MEMORANDUM FOR: MEMBERS OF THE AFEB

SUBJECT: Tuberculosis Control in the Army

The enclosed copy of a letter from Colonel J. W. Cooch, MC, Medical Division, USAREUR, is forwarded for information at the suggestion of Colonel Rapalski.

Encl.

Copy ltr 3 April 64

cc: Dr. Jordan
    Dr. Middlebrook
    Col Rapalski, MC, USA
    Col Bowling, MC, USAF
    Capt Millar, MC, USN
Dear Adam:

I am much disturbed that there is any expectation that the Commission on Acute Respiratory Diseases will recommend to the AFEM, which in turn may recommend to the Services that BCG be made mandatory for the Armed Forces. While your letter of 27 March does not indicate whether or not the requirement will be service-wide, the thought that it may be so is, to my way of thinking, most upsetting.

Without entering into a controversy as to whether BCG has ever been proved to be effective in preventing active tuberculosis, and without, on the other end of the spectrum, discussing whether there are certain areas of very high incidence of disease (tuberculosis hospitals, certain special forces assignments or geographic areas where military personnel must live in very close association with a potentially highly infected group), I hope that what I have to say about general use of BCG will be considered carefully before any decision is made on this subject.

First, and possibly of no importance from an immunologic standpoint is the repeated observation, made by, among others, Phil Beckjord, that individuals with positive tuberculin tests are more likely to develop active tuberculosis than are other people. While the artificially induced tuberculin sensitivity resultant from BCG may not have the same predisposing effect, my limited reading has not shown such a difference to have been demonstrated. To induce deliberately a state which is more conducive to disabling disease, rather than less so, seems unwarranted, unless there is a large mass of supporting data to show other advantages.

Next and in my opinion most important, is the deliberate destruction of our most important case-finding tool in tuberculosis control, namely the tuberculin test. We are just now in a position to reap the rewards of doing tuberculin tests on recruits and I believe very strongly that we should not give up the advantage of being able to know when a tuberculin test becomes positive. More frequent tuberculin testing (such as at the beginning or end of an overseas tour, with each annual or re-enlistment physical examination, or some other scheduled basis) would be more work, in the long run, particularly if we should increase the frequency with which we give antibiotic therapy to converters, but would contribute more
to real tuberculosis control than the vaccination with BCG. At the present time, the increased use of tuberculin testing which the Tine Test permits, has given us in USAREUR an increased number of cases, as compared with the same period in previous years, but I do not believe we should be stampeded into tossing out the very means whereby we are able to pick up the early cases and treat them, not only for their own benefit, but for the protection of their associates. Granted that we may develop strains of \( M. \) tuberculosis which are resistant to INH, I think it will be possible to develop other antibiotics to take the place of INH by the time it begins to lose its usefulness. If we take away the tuberculin test, we will be dependent upon the x-ray for our case-finding. Besides the hazards from increased radiation, which radiation will be most necessary, we know that tuberculous infection is often well developed before being detectable by x-rays. The logistics of x-rays, I need not remind you, are much more complicated than those of the Tine Test. The other considerations of the importance of having the tuberculin test available as a diagnostic tool have been so fully delineated in the article by Anderson, et al, in the British Medical Journal of 6 June 1959, that its relative merits need no further defense by me.

Perhaps not finally, but, at any rate, sufficient for one communication, is the fact that tuberculosis is, at least in our area on a continual decline. I do not believe that our apparent increase reflects any real increase in incidence, but rather an energetic case-finding campaign. I concur that we are a long way from eradication, but I believe that we are more likely to approach this goal more nearly by continuing and strengthening our current technics that we are by the use of BCG. The improved economic conditions in the parts of the world where the greater parts of our various Armed Forces are stationed will, I believe, do more to decrease the incidence of tuberculosis than the various things we, as preventive medical people do, but when we combine the fortuitous effects of an improved socio-economic environment with the deliberately induced effects of improved and strengthened case-finding and management I am sure that we will accomplish much in tuberculosis control. In my opinion, the use of BCG would be a retrograde step, rather than an advance.

You not only have my permission to use these arguments in any discussions you may have on this subject but I encourage it.

Cordially,

JOSEPH W. GOOCH
Colonel MC
Preventive Medicine Officer