

treatment for those with active TB, including contagion precautions or a course of directly observed therapy. In addition, the rules allow the removal or detention for treatment of people who are infectious and cannot be separated from others sufficiently to prevent disease transmission, or people who have active disease but are unwilling or unable to participate in a prescribed course of treatment and/or to observe precautions to avoid infecting others.

Although the new rules drew praise from advocates for tuberculosis (TB) patients, there is a concern that as the caseload of TB cases rises, public fear may lead to more aggressive and inappropriate detention. The New York City Health Department was commended for convened working groups to discuss concerns raised by patient advocacy groups and adopting their suggestions in the rule.

The new rules were prompted by the rapid rise in TB cases in New York City and the core of noncompliant patients who cannot or will not take their prescribed medications through completion of necessary treatment. New York City had 3,673 TB cases in 1991, a 143% increase from 1980. With only 3% of the U.S. population, the city has 14% of the national total of TB cases. Many of the cases are from outbreaks in hospitals, prisons, and shelters. It has been estimated that a third of TB cases in New York City are resistant to at least one antituberculosis drug and possibly 15% of cases resistant to at least two drugs.

## CDC Issues Guidelines for Counseling Persons Infected with HTLV-I and HTLV-II

The human Tlymphotropic viruses type I (HTLV-I) and type II (HTLV-II) are closed related but distinct retroviruses that can infect humans. They differ from the human immunodeficiency virus that causes AIDS. Screening of the United States blood supply for HTLV-I/II, which began in 1988, identifies HTLV-I and HTLV-II-infected persons. However, the screening tests, and the investigational supplementary tests used to confirm seropositivity, do not reliably differentiate between antibodies to HTLV-I and HTLV-II. In addition, the licensed screening tests, which use HTLV-I antigens, vary in their sensitivity to detect antibodies to HTLV-II. Approximately 2,000 HTLV-I/II infected volunteer blood donors were identified in the first year of screening in the United States; testing, after amplification by the polymerase chain reaction (PCR), indicated that one half are infected with HTLV-I and one half with HTLV-II. These donors are counseled and permanently deferred from donating blood. Because the PCR test is not

routinely available, many donors and other individuals who tested positive by serologic assays have been told they are infected with HTLV-I/II. The uncertainty regarding the identity of the infecting virus and the different epidemiologic and clinical correlates of these infections have made counseling these persons complicated and sometimes confusing.

The Centers for Disease Control and Prevention and the United States Public Health Service Working Group have summarized current information about the HTLV viruses and developed guidelines to be used by health care workers and public health officials for counseling HTLV-I, HTLV-II, and HTLV-I/II-infected persons. Persons found to be seropositive for HTLV-I or -II should be given information regarding modes and efficiency of transmission, disease associations, and the probability of developing disease. In addition, they should be advised to share the information with their physician; not donate blood, semen, body organs, or other tissue; not share needles or syringes with anyone; and not breastfeed infants. Individuals found to be seropositive for HTLV-II also should be advised to consider the use of latex condoms to prevent sexual transmission. In addition, if the HTLV-I positive individual is in a mutually monogamous sexual relationship, testing of the sex partner is recommended to help formulate specific counseling advice. Medical follow-up is recommended for HTLV-I or HTLV-I/II-infected persons. Medical evaluation of confirmed HTLV-II-infected persons is considered optional.

*FROM: Centers for Disease Control and Prevention and the USPHS Working Group. Guidelines for counseling persons infected with human Tlymphotropic virus type I (HTLV-I) and type II (HTLV-II). Ann Intern Med 1993;118:448-454.*

## ASTM Releases Emergency Standards for Protective Clothing

The American Society for Testing Materials (ASTM) recently released two new emergency standard test methods to evaluate the barrier effectiveness of materials used for protective clothing.

The first of the two standards (ES 21) is a pass/fail test that evaluates a material for visible fluid penetration by using synthetic blood applied at a specific pressure and time interval. Materials passing this test would be considered a fluid barrier and then may be evaluated against a more rigorous standard, the ES 22 test. The ES 22 test uses the same pressure and time intervals as the ES 21. However, a high concentration of a surrogate virus is added to the synthetic blood. The surrogate virus, bacteriophage PhiX174, is similar to hepatitis B, although smaller