

SHORT COMMUNICATION

Giant Mantoux in Tubercular Lymphadenitis

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Mantoux test has been in vogue as ancillary aid for diagnosis of tuberculosis. The type of organ involvement, immune status of the patient, nutrition, drug intake and endemicity alters the tuberculin reactivity pattern. Mantoux is done by injecting intradermally purified protein derivative of tubercle bacillus. The positive reaction usually involves erythema and induration at 48 to 72 hours which usually settles down by one week. It is expected to have active tuberculosis in those immunocompetent patients whose Mantoux reads more than 20 mm induration.¹

We present three patients who had lymphadenitis with highly reactive Mantoux test.

(FIG I)

Patient 1 is a young girl with cervical lymphadenopathy; her Mantoux read 55 by 45mm induration after 12 hours of injecting PPD. There was central bullous elevation and subsequent necrosis.



(FIG II): Patient 2 is a middle aged female with unilateral cervical lymphadenopathy and her Mantoux read 40 by 35 mm induration after 24 hours of injection.

FIG III: Patient 3 is a young man with past history of pulmonary tuberculosis who presented with cervical lymphadenopathy. The tuberculin test done revealed 35 by 30 mm induration at 72 hours.



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All of them presented with fever and lymphadenopathy. All the three patients were HIV negative, Hepatitis serology was not reactive, VDRL was negative. They had normochromic normocytic anemia, with normal liver and kidney function tests.

Chest X ray was normal in first two cases while third case had sequel of old treated pulmonary tuberculosis in form of upper lobe fibrosis. All of them were sputum smear AFB negative and sputum for tubercular culture & sensitivity was not contemplated.

The mean ESR for them was 58. Ultrasound of abdomen and pelvis revealed normal examination. 24 hour urine examination for AFB was unyielding. Mantoux test was performed by injecting .One ml of PPD containing 5 Tuberculin units on anterior aspect of the forearm.

The patients under discussion were subjected to lymph node excision biopsy. The report revealed caseation necrosis with langerhan type giant cells. There was granuloma formation. In view of highly reactive Mantoux, clinical profile of the patients and histologic features of lymph node, all these patients were put on antitubercular treatment category 1 i.e INH, RMP, ETHMB & PZA for a period of 2 months. Although the node samples were not subjected to tubercular culture & sensitivity but there was objective and clinical resolution of signs during this period. Presently patients are stable on maintenance ATT therapy i.e INH & RMP for next 4 months.

Although reaction to PPD is significant in this part of the world but such highly reactive ulceration and induration was not seen before.

Though importance of Mantoux cannot be overemphasized but it still remains as ancillary diagnostic aid for treatment and prognostication of tubercular burden in high prevalence zones like India and south East Asia³. Although high reactions to PPD is seen in leprosy, but none of our patients had clinical profile pointing towards leprosy neither they had contact with patients suffering from lepromatous leprosy².

The second aim of highlighting these cases is that importance of Mantoux cannot be underestimated in tubercular lymphadenitis over pulmonary TB and considering high burden of tuberculosis in our community (WHO interim report 2012)⁴. In our opinion high reaction to PPD in high prevalence zones of tuberculosis like India, Pakistan, South East Asia, China and Russia especially in immunocompetent patients deserves through introspection for TB.

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