

### Inmate Access to Postrelease Medical Care: Public Health Implications

In their 1994 study, Warren et al<sup>1</sup> interviewed inmates who were seropositive for the human immunodeficiency virus (HIV) in a New York City correctional facility during their incarceration and after their release to determine accessibility to medical care services. The authors discovered that HIV-infected inmates were encountering considerable difficulties obtaining postrelease medical care in the community. Of 13 inmates who had been receiving isoniazid prophylaxis during their incarceration, only 1 was able to continue isoniazid prophylaxis after release into the community. The authors warned that such discontinuity of HIV care could potentially lead to active infectious tuberculosis in the community.<sup>1</sup>

Two years after their article was published, their prediction has become reality. In 1996, an HIV-infected inmate tested positive to a tuberculin purified protein derivative skin test. Because the results of his previous tuberculin purified protein derivative skin tests had all been negative, he was deemed a recent convertor and administered isoniazid prophylaxis. Three weeks later he was released into the community. However, the correctional facility did not notify the local public health department that this patient was a recent convertor or that he would require continuation of the isoniazid prophylaxis in the community.

Three months after his release, he had a productive cough, fever, night sweats, and weight loss. A chest x-ray film demonstrated a cavitary right upper lobe infiltrate. Acid fast bacilli were demonstrated in smears of sputa; cultures grew *Mycobacterium tuberculosis*.

The risk of active tuberculous disease developing in patients with HIV infection and latent tuberculosis is 7% to 10% per year, which is a relative risk of 113 compared with persons without HIV infection.<sup>2,3</sup> For HIV-infected patients with latent tuberculosis, isoniazid prophylaxis has documented efficacy in reducing the 2-year risk of developing active disease from 24% to 30% to 4% to 5%.<sup>4,5</sup> Therefore, HIV-infected patients with latent tuberculous infections should receive prophylaxis as a high priority.

Public health departments must collaborate with correctional primary care providers and administrators to design systems in which inmates have access to postrelease HIV and tuberculosis care. Otherwise, HIV-infected inmates will continue to suffer unnecessary morbidity and communities will be exposed to additional persons with acid fast bacilli smear-positive untreated pulmonary tuberculosis.

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1. Warren N, Bellin E, Zoloth S, Salyer S. Human immunodeficiency virus infection care is unavailable to inmates on release from jail. *Arch Fam Med*. 1994; 3:894-898.
2. Selwyn P, Hartel D, Lewis V, et al. A prospective study of the risk of tuberculosis among intravenous drug users with human immunodeficiency virus infection. *N Engl J Med*. 1989;320:545-550.
3. Bartlett J. *Medical Management of HIV Infection: 1996 Edition*. Glenview, Ill: Physicians & Scientists Publishing Co; 1996:47, 217.
4. Pape J, Jean S, Ho J, et al. Effect of isoniazid prophylaxis on incidence of active tuberculosis and progression of HIV infection. *Lancet*. 1993;342:268-272.
5. Moreno S, Baraia-Etxaburu J, Bouza E, et al. Risk for developing tuberculosis among anergic patients infected with HIV. *Ann Intern Med*. 1993;119:194-198.

#### Clinical Pearl

A meta-analysis of oral antibiotic therapy for simple wounds found no benefit. Patients treated with antibiotics actually had a nonsignificantly higher rate of infection (odds ratio, 1.16). (*Am J Emerg Med*. 1995;13:396-400.)