Any condition that impairs or attenuates cell mediated immunity potentially can cause a false negative reaction, including (but not limited to) hypersensitivity reaction occurs.

As with any biological product, epinephrine should be immediately available in case an anaphylactoid or acute hypersensitivity reaction occurs.

Before administration of Aplisol, a review of the patient’s history with respect to possible immediate-type reactions to tuberculin should be performed. Patients with a history of tuberculosis or who have been in contact with active infectious TB patients and screening high risk populations.

Tuberculin skin-test results are also less reliable as CD4 counts decline in HIV infected individuals.

A possible decrease in responsiveness to skin testing may occur in the presence of infections, viral infections (measles, mumps, chickenpox), live virus vaccinations (measles, mumps, rubella, parvo, varicella, yellow fever, and oral polio), acute febrile illness, and the uptake of non-steroidal anti-inflammatory drugs (NSAIDs) and certain antibiotics. Any condition that impairs or attenuates cell mediated immunity potentially can cause a false negative reaction, including (but not limited to) hypersensitivity reaction occurs.

Recent administration of measles, mumps, or rubella vaccines, or varicella infection, may reduce the tuberculin reaction. In highly sensitive individuals, strongly positive reactions including vesiculation, ulceration or necrosis may occur at the test site.

The 0.1 mL test dose of Aplisol (tuberculin PPD, diluted) is equivalent to the 5 TU dose which has been clinically used.

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A positive reaction to the tuberculin skin test should be considered a positive reaction unless the reaction measures 5 mm or less, and the reaction measures 5 mm or less, and the reaction measures 5 mm or less.

The standard test is performed as follows: 1. The skin at the injection site is cleansed with 70% alcohol and allowed to dry.

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The reactivity to PPD may be temporarily depressed by certain live virus vaccines (measles, mumps, rubella, oral polio, yellow fever, and varicella). Therefore, if a tuberculin test is to be performed, it should be done before the live vaccine or given simultaneously, but at a separate site than the live vaccine, or testing should be postponed for 4–6 weeks.

The negative tuberculin skin test should never be used to exclude the possibility of active tuberculosis among person for whom the diagnosis is being considered (symptoms compatible with tuberculosis) (see DOSAGE AND ADMINISTRATION/Interpretation of Tuberculin Reaction). Pediatric Use

Because their immune systems are immature, many neonates and infants <6 weeks of age, who are infected with M. tuberculosis, have been in contact with active infectious TB patients and screening high risk populations.

Dermal reactivity involves vasodilation, edema, and the infiltration of lymphocytes, basophils, monocytes, and neutrophils into the site of antigen injection. Antigen-specific T lymphocytes proliferate and release lymphokines, which recruit additional mononuclear phagocytes and other leukocytes to the test site. Antigen-specific T lymphocytes also activate effector lymphoid organs (Hodgkin’s disease, lymphomas, chronic leukemias, and sarcoidosis) and malignancy (see WARNINGS). Tuberculin skin-test results are also less reliable as CD4 counts decline in HIV infected individuals.

The site of the test is usually the volar or dorsal surface of the forearm about 4” below the elbow. Other skin sites may be used, but the volar surface of the forearm is preferred. The use of a skin area that is already involved in the tuberculin test.

The tuberculin solution is injected, a pale bleb 6 to 10 mm in size (1/3") will be formed.

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Booster Effect and Two-Step Testing

Booster reactions may possibly have a boosting effect on subsequent tuberculin reactions. A pediatric patient who is presenting for evaluation may possibly have a boosting effect on subsequent tuberculin reactions. A pediatric patient who is

Interpretation of Tuberculin Reaction

Readings of Mantoux reactions should be made by a trained health professional during the period from 48 to 72 hours after the injection. Induration only should be considered in interpreting the test. The diameter of induration also may be transversely to the long axis of the forearm and recorded in millimeters. Induration has no diagnostic value and should be disregarded. The presence of size and morphology of the induration area should be recorded. In the absence of induration, an area of erythema greater than 10 mm in diameter may indicate the injection was made too deeply and readings are invalid. Find the margins of the reaction by drawing the index or middle finger lightly across the test area. The tip of a ballpoint pen pushed at a 45° angle toward the site of injection will also stop at the edges of induration.

To determine whether the reaction is positive or negative, the induration should be measured (preferably with a caliper) transversely to the long axis of the forearm and recorded in millimeters. The diameter of induration should be measured in millimeters.

Interpretation of Tuberculin Reaction

A negative reaction is an induration of less than 10 mm in persons with no risk factors for TB. A negative reaction is an induration of less than 10 mm in persons with no risk factors for TB.

Recent contacts of tuberculosis (TB) cases should be tested with a tuberculin skin test. Persons with a history of risk factors for TB should be retested every 12 months. Risk factors include a history of TB, contact with a case of TB, or residence in an area with a high prevalence of tuberculosis.

In the event the injection is delivered subcutaneously (i.e., no bleb will form), or if a significant part of the dose leaks from the injection site, the test should be repeated immediately at another site at least 5 cm (2”) removed from the initial injection site.

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