stated that, "Another issue is the cost of surgical material. We have become a disposable society. We suddenly are presented with a whole world of plastics in hospitals that you didn't ask for. You have your own plastic bed pan, your own plastic spittoon, toothbrush, soap dish, plastic tubes, plastic needles, plastic everything. And because they are disposable, our society thinks they must be cheap. They are extraordinarily expensive."[3]

There is no doubt that today's concern for the environment is accompanied by a clear and distinct message. The surprise may be that we could conceivably find a real economic as well as environmental benefit in the reprocessing of reusables.

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REFERENCES

1. Rutala WA, Mayhall CG, Society for Hospital Epidemiology of America. Medical waste. *Infect Control Hosp Epidemiol.* 1992;13:38-48.
2. Occupational Safety and Health Administration, Occupational Exposure to Bloodborne Pathogens; Final Rule. 29 CFR Part 1910. *Federal Register.* 56641 75 64182.
3. Koop speaks out on health care crisis. *St. Louis Post Dispatch.* November 9, 1991.

The authors reply.

The term "regulated waste" as defined by the Occupational Safety and Health Administration (OSHA)[1] was not used in the Society for Hospital Epidemiology of America (SHEA) position paper on medical waste because the OSHA final rule had not yet been published when the paper was submitted to the *Journal* in October 1991. Regarding the issue of source reduction, the intent of the SHEA position paper as described in the introduction was "to summarize the available scientific data with respect to the public health and environmental hazards associated with the disposal of medical waste, and to present conclusions as to its public health importance." Thus, while I and my colleagues have stated on two occasions[2,3] that we believe that proper hospital waste management must include methods to reduce the total output of waste and recycle or reuse medical materials when feasible, it was not the purpose of this paper to discuss this important issue.

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REFERENCES

1. Occupational Safety and Health Administration, Occupational Exposure to Bloodborne Pathogens; Final Rule. 29 CFR Part 1910.1030. *Federal Register.* 566400464182.

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2. Rutala WA, Weber DJ. Infectious waste—mismatch between science and policy. *N Engl J Med.* 1991;325:578-582.
3. Rutala WA, Mayhall GC, Society for Hospital Epidemiology of America. Medical waste. *Infect Control Hosp Epidemiol.* 1992;13:38-48.

Tuberculin Skin Testing of Hospital Employees During an Outbreak of Multidrug-Resistant Tuberculosis in Human Immunodeficiency Virus (HIV) -Infected Patients

To the Editor:

Several outbreaks of multidrug-resistant tuberculosis among persons with human immunodeficiency virus (HIV) infection have been reported recently.[1] During such an outbreak, which occurred at a hospital in New York City in 1989 through 1990,[2] we studied the tuberculin skin test (TST) results of nursing and clerical workers on five inpatient units: three medical units where patients with HIV infection or tuberculosis were routinely hospitalized and two nonmedical (general surgery and neurology) units where patients with known HIV infection or tuberculosis were not hospitalized. During May through September 1990, employee health records and a questionnaire self-administered by workers were used to determine nonoccupational exposures to tuberculosis, symptomatology, and the results of a baseline and followup TST. Workers without a TST after January 31, 1990, were offered testing using the Mantoux technique (intradermal injection of 0.1 ml of purified protein derivative [PPD]); induration of 10 mm or more at two to three days was read as reactive.

Of 165 workers employed on the five units, baseline TST was recorded as reactive in 85 (51.5%), nonreactive in 68 (41.2%), and not recorded in 12 (7.3%). A followup TST was available for 60 workers with a negative baseline TST. Among 31 of the 60 workers for whom duration from baseline to followup TST was more than two years (median = 4.4 years, range = 2.2-21.0 years), nine (29.0%) had a positive followup TST. Among 29 of the 60 workers for whom duration from baseline to followup TST was two years or less (median= 1.1 years), two (6.9%) had a positive followup TST and were defined as TST converters. TST conversion was not significantly more common among workers on medical units (2/22) than among workers on nonmedical units (0/7,

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