Dr. Malaviya, *et al* reply

To the Editor:

We are grateful to Dr. Abud-Mendoza, *et al* for their observations on our report[1]. We fully agree that tuberculin skin test (TST) alone may not be an ideal method for screening of latent tuberculosis infection (LTBI), especially in high-burden TB regions. It was for this reason that we used 3 different LTBI screening methods: (1) a higher than usual dose of tuberculin (10 TU) for the Mantoux test; (2) added Quanti-FERON-TB Gold test (a test that bypasses the effector limb of the immune response, a defect that is supposed to be one reason for Mantoux negativity) for screening of LTBI; and (3) chest imaging, including standard radiograph and contrast enhanced-computed tomography of the chest. Based upon our observations since the implementation of the modified LTBI screening regimen, we were able to reduce the incidence of TB flare, but as conceded in our paper, it could not be eliminated completely.

We understand and sympathize with the dilemma of Dr. Abud-Mendoza and colleagues, and giving TB prophylaxis treatment to all, as they suggested, could be an alternative approach. However, there are difficulties in implementing this approach. It delays the treatment with tumor necrosis factor-α (TNF-α) inhibitor, while most of these patients need treatment as soon as possible. More importantly, the broad use of TB prophylaxis exposes a number of patients to medications without specific indication (e.g., 35% of his patients) and may both increase the incidence of resistant TB (unless multiple drugs are used) and increase the probability of adverse events (especially if a multidrug regimen is used). In fact, it has been our experience that, with the background disease-modifying antirheumatic drugs and nonsteroidal antiinflammatory drugs that most of these patients are already taking, adding anti-TB therapy has caused liver enzyme elevations in a significant number of patients. An alternative that needs to be looked into could be that before every patient (especially > 35 years of age) is started on TB prophylaxis, formal risk-benefit analysis is carried out and TB prophylaxis is given to those for whom the benefit outweighs the risk. A similar approach was suggested in another clinical scenario, i.e., use of cyclophosphamide for active scleroderma lung disease[2].

We feel that the screening method we suggested could be satisfactory in our setting.

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