

## SHORT REPORTS

### Lymphangitis after tuberculin tests

Lymphangitis after tuberculin testing has rarely been reported. I report 12 such reactions seen during 1979-83, five after Mantoux and seven after Heaf tests. I had not seen any in the previous 39 years.

#### Case reports

An Indian patient aged 21 presented on 1 May 1979 with cough and sputum after influenza. Clinically his chest was clear, but radiography showed an 8 mm round focus in the second left interspace and tiny right apical fibrotic scars. He had a small pigmented scar in the left posterior triangle of the neck marking the removal of a lymph node three years previously; it was not examined histologically. No family or contact history of tuberculosis was elicited. A Mantoux test with 0.1 ml of 1 in 1000 tuberculin purified protein derivative (10 IU) was done on the left forearm. Later that day he suffered faintness, shivering, vomiting, and fever (40°C). After three days the test site showed erythema (5×6 cm) and induration (4×5 cm) with central blistering. Two red lines extended upwards from the top of the lesion (figure).



Site of Mantoux test showing erythema, induration, and lymphangitis indicated by lines extending from top of lesion.

In three weeks a large scab had formed; subsequently the site of the blister remained pink.

From October 1979 to October 1980, of 47 staff who underwent Mantoux testing in the occupational health department of one hospital, four developed lymphangitis. Three had been injected with 10 IU tuberculin purified protein derivative and one with 5 IU. Two subjects complained of malaise and one also felt febrile. Chest radiographs showed no abnormalities. Ages varied from 45 to 55.

From July to October 1983 a health visitor performed 371 Heaf tests in three other hospitals after the discovery of two cases of culture positive pulmonary tuberculosis. Seven of the subjects developed lymphangitis together with grade IV reactions, six reported malaise, and three reported nausea, muscle ache, and fever. Their ages ranged from 35 to 56. Chest radiographs of those with severe reactions showed no evidence of active tuberculosis but five showed fibrotic scars with calcification in three. All those with severe reactions were white.

#### Comment

I have found only two other case reports of this reaction, one after a Tine test, which the author described as very rare,<sup>1</sup> and one after a Heaf test.<sup>2</sup> Nevertheless, colleagues report having seen lymphangitis

after Tine testing in three tuberculous contacts, and after Mantoux testing in one tuberculous patient, and one colleague had himself suffered lymphangitis and lymphadenitis with malaise and fever after Heaf testing. Severe reactions to Heaf tests (including one case of lymphangitis) occurred in some schoolboys who had been vaccinated five years previously with BCG (C L Miller, personal communication, 1984).

In recent years increasingly severe reactions to Mantoux tests with 10 IU have been reported at case conferences; initial doses of 5 IU, or even 1 IU if the index of suspicion is high are now common. In 1979 severe reactions to the Mantoux test were reported to the suppliers, but tests on guinea pigs found no change in the potency of the tuberculin. A report has described the Heaf test as convenient for use on hospital staff but stated that the Mantoux test may be used, although the dose was not specified.<sup>3</sup> Some figures suggest that the strength of tuberculin used in Heaf tests may vary from 10 to 50 IU,<sup>1</sup> though the late Professor Heaf told me that he regarded his test as equivalent to 15 IU (personal communication, 1952). Use of the Mantoux test instead of the Heaf test whenever possible may avoid some of these severe reactions. This would also avoid the persistent puncture marks at the site of the Heaf test, to which some subjects object.

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<sup>1</sup> Caplin M. *The tuberculin test in clinical practice*. London: Baillière Tindall, 1980: 24, 42.

<sup>2</sup> James DG, Studdy PH. *Colour atlas of respiratory disease*. London: Wolfe Medical Publications, 1981:108.

<sup>3</sup> Joint tuberculosis committee of the British Thoracic Society. Control and prevention of tuberculosis: a code of practice. *Br Med J* 1983;**287**:1118.

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Southport General Infirmary, Southport, Merseyside PR8 6PH  
J B MORRISON, BSC, MD, honorary consultant physician

### Availability of non-steroidal anti-inflammatory drugs over the counter: information needed

During the period in which a number of non-steroidal anti-inflammatory drugs have been withdrawn because of adverse effects,<sup>1</sup> others have been available over the counter without prescription. Duplication of treatment may ensue if details of the availability of drugs over the counter are not known. To assess whether there is a problem a group of doctors was sent a standard questionnaire.

#### Methods and results

We asked 140 rheumatologists what non-steroidal anti-inflammatory drugs were available over the counter; 93 returned the questionnaires.

Most were aware that naproxen (89.2%), diclofenac (86%), and indomethacin (92.4%) were not available over the counter and that ibuprofen (96.5%) was. Only 25.8% recognised that benorylate was available over the counter. The table shows how many knew the content and availability of some over the counter formulations. Only 43 (46.2%) asked their patients what preparations they took that they had obtained over the counter. Eighty eight (94.6%) thought that the profession should be better informed of the availability of drugs over the counter.

#### Comment

Higham and Jayson showed that 79% of patients with rheumatoid arthritis or back pain used self prescribed analgesics.<sup>2</sup> Although there is