consensus on the topic stems from a need for quality scientific research regarding the subject matter. Preventing the devastating outcomes associated with surgical site infections (SSIs) should not be left up to guesses.

We acknowledge and commend the Association of Perioperative Registered Nurses for their continued focus in optimizing perioperative care and for modifying their guidelines in July 2019 prior to the publication of our study. However, the new guidelines raise similar concerns of waste without proven patient benefit. The updated recommendations are based on a single study by Markel et al1 that found a statistically significant reduction in airborne particle sizes when arms were covered with disposable sleeves while patients were undergoing preoperative skin preparation. Despite a reduction in particle sizes, there was not a significant difference in bacterial count and the settle plate colony-forming units. They did find a reduction in the bacterial genus Micrococcus vs coagulase negative Staphylococcus aureus and Corynebacterium; however, this genus of bacterium is unlikely to cause SSIs.2

Most causes of SSI are owing to the patient's endogenous flora.3 Mundhada et al4 investigated the microbiology of SSIs of class 1 and 2 surgical wounds across multiple surgical subspecialties and found the most common bacteria isolated were S aureus (29%), Escherichia coli (21%), Pseudomonas aeruginosa (19%), Klebsiella pneumoniae (15%), Acinetobacter (12%) and Staphylococcus epidermidis (4%). Interestingly, there were no SSIs reported caused by Micrococcus,1,4 supporting the current stance in the literature that the association between airborne contaminants, bacteria, andSSI incidence has yet to be validated. In our opinion, the current recommendations will again lead to economic and environmental waste without patient benefit.

The resultant environmental burden following policy implementation in our study is certainly quite significant. The environmentally extended input-output Life Cycle Assessment model provided by Thiel et al showed an estimated 344,613 kg of carbon dioxide (or the equivalent of an additional 73 cars on the road) were produced as a result of the “Blue Jacket Policy.” This analysis provides excellent perspective for readers. The increased trash disposal also bears a financial cost, adding to the already enormous $1.7 million price tag that came with 2 years of disposable jacket use.

We believe our study is bigger than disposable jackets and infection prevention. It serves to call attention to the importance of evidence-based research prior to implementation of new policies, which will undoubtedly help reduce economic and environmental burden without compromising patient care.

Erik J. Stapleton, DO
Nicholas Frane, DO
Adam D. Bitterman, DO

Author Affiliations: Donald and Barbara Zucker School of Medicine at Hofstra/ Northwell, Department of Orthopaedic Surgery, Plainview Hospital, Plainview, New York (Stapleton, Frane); Department of Orthopaedic Surgery, Donald and Barbara Zucker School of Medicine at Hofstra/Northwell, Hempstead, New York (Bitterman).

Corresponding Author: Erik J. Stapleton, DO, MS, Northwell Health, 888 Old Country Rd, Plainview, NY 11803 (erik.stapleton1@gmail.com; estapleton2@northwell.edu).

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CORRECTION

Errors in Methods and Results: The Research Letter titled “Evaluation of Triple-Negative Breast Cancer Early Detection Via Mammography Screening and Outcomes in African American and White American Patients,”1 published online February 19, 2020, included an error in the Methods section and another in the Results section. The Methods section notes the date of study termination as April 30, 2018. In fact, it was September 14, 2018. The Results section notes a median (range) follow-up time as 50.3 (1-36) months for African American patients; this should have been reported as 50.3 (1-91) months. Both errors have been corrected online.


Correction to Affiliations and Supplement: The Original Investigation titled “Association of Low-Dose Whole-Body Computed Tomography With Missed Injury Diagnoses and Radiation Exposure in Patients With Blunt Multiple Trauma,”2 published online January 15, 2020, was corrected to add missing affiliations for Drs Mutze and Ekkernkamp and to add a missing data point in eTable 4 in the Supplement. This article was corrected online.