in the transparent dressing group: longer dressing change interval, longer duration of catheter use, and less use of topical antibiotics. The authors discuss but dismiss these covariates. Also, they combine studies with different brands of transparent dressing—brands are not interchangeable. A typographical error in Table 3 inadvertently exchanged proportions of phlebitis in the Nicola and DeChairo study: 78/255 (30.6%) applies to gauze and not transparent; 58/270 (21.5%) applies to transparent and not gauze dressings (the relative risk [RR] is correct). This difference is statistically significant in favor of transparent dressing. Maki and Will did not find skin colonization rates significantly greater using transparent as opposed to gauze dressings when both were changed every 2 days. Arterial catheter data from Maki and Will should have been excluded; some transparent dressings are contraindicated for arterial use. Abstracts are subject to the same biases as published articles, and so do not "avoid publication bias."

Significant differences in catheter-tip infection do not imply correspondingly significant differences in clinical infection. There were no statistically significant increases in any clinical infection due to transparent dressings. Finally, covariates not considered in the authors' statistical analyses could more than make up for observed differences in dressing type.

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Since 1980, Dr. Berry has been a paid consultant to the 3M Corporation, manufacturer of Tegaderm® transparent dressing.


In Reply.—When comparing the infection risks of transparent vs gauze dressings used on central venous catheters, the RRs were 1.78 for catheter-tip infection, 1.63 for bacteremia, and 1.69 for catheter sepsis. These RRs represent the best assessment of the overall risk associated with the use of transparent dressings. (For catheter-tip infection, P<.001; for catheter sepsis, P=.06.) In our discussion we used the word "trend" in discussing this level of significance. The choice of .05 as the level of "statistical significance" is arbitrary, and given the RRs demonstrated in the meta-analysis, further studies are warranted prior to accepting transparent dressings as safe.

Dr. Berry notes that a recent review by Maki states that quantitative cultures of catheter tips have a "15 to 40 percent association with concomitant bacteremias." We disagree with Berry's conclusions regarding the significance of a positive catheter-tip culture. Dr. Maki notes that "most catheter-related septicemias derive from local infection of the transcatheter cannula tract." We did not state that catheter-tip infection and catheter sepsis need occur simultaneously, but rather that the former is a precursor to the latter. We also recognize that not all catheter-tip infections proceed to sep-

T-Lymphocyte Subsets in Intravenous Drug Users With HIV-1 Infection

To the Editor.—Recently, Margolick et al1 reported on changes in CD4 and CD8 T-lymphocyte subsets in intravenous drug users (IVDUs). In their words, "The principal finding was the slow rate of decline in CD4 lymphocyte counts in HIV-1 [human immunodeficiency virus type 1] seropositive IVDUs over a 2.5-year period of observation." (Actual observation period was 18 months.) The authors assert that this finding contradicts "the common perception that HIV-1 infection in IVDUs leads to rapid decline in CD4 lymphocytes." Howev-