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 Tlymphotrophic 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 where 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 -11 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 T-lymphotrophic ***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

and noninfectious to humans. The ability of the virus to penetrate the fabric is assessed by a culturing technique.

Manufacturers of protective materials have praised the development of these standards because, until now, there has been no universally acceptable test method. Critics of the test method charge that the tests do not necessarily simulate the "conditions of use," that is, the amount of pressure and time the materials are exposed to the liquid. Concern has been raised by some users regarding the clinical implications, that is, whether all protective barriers, regardless of the amount and type of anticipated exposure to blood and body fluids, would be required to pass these ASTM tests.

These test methods were developed by the ASTM Committee F23 on Protective Clothing and issued as emergency standards by ASTM for a period of only two years. Comments will be taken from the user community throughout this two-year period and will be used to evaluate the standards and the need to change their status to permanent, full-consensus standards.

Norman W. Henry, chairman of a subcommittee of F23 has said that "despite skepticism about the test conditions and methods, at least we have a consensus. These are emergency standards and can always be improved."

ASTM invites interested parties to participate in the development of these and other standards within Committee F-23. The next committee meeting is scheduled for June 23-25, 1993, in Atlanta. For more information, contact Norman W. Henry III, E.I. du Pont de Nemours & Co., Haskell Laboratory, Elkton Rd., PO. Box 50, Newark, DE 19714. Telephone (302) 366-5250.

Loofah Sponges Added to List of Source for *Pseudomonas aeruginosa* Pustular Folliculitis

Whirlpools, swimming pools, and hot tubs have been reported as sources of ***Pseudomonas aeruginosa*** causing cutaneous infections. Such infections are characterized by small pustular lesions on an erythematous base involving the skin of the trunk, buttocks, and extremities. A recent report indicates another source for this infection.

A 25year-old woman was reported to have a two-week history of perifollicular pustular lesions on her abdomen, thorax, and lower extremities. The lesions first appeared on her abdomen and then progressed to her legs. She then developed tender axillary lymphadenopathy. Gram stain of several pustules revealed many polymorphonuclear leukocytes and gram-negative bacilli and ***Pseudomonas aeruginosa*** was recovered from the culture.

The patient denied using spas, hot tubs, or swimming pools but reported using a loofah sponge that was kept hanging in her shower. Cultures of the sponge yielded heavy growth of ***P aeruginosa*** that was identical by serotyping and pyocin typing to the skin isolate. Although newly purchased loofah sponges yielded only a few colonies of ***Staphylococcus epidermidis*** and ***Bacillus*** species, sterilized sponges served as an excellent culture medium when inoculated with ***P aeruginosa*** (4 log10 increase in colony forming units per ml over 24 hours). Keeping sponges hanging in a moist shower may have allowed ***P aeruginosa*** to proliferate.

Because this organism has been recovered from sinks, baths, and tap water, inadequately maintained hot tubs, spas and sponges kept in such a moist environment may have contributed to this incident.

FROM: Bottone EJ, Perez II AA. *J Clin Microbiol* 1993;31:480-483.

New AIDS Research Institute Opens in San Francisco

The Gladstone Institute of Virology and Immunology at San Francisco General Hospital, affiliated with the University of California, San Francisco (UCSF), opened its doors in April 1993. Warner C. Greene, MD, PhD, has been named as Director. In addition to the National Institutes of Health, the Gladstone Institute is the largest AIDS research unit in the United States. With funding of $28 million for operating expenses donated by the J. David Gladstone Institute and $4 million from UCSF, five principal research groups will work cooperatively to study the HIV life cycle and new drugs, vaccines and treatments for HIV infection.

This is one of the few privately funded research centers in the country and has resulted from a unique partnership between the private sector, UCSF, the City of San Francisco, and the State of California.

Computer Reminders Double Rates of Influenza Vaccination in High-Risk Patients

Doctors who receive computer-generated reminders are twice as likely to administer influenza vaccine to patients at high risk for pulmonary disease during the winter. Dr. Clement J. McDonald and colleagues at Indiana University School of Medicine found that