
Letters to the Editor

Generalized BCG Tuberculosis

With reference to this report(1), we would like to opine as follows:

It is not clear why this has been labelled as generalized BCG disease. It was probably just a co-incidence that BCG was given 20 days before the first symptoms were noticed. Infact after reading the report, we got the impression that the child's symptoms were present much before BCG was given.

Here we would also like to point out that authors have given drug resistance or immunodeficiency as the cause of treatment failure. In fact they have not given any evidence of treatment failure. Development of new lymphnodes, enlarging of existent lymphnodes and caseation as seen in this case are actually immunological phenomena and are seen with good frequency in lymphnode tuberculosis. Hence, the treatment recommended is surgical in addition to anti-tubercular drugs. In such a

child, symptoms of fever and weight loss may be a true indicator of poor response.

Secondly, the authors have not given any proof of immunodeficiency, Mantoux test and immunoglobulin levels have not been reported. In fact, finding of granuloma in biopsied lymphnode is suggestive of good hypersensitivity and hence T-cell function(2).

In all it looks just an another case of disseminated tuberculosis at an early age, without any known tuberculous contact.

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Reply

This case has been labelled as generalized BCG tuberculosis because of sequence of events after BCG vaccination

and absence of contact with an open case of tuberculosis. Infection acquired at the time of birth usually develop poor feeding, failure to thrive, anemia, and gastrointestinal and respiratory distress at 4 to 8 weeks(1). It is very clear from the report that, symptoms in this case started after

the appearance of swelling on the left side of the neck.

Apart from enlargement of lymph nodes this patient also had persistent fever and poor feeding which are the indicators of progressive disease and poor response.

We agree with the authors that, presence of granuloma indicates good hypersensitivity and hence T-cell function. Patients with leukocyte and monocyte deficiency associated disseminated BCG infection may show miliary granuloma composed of mononuclear, plasma and giant cells(2). These children will have normal or increased levels of immunoglobulins and no lymphopenia. Our case might be one such and categorization of immune deficiency was not possible with available facilities. Disseminated BCG lesion can also follow vaccination soon after birth(3), as already mentioned in the report.

Inspite of such rare complication due to BCG vaccination, we also strongly feel BCG vaccination should be supported whole heartedly.

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Generalized BCG Tuberculosis

We read with interest the letter "Generalized BCG tuberculosis" by Dhaded *et al.*(1) and would like to make the following observations.

That disseminated form of the disease due to BCG vaccination is extremely rare and is usually associated with immune system abnormalities. A thorough contact survey, detailed investigations of the mother and liver biopsy would have proved fruitful in pointing at a source of infection.

Even with BCG dissemination, usually only the axillary lymph nodes are involved.

Unless BCG adenopathy in the axilla is looked for, the relationship of lymphadenopathy to vaccine may not be established(2).

Unless BCG organisms are identified in the different sites involved(3), the possibility of disseminated disease being due to BCG vaccine remains hypothetical.

A paradox is also apparent in the case report in that while there was no evidence of immune deficiency in the child the lack of response to anti-tubercular therapy has still been explained by an underlying immune-deficiency.

The occurrence of a disseminated form of disease in a recent BCG recipient can