on the treatment of tuberculosis most enlightening.[1] I left the tuberculosis field when it seemed as if these drugs were going to revolutionize therapy, as they have to a great extent.

However, it seems that now we are facing an onslaught by drug-resistant bacilli. It may well be time for phthisiologists to look at the older treatments, such as collapse therapy by artificial pneumothorax and pneumoperitoneum, thoracoplasty, phrenic nerve crush and the old standby, prolonged bed rest. Perhaps some of us older physicians may be called on to help, while we are still around and remember how these treatments were carried out.

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Reference

1. Hershfield E. Tuberculosis: 9. Treatment. *CMAJ* 1999;161(4):405-11.

A false-positive tuberculin test result

The tuberculin test can be helpful in the diagnosis of *Mycobacterium tuberculosis* infection. A recent *CMAJ* article mentions that false-positive test results can occur in those who have received BCG (bacille Calmette-Guérin) vaccination in childhood[1] but that positive reactions usually wane over time. No mention is made of the effect on the tuberculin test of intravesicular BCG therapy.

Patients with a positive tuberculin test reaction are usually asked if they have a history of BCG vaccination; however, most physicians do not ask their elderly patients if they have a history of intravesicular BCG therapy, which is commonly used for bladder cancer.[2] The following case illustrates how careful review of a patient's history and medical records confirmed a false-positive reaction.

A 74-year-old man presented with a 9-kg weight loss. A chest x-ray film revealed fibrotic changes in the left lower lobe. A Mantoux test was strongly positive with induration of 18 mm at 48 hours. The patient denied constitutional symptoms of fever, chills or night sweats. He had a mild dry cough. He denied hemoptysis. He had been smoking for 60 years and had a history of emphysema and throat and bladder cancer. There was no history of exposure to tuberculosis, and he did not recall having a BCG vaccination in childhood. He had a negative tuberculin skin test in 1995. Chest CT showed old granulomatous changes and emphysema. The possibility of active tuberculosis was entertained. Findings on the chest x-ray film were unchanged from 1991. Urine and sputum cultures for acid-fast bacilli were negative. Isoniazid prophylaxis was considered in view of induration of 15 mm or greater and recent conversion.

The patient did not know what treatment he had received for bladder cancer other than that it was some form of "chemotherapy," but hospital records confirmed that he received intravesicular BCG immunotherapy in 1996. The recent tubercular conversion was concluded to be false positive and isoniazid prophylaxis was avoided.

Among patients given intravesicular BCG treatment for superficial bladder cancer, up to 65% may have a positive tuberculin skin test reaction.[2] For patients with a positive reaction who have a history of bladder cancer, physicians should investigate whether they have had intravesicular BCG therapy before they commit to isoniazid prophylaxis.

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References

1. Menzies D, Tannenbaum TN, FitzGerald JM. Tuberculosis: 10. Prevention. *CMAJ* 1999; 161(6):717-24.
2. Lamm DL. Bacillus Calmette-Guerin immunotherapy for bladder cancer. *J Urol* 1985; 134(1):40-7.

Corrections

A recent article by Charlotte Gray[1] attributed information on the shortage of anesthetists in Canada to the Canadian Institute of Health Information. The information was correct, but it should have been attributed to the Canadian Anesthesiologists' Society.

Reference

1. Gray C. How bad is the brain drain? *CMAJ* 1999;161(8):1028-9.

The author byline for the specialty spotlight on xenotransplantation in the Nov. 16 issue[1] should have read "Lindsay E. Nicolle, MD."

Reference

1. Nicolle LE. Xenotransplantation: An animal future? *CMAJ* 1999;161(10):1291.

A copyediting error was made in a recent article by Paula Rochon and colleagues.[1] The first sentence in the Interpretation section (page 1406) should have read: "We found that almost half of all patients in Ontario aged 66 or more who survived an MI did not receive β-blocker therapy despite its proven secondary prevention benefit."

Reference

1. Rochon PA, Anderson GM, Tu JV, Clark JP, Gurwitz JH, Szalai JP, Lau P. Use of β-blocker therapy in older patients after acute myocardial infarction in Ontario. *CMAJ* 1999;161(11):1403-8.

The number of articles retrieved in a MEDLINE search using the search terms peppermint oil and irritable bowel was reported incorrectly in recent letters to the editor.[1,2] MEDLINE lists 13 articles on peppermint oil and irritable bowel.

References

1. Lépine P. Reaching a consensus on irritable bowel syndrome. *CMAJ* 1999;161(10):1237.
2. Paterson WG, Thompson WG, Vanner SJ, Faloon TR, Rosser WW, Birtwhistle RW, et al. Reaching a consensus on irritable bowel syndrome [reply]. *CMAJ* 1999;161(10):1237.

The author of the final letter to the editor on the CMA Charter for Physicians in the Nov. 30 issue[1] is Derryck H. Smith of Vancouver, BC.

Reference

1. Smith DH. Cheers and jeers for the Charter for Physicians. *CMAJ* 1999;161(11):1396.