within 48 hours and at −20°C or lower if it is to be stored for more than 48 hours.[5] Microbiological screening of breast milk for random monitoring or as part of a septic screen in sick infants might be useful.

In environments and specific instances where the expression, handling, and storage of breast milk are found consistently to be of unacceptable standards, using only breast milk expressed under supervision in the NICU may be advisable until the health and hygiene education program is strengthened.

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TABLE 1
QUESTIONNAIRE SURVEY: COLLECTION, STORAGE, AND TRANSPORT OF EXPRESSED BREAST MILK

Number of samples submitted	139
Breast hygiene	
Cleaned before and after expression	99 (71.2%)
Cleaned only before expression	29 (20.8%)
Used soap and water	74 (53.2%)
Used only water	54 (38.9%)
Breast pump hygiene*	
Used pump from sterile package	28 (20.1%)
Pump cleaned and immersed in boiling water	52 (37.4%)
Cleaned just with soap and water	23 (16.5%)
Cleaned with water alone	20 (14.5%)
Storage and transport†	
Samples brought in soon after expression (<45 minutes)	16 (11.5%)
Samples stored in refrigerator(4°C)	24 (17.3%)
Samples stored in freezer compartment	60 (43.2%)
Samples left in room air	25 (18.0%)

* Eleven of the answers were unclear.
† Fourteen of the answers were unclear.

TABLE 2
BACTERIOLOGICAL PROFILE OF EXPRESSED BREAST MILK SAMPLES*

Organism	Number (%)
Nonpathogenic bacteria	
Staphylococcus epidermidis	104 (74.8)
Bacillus species	1 (0.7)
Streptococcus viridans	3 (2.1)
Potential pathogens	
Escherichia coli	1 (0.7)
Enterobacter and *Shigella*	2 (1.4)
Streptococcus pyogenes	2 (1.4)
Staphylococcus aureus	29 (20.8)
Pseudomonas aeruginosa	6 (4.3)
Klebsiella pneumoniae	5 (3.5)
Serratia marcescens	1 (0.7)
Acinetobacter	1 (0.7)

* Two samples did not have any growth; 18 samples grew more than one organism.

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Brita Water Filters

To the Editor:

I am writing in response to a letter published in your August issue (1995;16:440-441), from Drs. Daschner and Rüden of Germany, that implied that Brita water filters sold in the United States may be contaminated by bacteriological growth, based on tests conducted on German filters. I would like to take this opportunity to set the record straight.

All Brita water filters sold in the United States are bacteriostatic; that is, they are treated to control bacterial growth in the filter. Brita filters are registered with the Environmental Protection Agency, and their bacteriostatic effectiveness has been proven in independent laboratory tests for the EPA. Furthermore, the bacteriostatic effectiveness of Brita filters sold in the United States has been confirmed by NSF International, the nation's leading certification laboratory for water filtration products. The Brita filter is certified by NSF International under Standard 42 for bacteriostatic effects. Although there are a number of pour-through water filters sold in this country, Brita is the only one that is bacteriostatic.

Furthermore, US filters use a different formulation than the German filter cartridge tested by the authors. Therefore, the test conduct-

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ed on German filters is not reflective of US conditions.

Finally, the Brita Baby Water Filter referenced in the letter was never sold in the United States. This product was *voluntarily* withdrawn from the German market due to limited market potential. There are no plans to sell this product here.

The Brita Water Filtration System remains a safe, simple, and effective way to improve the taste and quality of municipally treated tap water.

Charles M. Couric, President
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The above reply and the original letter from Drs. Daschner and Rüden reflect issues that have been debated vigorously in Germany. Rather than extend that debate here, we have urged both parties to submit original manuscripts reporting scientific investigations of the issues in question. Dr. Daschner informs us that a manuscript reporting his results, "Microbiological Contamination of Drinking Water in a Commercial Household Water Filter System," has been published in the European Journal of Clinical Microbiology & Infectious Diseases *(1996; 15:233-237).—Ed.*

Pseudoepidemic of Nontuberculous Mycobacteria in a Community Hospital

To the Editor:

We read with interest the report entitled "Pseudoepidemic of Nontuberculous Mycobacteria in a Community Hospital" by Mehta JB, Kefri M, Soike DR,[1] which appeared in your journal, *Infection Control and Hospital Epidemiology* (1995;16:633-634), since we recently experienced a similar pseudo-outbreak from acid-fast bacilli (AFB) at our institution. We do not use the BACTEC System implicated in Mehta's report. Our pseudo-outbreak probably was due to water contamination during the acid-fast smear and culture process.

In the fall of 1995, five patients were reported to infection control as growing AFB-positive organisms. All had been smear negative on September 13, 14, and 15, yet grew AFB-positive organisms 3 weeks later (October 5, 1995).

Clinical investigation of the five patients involved was begun to determine if this unusual occurrence truly represented five cases of tuberculosis. If so, contact investigation of potentially exposed personnel would have to be undertaken.

Two of the patients involved had been on special respiratory isolation, which was discontinued when the AFB smears were reported as negative. Three of the patients were bronchoscoped, one had submitted sputum, and one had colonic washings and stool tested for AFB.

We found that the clinical picture of the patients did not substantiate a high index of suspicion for pulmonary tuberculosis. We therefore entertained the thought that this might be a pseudoepidemic.

While awaiting identification of the AFB-positive organism, those patients who still were hospitalized were placed on special respiratory isolation. The laboratory identified the organism as *Mycobacterium fortuitum* (October 18, 1995) 2 weeks after the initial AFB-positive diagnosis was made. Special respiratory isolation was discontinued at this time.

Pseudoinfections often are difficult to recognize and may go on for weeks or months. Recognition requires alertness on the part of infection control and laboratory personnel to unusual increases in the recovery of microorganisms from a particular body site. Discrepancies between the patient's actual condition, expected clinical findings, and positive cultures or Gram stain from clinical specimens should provide assistance in determining that the problem is pseudoinfection and not infection. This is important in preventing the use of unnecessary therapy.[2]

Unexpected AFB-positive smears of sputa or bronchial washings force clinicians to weigh the benefits of initiating antitubercular therapy while waiting for final laboratory confirmation of AFB cultures.

Most outbreaks of pseudo-infection due to *Mycobacteria* have been associated with water-contaminated solutions or instruments, which we believe also was the case in our recent outbreak.[3-5] Therefore, it is important, with the current resurgence of tuberculosis, that the clinician be aware that the initial positive mycobacteriology report for tuberculosis may be a false alarm. Quality control improvement programs are of utmost importance in maintaining vigilance in this area.

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Analysis of Infection Control Surveillance Data in a Long-Term–Care Facility: Use of Threshold Settings

To the Editor:

The study by Dr. Mylotte,[1] based on a statistical approach proposed by Drs. JA Childress and JD Childress,[2] selects threshold levels at an arbitrary distance above endemic levels, but reports neither sensitivity nor specificity with that approach. Other research has attempted to determine the statistical distance required to optimize sensitivity and specificity.[3] Moving averages also have been considered as another refinement.[4] These studies make use of only one or two of eight possible run tests for interpreting statistical process control (SPC) charts.[5] Threshold levels based on binomial- or poisson-derived warning limits can improve the efficiency of infection surveillance; the calculations are simple, and the predictive accuracies are attractive. However, further work is needed to confirm optimal threshold distances and to determine the relative contribution of the different SPC decision rules. Future "Statistics for Hospital Epidemiology"