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Migration Medicine
The Challenge of Tuberculosis

To the Editor:

The recent phenomenon of populational movement from developing areas with high tuberculosis (TB) prevalence to industrialized countries of Western Europe and North America has elicited a new component to TB epidemiology. These host countries that have had their TB control programs compromised by the problem of HIV coinfection now have a new feature to deal with. Although some studies suggest that detected TB cases among immigrants does not represent a real threat to local population, this is not true for immigrants themselves, considering the precarious socioeconomic conditions in which the majority of them live.

With the aim of evaluating the clinical and epidemiologic profile of TB in migrant populations, a retrospective study of all TB cases in this group admitted to a sanatorium in Lombardy, Italy, was done. Between January 1988 and February 1993, 269 patients were evaluated (11 percent of total patients admitted in this period), 91 percent men (246/269), mean age of 30 y (SD 7.49). The mean staying time from arrival in Italy was 30 months. Provenience areas were distributed as follows: East Europe 3 percent, South America 7 percent, Asia 11 percent, Africa 79 percent, with the latter subdivided in 5 percent East Africa, 31 percent North Africa, and 43 percent West Africa. A history of prior TB diagnosis was referred by 22 percent (55/250). Data on previous treatment with antituberculosis drugs and anterior bacille Calmette-Guérin vaccination were not considered reliable. The HIV serology (Elisa and Western Blot) performed in 76 patients was positive in 16 percent. Tuberculin skin test (5 tuberculin unit, purified protein derivative by Mantoux test) was positive (induration 10 mm) in 67 percent (46/72) of investigated cases, all of them HIV negative. Pulmonary involvement was present in 77 percent of patients, lymphonodal tuberculosis being the most frequent presentation among the extrapulmonary forms (57 percent, 55/61). Bacteriologic diagnosis was possible in 52 percent by smear examination and in 51 percent by culture, with identification of Mycobacterium tuberculosis. Among the antiglobulins performed (129), resistance to at least one drug was present in 28 percent of cases, with the following distribution: 78 percent to isoniazid, 50 percent rifampin, 42 percent streptomycin, and 22 percent ethambutol. Multidrug resistance was detected in two patients. Resistance to rifampin was present in one HIV-positive patient.

Our findings support the need for a new approach to the problem of TB among immigrants. Apart from ethnic and economic prejudices, this population is at great risk of reactivation of previous TB infection in the first years after migration and associated with a high rate of drug resistance and possible transmission within their own group. Therefore, special preventive and therapeutic measures for these particular groups are urgently required.

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Raised Pleural Adenosine Deaminase
Does it Mean Tuberculosis?

To the Editor:

We read with interest, the article by Valdes et al who conclude that raised pleural adenosine deaminase (PADA) and interferon (IFN) are both useful for early diagnosis of tuberculous pleural effusions (note that determining PADA is much less expensive). Since its initial description by Piras et al raised PADA has been assumed as a great/useful diagnostic tool for tuberculous pleurisy. But some of the works from the continents conclude that PADA has poor diagnostic value in tubercular pleural effusion. The methods of adenosine deaminase (ADA) activity estimation are either colorimetry or spectrophotometry, following the enzyme-substrate reaction. It may be one of the reasons why the cut off points for significant ADA activity has been described variously as that of 25 U/L.3 30 U/L.5 45 U/L.9 47 U/L.1 50 U/L.7 Besides the ambiguity of significant PADA level, raised PADA has also been reported in pleural effusions due to rheumatoid arthritis, lymphoma, lung cancer, and mesothelioma, and it has been aptly quoted in a recent editorial. Besides the above conditions, increased PADA activity has been recorded in effusions associated with spontaneous pneumothorax and also parapneumonic effusions. All the above facts point to the fact that raised PADA is unlikely to be a useful diagnostic aid (definitely not confirmatory) for tuberculous effusion; however, sufficiently raised PADA may be an aid to differential diagnosis and should be taken into cognizance along with other clinical and laboratory parameters.

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