Dr. Malaviya, *et al* reply

To the Editor:

Kharbanda, *et al* report development of tuberculosis (TB) infection in 2 of their patients, 3 weeks and 3 months after the last dose of infliximab, despite following the LTBI screening strategy suggested in our publication¹. One of their patients was in a pediatric age group. We had also reported post infliximab TB infection in one of our patients despite following the latent TB infection (LTBI) screening strategy that we recommended¹. We had, therefore, cautioned vigilance against TB flare especially in high TB-burden countries like India. Observations of Kharbanda, *et al* add weight to our argument.

Also, it is to be noted that the LTBI screening strategy that we recommended is only for adults, as we did not study children. The strategy may or may not be applicable in children and needs further work. Regarding the adult patient reported by Kharbanda, *et al*, the dose of tuberculin used for the tuberculin skin test (TST) was not mentioned. It is important to use 10 tuberculin units for TST to “break through” the relative anergy known in RA¹. It is the single most important point of our paper and needs to be followed stringently.

Of course all the other standard methodological details for TST, including appropriate standardized preparation of purified protein derivative (PPD), must be followed for satisfactory performance of the test. Since our original report, we have used a similar LTBI screening strategy in another 33 patients given infliximab. We did not encounter the problem of TB flare in any of them². Whether using ELISpot test would improve the sensitivity for detecting LTBI remains to be established.

We feel that clinical vigilance and recurrent testing are better strategies than continuing longterm therapy in patients once the underlying presumed

infection has been treated, thus decreasing the likelihood of toxicity from longterm continual use and, potentially, allowing emergence of resistant strains.

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