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TB Transmitted to Healthcare Worker from Intubated Neonate

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A healthcare worker is believed to have developed TB while caring for an intubated neonate with undiagnosed congenital TB. The 25-day-old infant was transferred to a university medical center (MC1) from another medical center (MC2) with a 1-day history of respiratory distress, vomiting, and poor feeding. Within 24 hours after admission to MC1 the infant required mechanical ventilation. Tracheal and gastric aspirates demonstrated 3+ AFB on direct smear and *Mycobacterium tuberculosis* was subsequently isolated. Precautions consisting of a private room and respiratory protection were instituted.

Eighty-six employees had direct exposure to the child at both medical centers. There were no tuberculin skin test (TST) converters among the 53 employees at MC2 who were TST negative at baseline. At MC1, the 33 employees with direct exposure to the child while intubated had a two-step TST baseline and a follow-up TST at 12 weeks using Tubersol R (STU). All of these contacts were negative at baseline and one contact had a positive TST (18-22 mm induration) at 12 weeks. She had assisted with suctioning the intubated infant three times prior to institution of isolation precautions. Her chest radiograph revealed no active disease, and she denied any exposures outside the hospital and had used AFB precautions in car-

ing for other patients suspected of having TB. All of these suspect patients were smear and culture negative to date.

These data suggest that TB may be transmissible from intubated neonates and future recommendations for pediatric TB isolation guidelines should consider this.

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