to septicaemia and even to endocarditis in susceptible persons, and also, of course, to wound infections. Infection arising after piercing the cartilage of the ear is a particular and urgent problem, brought about as frequently by poor aftercare as by an unhygienic piercing.

The hygiene of non-medical skin piercing needs to be addressed urgently in the EU, so that uniform and effective guidelines can be applied throughout the Community. Otherwise, with different guidelines, standards of practice will vary from country to country.

Other factors that need to be addressed urgently (not all to do with hygiene) are

Besides the hygiene of non-medical skin piercing, other factors need to be addressed such as training and accreditation of practitioners

- Age of consent for each type of piercing, as well as competence to give consent;
- The use of disinfectants, including alcohol for skin disinfection and work surfaces, chlorine-based solutions for surfaces and blood spills, etc
- The training and accreditation of practitioners, which follows from the above;
- The use of anaesthetics, including ethyl chloride which is more painful than the piercing and may cause freezer burns, and local anaesthetic creams;
- Pre-piercing advice, including warning of the possibility of complications (for ear-cartilage piercing in particular);
- Aftercare advice given to customers;
- Record keeping;
- Ethical issues, such as forming an accredited association of competent practitioners who will ensure high standards so that members of the public know they will receive a guaranteed service of competence and safety, as well as those (alcohol and drugs) referred to by Worp and colleagues. There should be one national association for each type of practitioner, so that uniform standards are followed.
- Epidemiological studies of the rate and incidence of complications following the different types of piercing. A study is currently being conducted by the Health Protection Agency Centre for Infections in England and Wales.

The use of non-sterile or chemically toxic pigments, as specified by Worp and colleagues, undoubtedly also needs attention but I am not aware of infection caused by pre-contaminated pigment and the problems of toxicity and allergy need more research before making recommendations. Guidelines for hygiene and the other factors mentioned should not have to wait for these.

The authors are to be congratulated for their fine work in controlling non-medical skin piercing in Amsterdam, and in particular for their work in monitoring the performance of skin piercing establishments.

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