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Coverage by selective neonatal BCG vaccination should be monitored

EDITOR,—Meirion R Evans raises important points relating to the provision and uptake of neonatal BCG vaccination by babies at increased risk of tuberculosis.[1] This matter has been addressed in Dudley, where we have increased the uptake of neonatal BCG vaccination in identified ethnic minority babies to 93·5% and have introduced a system for monitoring the coverage among ethnic minority groups.

The department of public health medicine reviewed the effectiveness of both neonatal and infant BCG vaccination and the relative benefits of the two methods of vaccination. The findings were used to support the introduction of a programme of neonatal BCG vaccination with the percutaneous multiple puncture method for babies at increased risk of tuberculosis; the programme was based in maternity units.[2]

During the first six months of the programme it proved extremely difficult to monitor the coverage among ethnic minority groups. By using the Office of Population Censuses and Surveys' weekly birth returns to identify the place of birth of both parents and their surnames, however, we estimated that the coverage among ethnic minority babies was 87% (95% confidence interval 82% to 92%). Dudley Health Authority recognised the need to continue to monitor coverage and introduced ethnic monitoring of births in its contracts from April 1995, to coincide with the ethnic monitoring of adults. The authority now has a system that is used to monitor the uptake of and coverage by BCG vaccination in higher risk groups and simultaneously allows us to arrange for further follow up of any baby who misses BCG vaccination. The quality, efficiency, and cost effectiveness of the neonatal BCG programme in Dudley have increased considerably.

We support Evans's call for increased emphasis on selective neonatal BCG vaccination. The Department of Health should urgently consider the introduction of a national system for monitoring coverage by infant BCG vaccination among those babies at higher risk of tuberculosis. In Dudley we have shown a simple method by which this may be achieved.

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Standards for control may not be consistent across United Kingdom

EDITOR,—Meirion R Evans's analysis of the control of tuberculosis in the United Kingdom raises several pertinent issues.[1] The joint tuberculosis committee of the British Thoracic Society (whose members treat nearly 90% of all patients with tuberculosis in the United Kingdom) has produced detailed guidance on chemotherapy and management,[2] the interaction between tuberculosis and HIV infection,[3] prevention and control,[4] and promoting awareness of and education about tuberculosis. The committee agrees that the surveillance system for tuberculosis needs to be changed from limited notification and short, cross sectional, five yearly surveys. An enhanced continuous surveillance system proposed by the Public Health Laboratory Service Communicable Disease Surveillance Centre has the committee's support.

Whatever the position on the unselective BCG programme in schools, for which England and Wales meet some of the international criteria for cessation,[5] the committee shares the concerns about the variable coverage and quality of selective BCG programmes. To stop the unselective programme without comprehensive and effective selective programmes being in place would be dangerous. In addition, without a continuous surveillance system we do not have a sufficiently reliable reporting system to enable the annual incidence of active tuberculosis to be determined by age and risk group; this is a prerequisite for considering stopping unselective BCG vaccination.

The "port of arrival" system for identifying new immigrants performs poorly. It should be replaced by the capture of complete data at ports and their rapid electronic transmission to the consultant in communicable disease in the district of intended residence, so that early health screening can be carried out locally. This too has been strongly urged on the Department of Health.

The concern regarding undernotification of patients with both tuberculosis and HIV infection was addressed by a circular from the Department of Health to all physicians in genitourinary medicine and will form a substantial part of revised guidelines on notification of tuberculosis to be issued soon by the joint tuberculosis committee.

A system for continuous monitoring of drug resistance has been set up by the Public Health Laboratory Service. All the above issues are being assessed by a working party at the Department of Health, of which I am a member. Whatever the working party's recommendations, however, because many purchasing decisions are now taken by local health care consortiums it may be impossible to ensure that adequate resources are devoted to local programmes to control tuberculosis unless local experts ensure that minimum standards for provision[4] are met.

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Treatment should be free for everyone

EDITOR,—Meirion R Evans believes that an action plan for tuberculosis is urgently required in the United Kingdom.[1] We are codirectors of the East London Tuberculosis Service, an organisation that is concerned with making sure that the highest possible standards of care are achieved for patients with tuberculosis. Antibiotic treatment for six months is an essential part of a programme to control tuberculosis. To encourage compliance we need to make it as easy as possible for patients to obtain such treatment. Many of our patients have free prescriptions because of their social circumstances or their age. Refugees and those not eligible for free treatment under the NHS remain a public health risk to the rest of the population. This small group of patients should also receive free treatment if we are to limit the spread of tuberculosis. We believe that free treatment would encourage compliance and is an essential part of the strategy to control the spread of tuberculosis.

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1 Evans MR. Is tuberculosis taken seriously in the United Kingdom? *BMJ* 1995;311:1483-5. (2 December.)

Public health legislation should be changed

EDITOR,—We were interested in Meirion R Evans's article about tuberculosis in the United Kingdom.[1] A problem recently arose in this district concerning the screening of contacts of a patient with multidrug resistant tuberculosis acquired in a nosocomial outbreak in the Chelsea and Westminster Hospital.[2] The contacts identified were sent several invitations to attend the tuberculosis screening clinic, but they failed to attend despite intervention by their general practitioners and the tuberculosis health visitor. As a last resort, the feasibility of applying for an order from a magistrate for compulsory medical examination under section 35 of the Public Health (Control of Disease) Act 1984 was considered. Although this legislation is rarely used, the threat of implementation is occasionally useful.

To obtain an order under section 35 several criteria need to be fulfilled. These include (para 1(a)) that there is reason to believe that a person (*i*) is or has been suffering from a notifiable disease or, (*ii*) though not suffering from such a disease, is carrying an organism that is capable of causing it. Clearly, para 1(a)(ii) may be applied to the contacts of patients with notifiable diseases. Under regulation 4 of the Public Health (Infectious Diseases) Regulations 1988, however, this paragraph is specifically excluded in relation to tuberculosis. Since the aim of contact tracing in tuberculosis is to identify infected people before they become clinically ill, use of section 35 would seem not to be appropriate in this context. Section 20 of the same act, which enables a person to be excluded from work, might be applicable but would not be useful for diagnostic purposes. This would be an expensive option for the local authority, which would be required to compensate for loss of earnings.

The lack of appropriate legislation is of particular concern in view of the recognised association between tuberculosis and HIV infection. People infected with HIV are at greatly increased risk both of reactivation of latent tuberculosis and of acquiring tuberculosis from contact with infected patients. It has been shown in the United States that the proportion of patients with multidrug resistant tuberculosis is relatively high among patients with HIV infection.[3] We hope that the long awaited parliamentary debate after the review of public health legislation[4] will adjust the law to meet this threat to the public health.

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