apy demonstrated ... in Newark, and therefore should provide long-term inpatient care for tuberculosis patients who are homeless or require retreatment because of compliance problems. In their rejoinder, Drs. Sbarbaro and Iseman agree that we need some specialized programs at public expense for resistant patients.

I have some reservations about this thrust, but first must correct an inaccuracy. In citing the Newark experience, the authors mistakenly suggest that it was Newark's ample resources that made our innovative and successful program possible. Contrary to that assertion, it was the dedication and concern of Drs. Reynard McDonald and Dr. Abdul Memon,2 and the closure of the former state tuberculosis sanatorium with dedicated transfer of funds to ambulatory care,3 which built the program. Unfortunately, Newark still has the problems of many urban areas and tuberculosis control is not yet a priority.

However, of more concern is the assertion that specialized long-term care is required at public expense. It has long been my experience that existence of a state sanatorium (ie, long-term care beds) may actually mitigate against establishment of a viable tuberculosis care system.4,5

It could probably be considered tantamount to "law" in tuberculosis control that care of problem patients in an imaginative and hopefully successful way is inversely proportional to the ease and cost of obtaining alternative care (ie, "turfing" or "dumping" the patient.)

If these specialized, long-term beds existed (and I do not agree that a few are necessary), what would keep them from becoming the preferred management locale for most care, eliminating the need, desire, or impetus to develop and maintain the innovative ambulatory programs described in the first part of Sbarbaro and Iseman's rejoinder?

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5 Reichman LB. Updated TB care means patients get well. Am Lung Assn Bull 1981; p 2-6

To the Editor:

We would like to make the following comments on the article by Yeager RL, Cashman HH, Farer LS, Flynn JGP, Pollack B, Reichman LB. Guidelines for long-term institutional care of tuberculosis patients. A statement of the ATS Ad Hoc Committee, Scientific Assembly on Tuberculosis. Am Rev Respir Dis 1976; 113:253.


To the Editor:

We appreciate the thoughtful comments of Dr. Reichman and Dr. Furth and colleagues in response to our clinical dialogue about the continued need for long-term beds for the treatment of tuberculosis. We also thank Dr. Reichman for setting the record straight about the Newark experience.

It is the ten percent or so of patients who do not respond to ambulatory observed chemotherapy that concern us most. Incidentally, we note that there were two of 21 failures at ambulatory therapy in the report of Reichman and coworkers that we cited.1 Perhaps what we need now is a multifaceted approach, as proposed by Drs. Sbarbaro and Iseman.5 The beds that should be made available should not be part of an isolated (and sometimes second-class) system, but should be part of community residential facilities or chronic disease hospitals that also have patients with other problems. Drs. Leff and Leff have recently written about what happened in some parts of the country in the last days of tuberculosis sanitaria.6 We applaud, and we suppose Drs. Sbarbaro and Iseman will also, the maintenance of the Tuberculosis Unit at the Montebello Rehabilitation Hospital, Baltimore for the state of Maryland. We hope to be placed in other long-term institutional settings because of anxiety relating to the diagnosis of tuberculosis (ie, a communicable disease) or patients with drug-resistant tuberculosis.

The beds at Montebello Rehabilitation Hospital certainly serve as an outlet and back-up for a nonavailability of appropriate resources within the healthcare delivery system and can only be considered as such. In particular, group homes or other appropriate institutional settings to manage concurrent diagnoses in the community could be used to manage the large proportion of patients hospitalized at Montebello. However, we can expect to see increased numbers of patients with human immunodeficiency virus infection and tuberculosis in the future. Some of these patients may require prolonged institutionalization in a setting where appropriate expertise is available; however, in view of the anxiety generated by each of these diagnoses, the concern generated by the combined diagnoses may over-challenge the institutional resources currently available.

The message in the original ATS statement still pertains at this time, and, aside from the reallocation of resources, there is the constant need for ongoing inservice education to alleviate the anxiety and myths surrounding the ambulatory or institutional management of patients with tuberculosis in the mainstream of medicine.

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