

## Employee Acceptance of INH Prophylaxis

### To the Editor:

Noteworthy in Price, Rutala and Samsa's article "Tuberculosis in Hospital Personnel" (1987; 8(3):97-101) was the wide variation in employee acceptance of isoniazid (INH) prophylaxis, ranging from 33% to 80%. To me, there is limited value to discovering that an employee has become infected with *M tuberculosis* if prophylaxis is not administered. My own bias is that employee acceptance of prophylaxis is influenced by convenience of administration and appropriate education of the employee. Do the authors have any information as to whether the hospitals with high INH prophylaxis acceptance rates have in-hospital (as opposed to referral to Public Health Department) INH clinics?

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*Ms. Price responds to Dr. Lumish:*

My coauthors and I thank Dr. Lumish for his thoughtful question regarding health care worker acceptance of INH treatment. We certainly agree that the intent of tuberculosis surveillance is to recognize tuberculosis infection and administer treatment to prevent development of active disease.

We have no reported data in our study regarding acceptance of INH therapy and Dr. Lumish's question addresses our citation of previously published reports of hospital tuberculosis control programs.<sup>1-4</sup> Ruben<sup>1</sup> and Vogeler<sup>2</sup> both experienced low acceptance of preventive therapy. Ruben reported that great efforts were made to educate convertors regarding preventive treatment, but 86% of the subjects refusing treatment were over age 35 and expressed concern regarding drug-induced hepatitis. Atuk<sup>3</sup> and Gregg<sup>4</sup> both experienced good acceptance of preventive treatment. Both report well developed programs in which employees' prescriptions were filled by the hospital pharmacy or provided free of charge and subjects were closely monitored at regular intervals throughout the course of treatment. Although it has not been carefully evaluated, these reports appear to support Dr. Lumish's hypothesis that (in the absence of medical contraindications) appropriate education and on-site management of convertors could positively influence compliance with therapy.

### REFERENCES

1. Ruben FL, Norden CW, Schuster N: Analysis of a community hospital employee tuberculosis screening program 31 months after its inception. *Am Rev Respir Dis* 1977; 115:23-28.
2. Vogeler DM, Burke JP: Tuberculosis screening for hospital employees: A five year experience in a large community hospital. *Am Rev Respir Dis* 1978; 117:227-232.
3. Atuk NO, Hunt EH: Serial tuberculin testing and isoniazid therapy in general hospital employees. *JAMA* 1971; 218:1795-1798.
4. Gregg DB, Gibson MS: Employee tuberculosis control in a predominantly tuberculosis hospital. *J SC Med Assoc* 1975; 5:160-165.

### Editorial note:

When rereading "Tuberculosis in Hospital Personnel" (*Infect Control* 1987; 8(3):97-101) the authors noted an error. The Mantoux method involved intradermal administration of 0.1 mL of Tween-stabilized PPD containing 5TU not 0.01 mL as indicated. The authors regret the error.

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## MRSA Colonization

### To the Editor:

Bacon et al have reported a study of patients and personnel colonized with methicillin-resistant *Staphylococcus aureus* (MRSA) over a six-month period.<sup>1</sup> Their findings emphasize the complexity involved in studying the spread of this organism. They treated personnel (but not patients) having MRSA nasal carriage with trimethoprim-sulfamethoxazole plus rifampicin for ten days. Their methods of detecting carriers before and after therapy involved streaking "cotton-tipped" applicators to nonselective TSA containing 5% sheep blood and then trying to isolate MRSA (details not given) from these plates. Several carriers persisted or became recolonized with the same or "different" strains of MRSA.