than hand hygiene and glove use were followed. Wearing gowns was a highly uncommon practice. With regard to antibiotic use, 61% of all patients in the unit received at least 1 dose of antibiotics; vancomycin and trimethoprim-sulfamethoxazole were prescribed to 13% and 15% of all patients, respectively. Quinupristin-dalfopristin and linezolid were not used. Moreover, patients were persistently colonized with MRSA, and, thus, antibiotics seemed to offer little protection anyway.

For all of the reasons noted above, we do not share the interpretation of Verbrugh [1], that our findings support a policy of surveillance and isolation of MRSA-colonized patients in single rooms, with cohort nursing and a highly motivated staff. In fact, under the conditions tested and with reasonably but not extraordinarily adherent staff, transmission of both MRSA and methicillin-susceptible S. aureus (MSSA) was prevented without knowledge of the surveillance culture results and without placing colonized patients in contact isolation—and, under such conditions, these measures might not be needed. We agree with Muto et al. [2] that the setting of the study may not be generalizable to any other ward, but that does not mean that our findings are not valid, and the findings suggest that a single intervention—the presence of a health care worker in an ICU to obtain surveillance cultures, even without further interventions—may control transmission of MRSA and MSSA.

Finally, at no place in our article do we caution against the introduction of active surveillance and isolation in guidelines or state that MRSA does not spread in hospitals and that surveillance cultures and contact precautions are thus unneeded; rather, we caution against blind acceptance of overarching recommendations for all circumstances without considering all of the scientific evidence.

Acknowledgments

Potential conflicts of interest. All authors: no conflicts.

How Late after Injection Can a Tuberculin Skin Test Be Interpreted?

Sir—Tat et al. [1] claim that a tuberculin skin test (TST) interpretation performed at day 7 after injection is reliable, compared with a reading performed at day 2. This conclusion seems premature on the basis of the data presented. Ten (40%) of 25 individuals classified as having positive TST results on day 2 were classified as having negative results on day 7. That is a large change in the proportion of positive TST results. Although the interpretation of readings performed on day 2 and day 7, presented in table 1 of Tat et al. [1], gives an overall agreement of 89%, this does not reflect agreement about results for patients with positive TST results at day 2 and their results at day 7.

The reasons for advising that results of TST be interpreted 48–72 h after injection for clinical decision making are well established. The data presented by Tat et al. [1] support that recommendation. In fact, the authors themselves agree that TSTs that had negative results at day 2 but positive results at day 7 were likely to be false-positive reactions. Readers should interpret these results with caution.

Reply to Munsiff

Sir—We thank Dr. Munsiff [1] for pointing out that our findings are not an endorsement of routinely delaying the reading of a tuberculin skin test (TST) past the 48–72-h window recommended by current guidelines. However, many individuals do not return for the reading in the 48–72-h time frame. Our study was directed at this group. Our data support accepting a positive TST result up to day 7 after placement. There were 91 individuals with a negative TST result at day 2; of these, only 3 were found to have signifi-

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Reference


Clinical Infectious Diseases 2005;41:270–1 1058-4838/2005/4102-0025$15.00 © 2005 by the Infectious Diseases Society of America. All rights reserved. 1058-4838/2005/4102-0026

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