

**Table.** Processes to be considered during an aeromedical evacuation high-level containment transport

Environment, process to consider
<b>Preflight</b>
Types of diseases
Decision to aeromedically evacuate
Training/drills
Regulations and legal limitation
Communication plan
Layout/space assessment
Other preparations
<b>In-flight</b>
Personnel
Personal protective equipment
Type of isolation units
Procedures/capabilities inflight
Liquid and solid waste handling
Death in flight
Other contingency procedures
<b>Postflight</b>
Decontamination
Equipment reuse
Waste disposal
Personnel monitoring

science that established these procedures or a broad continual review of such science, an inherent barrier persists for current or future researchers or practitioners attempting to build on ongoing research and experiences.

Finally, the limited amount of information about the processes, procedures, and equipment available from a small number of aeromedical organizations impedes scalability should the need arise. Most of the organizations that have historically conducted AE-HLCT missions often have limited capacity, personnel, or systems to conduct multiple missions, with most only able to conduct 1 or 2 AE-HLCT missions simultaneously. The lack of nonorganizational specific standards and specialization diminishes the ability to transfer such capabilities to other organizations that might have the desire and personnel to assist or to nations that currently lack such capabilities but might have a current or future need for such capabilities. A critical evaluation of the literature would enable the dissemination of lessons learned, thereby enhancing best practices and driving the field forward, ultimately leading to safer outcomes for patients, caregivers, and receiving communities. Because much of this information does not exist within

peer-reviewed literature, much would be gained through a conference on the subject that evaluates various procedures and establishes consensus recommendations for best practices, including creation of a verified information exchange mechanism. The time is ripe for the development of standards and consensus guidelines involving AE-HLCT.

### About the Author

Dr. Gibbs is executive associate dean and professor of environmental health at Indiana University School of Public Health–Bloomington. His research interests include industrial hygiene and environmental exposure assessment, focusing on environmental microbiology and disrupting transmission of highly infectious diseases.

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## Corrections

### Vol. 24, No. 10

A grant number was listed incorrectly in Human Pegivirus in Patients with Encephalitis of Unclear Etiology, Poland (I. Bukowska-Oško et al.). The Polish National Science Center grant number should be 2017/25/B/NZ6/01463. The article has been corrected online ([https://wwwnc.cdc.gov/eid/article/24/10/18-0161\\_article](https://wwwnc.cdc.gov/eid/article/24/10/18-0161_article)).

### Vol. 25, No. 2

The number of cases of West Nile neuroinvasive disease was listed incorrectly in the abstract of Acute and Delayed Deaths after West Nile Virus Infection, Texas, USA, 2002–2012 (D.C.E. Philpott et al.). The article has been corrected online ([https://wwwnc.cdc.gov/eid/article/25/2/18-1250\\_article](https://wwwnc.cdc.gov/eid/article/25/2/18-1250_article)).