

Letters to the Editor

Potential Consequences of Using Aplisol Tuberculin Tests in Prior Epidemic Investigations

To the Editor:

Several reports, including one by Shands et al (*Infect Control Hosp Epidemiol* 1994;15:758-760), indicate an apparent widespread high false-positive rate associated with the use of Aplisol (Parke-Davis) tuberculin material.^{1,2} Numerous other reports indicate that this problem is not recent.²⁻⁵ To date, investigators have emphasized the cost and increased frequency of false-positive rates obtained during routine surveillance in health-care workers (HCW). A second possible consequence of the high false-positive rate observed with Aplisol is an erroneously high rate of conversions observed during outbreak investigations.

I did a MEDLINE search of published reports from 1990 through 1994 using two separate word combinations: tuberculosis and health-care worker, and tuberculosis and hospital. Ten articles reporting on TB outbreaks in the United States that involved tuberculin testing of HCW were identified.⁶⁻¹⁶ None of these 10 articles reported the brand of tuberculin material, or PPD, that was used in their investigations.

Two other epidemics that were identified, one involving school children in St. Louis, Missouri, and the other involving an epidemic in a prison in Upstate New York, also failed to report the tuberculin brand that was used in the investigation.^{17,18}

The findings of this survey do not allow one to conclude whether recent outbreaks have used Aplisol, and therefore, whether the reported rate of conversion or tuberculin positivity may be erroneously high. Although it is unlikely that the conclusion of any controlled analyses would be altered, the rates of conversion and infection may be falsely elevated if Aplisol was used. Studies that used Aplisol should be interpreted cautiously, especially if

the rate of infection appeared unusually excessive.

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The above letter was shown
to Dr. Shands, who declined
to offer a reply.

Postexposure Varicella Management of Nonimmune Personnel

To the Editor:

I have a different reply to Ms. Haiduven et al (1994;15:329-334 and 1994;15:740-741) regarding postexposure varicella management of nonimmune personnel than Dr. O'Rourke's reply. It concerns statements about the wearing of masks for prolonged periods of time either by personnel who are susceptible and have been exposed to varicella or by patients with transmissible airborne infections.

When one wears a nonocclusive surgical mask for any length of time, the positive pressure created simply by breathing can disperse small particulate matter with some force to the outside of the mask into the air. Not only is this common sense, but it was described nicely with appropriate illustrations by Noffsinger MA and Halpern AA in "The OR Mask: What Protection Does It Afford?" (*Infections in Surgery*. 1990;9:17-20).

We have stopped the practice of letting patients wear masks for any reason for prolonged periods of time. They may wear masks while being