$p = 1.0$). None of the TST-positive workers had evidence of active tuberculosis.

Previously unrecognized TST reactivity was frequent among workers on these units. However, determining whether an outbreak of multidrug-resistant tuberculosis among patients increased the risk of TST conversion among these workers was difficult because of the small number of workers who had a recent negative baseline TST. Additionally, many workers who had received Bacille Calmette-Guerin (BCG) vaccine were unevaluable because they had been listed as TST reactive in employee health records, but the records were insufficient to determine whether PPD reactivity had been documented. Subsequent to the outbreak, increased efforts are being made to perform TST on employees on a routine basis.

The increasing incidence of tuberculosis in the United Sates3 coupled with reports of nosocomial outbreaks emphasizes the importance of tuberculous infection for healthcare workers.[4] All workers should have TST at the time of employment and following unprotected exposures to persons with infective tuberculosis; TST should be repeated regularly for those who work in patient care areas, including nonpatient care workers (e.g., dietary and housekeeping personnel and volunteers). Such testing may have been de-emphasized at some institutions5 because, until 1987, the incidence of tuberculosis had been decreasing.[3] Among workers who have received BCG, many will be TST-negative; among those who have received BCG and are TST-positive, many may be infected with *Mycobacterium tuberculosis* and should be evaluated for preventive therapy.[6] Additionally, recommended measures for diagnosis, treatment, and appropriate isolation of patients with known or suspected active tuberculosis should be taken to reduce the risk of transmission of tuberculosis within healthcare facilities.[4]

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Reduction of C *difficile*-Associated Diarrhea

To the Editor:

I read with interest the article by Brooks et al on reduction in the incidence of *Clostridium difficile*-associated diarrhea in an acute care hospital and a skilled nursing facility following replacement of electronic thermometers with single-use disposables in the February 1992 issue of ***Infection Control and Hospital Epidemiology.*** I am curious and concerned about several issues not addressed in the article. Did the authors verify that the Tempa-dot thermometers meet accuracy standards promulgated by ECRI and/or AAMI? Were patients diagnosed as having C difficile-associated diarrhea placed in private rooms? What agents were used for environmental disinfection? What is the authors' definition of "proper use of gloves"?

While the reduction in C *difficile* cases shows statistical significance when comparing the pre- and postintervention time periods, there seem to be a number of confounding variables that were not controlled for and that may have had a significant impact on the reduction of cases. Although the reduction in cases "began immediately following the intervention with single use thermometers," the attention being given to the outbreak and re-education of personnel surely must have played a role. A bar histogram showing dates of infection onset, dates of stool cultures, and dates of specific intervention strategies would be helpful.

The change in thermometer protocols appears to have had an impact; however, the role of other intervention strategies should not be dismissed. The accuracy of the disposable thermometers should also be verified.

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The authors reply.

The disposable clinical thermometers (Tempa-dot) that were employed in our intervention study are used in many hospitals throughout the country. They conform to ASTM standard E825-81 for performance ($\pm$ 0.2°F). Before