

- Lee LPY, Chiu WK, Chan HB. Enlarging tuberculous lymph node despite treatment: Improving or Deteriorating? *Hong Kong J Paediatr* 2009; 14: 42-45.

REPLY

- Isolated tuberculoma being a part of neuro-tuberculosis is a severe form of extrapulmonary tuberculosis and should be treated with category 1 regimen with steroids, similar to TBM.
- It is clearly mentioned that there are studies to suggest adequacy of 6 months treatment in TBM and military TB. However, in case of delayed response to assigned therapy in category 1 and 2, it is recommended to prolong intensive phase by 1 month and continuation phase by 3 months in such patients. This is based on observation that in few patients, standard regimen falls short of desired outcome that is achieved by extension of therapy(1). We note with interest that authors of this letter have data of 100 cases of TBM treated with standard 6 months of therapy and followed up to confirm cure and no relapse. It is worth publishing this data in peer-reviewed journal and we are sure that guidelines can be subsequently modified accordingly.

- While paradoxical reactions do occur, we feel that they cannot be considered as “fairly common”. In any case, such reactions are in the form of pleural effusion, tuberculoma or increase in size and number of existing tuberculomas or lymphnode enlargement. Tuberculoma and mediastinal compressive lymphadenopathy are mentioned as indications for steroids and it holds true irrespective whether such lesions represent initial disease manifestation or paradoxical reaction. Superficial lymphnode enlargement or pleural effusion are not indications of steroid therapy.
- As such protective effect of BCG vaccine is variable and administration of INH does not have any significant effect on take up of BCG vaccine. Moreover, BCG vaccine is routinely administered at birth and diagnosis of tuberculosis in mother is often made thereafter.

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Consensus Statement on Childhood Tuberculosis

The consensus statement on childhood tuberculosis constituted by the Working group on Tuberculosis, IAP 2008(1) claims that “Few studies have reported as high as 33% bacteriological positivity even in primary disease such as hilar lymphadenopathy.” This contradicts the concept of primary tuberculosis, which we understand till date as being difficult to diagnose by demonstration of AFB due to its paucibacillary nature, and the fact that Ziehl-Neelson stain can reveal AFB only if the sample contains >10,000 bacilli per mL. In fact, both the references

quoted by the working group(2,3); on which the entire algorithm for diagnosis of tuberculosis in children is based, are actually studies done on mixed population of primary, progressive primary and cavitary tuberculosis. In the study by Somu, *et al.*(2) of the 50 cases, there were only 6 cases of hilar/mediastinal lymphadenopathy, of which only one was positive for AFB on gastric lavage(2). In their study, the positivity rate was highest in cases with cavitation and consolidation. In the study by Singh, *et al.*(3) of the 58 children, only 13 cases had primary complex or paratracheal/hilar lymphadenopathy. The study did not separately reveal the positivity of AFB on gastric lavage/BAL in this subgroup of children, but only reported the overall positivity in the study as 34.5%. Thus, generalising the conclusions of these studies in the general population with predominant primary

complex seems to be unreasonable. Further studies in children with primary complex need to be done before such guidelines are laid down.

As regards treatment, the present algorithm rightly lays emphasis that there is no role for empirical trial of antitubercular therapy. However, in “probable cases” which includes all symptomatic children/children with history of contact with radiology suggestive of tuberculosis, positive skin test, but with bacteriology negative for AFB, the guidelines of treatment have not been specified. With the AFB positivity rate being actually low in primary complex (as mentioned above), and with not enough Indian data available, this would not be a good suggestion in a community set up in an endemic nation like ours where under-treatment of tuberculosis would be more hazardous than overtreatment.

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1. Working Group on Tuberculosis, Indian Academy of Pediatrics. Consensus statement on childhood tuberculosis. *Indian Pediatr* 2010; 47: 41-55.
2. Somu N, Swaminathan S, Paramasivan CN, Vijayasekaran D, Chandrabhooshanam A, Vijayan VK, *et al.* Value of bronchoalveolar lavage and gastric lavage in the diagnosis of pulmonary tuberculosis in children. *Tuber Lung Dis* 1995; 76: 295-299.
3. Singh M, Moosa NV, Kumar L, Sharma. Role of gastric lavage and broncho-alveolar lavage in the

bacteriological diagnosis of childhood pulmonary tuberculosis. *Indian Pediatr* 2000; 37: 947-951.

REPLY

1. It is true that there is scanty literature in India on bacteriological confirmation of childhood tuberculosis and specifically related to primary complex. Both studies quoted do show bacteriological positivity to an extent of 30% though separate data on primary complex is not available in one of the studies while the other study quoted 15% positivity in primary complex. Thus it was not possible to draw definite conclusion with studies involving small number of children. We intended to give a strong message that we must attempt bacteriological diagnosis in every case of childhood tuberculosis including primary complex irrespective of success, and I am sure more we try more we will find AFB.
2. As regards to “probable” case of childhood tuberculosis, decision of treating would depend upon individual physician’s analysis of probability. In case of doubt, one should consider another opinion and then take a decision. There cannot be structured protocol for such cases. It is not correct to presume that overtreatment is safer than undertreatment. In fact mistakes on both sides are hazardous and that is the reason we hope that our members follow the protocol to minimize both undertreatment and overtreatment. That is also the reason that we have stressed on bacteriological diagnosis.

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Consensus Statement on Childhood Tuberculosis

We read with interest consensus statement on childhood tuberculosis (1). This statement is not

only important for private practitioner but also for those working in the Government/ Public sector. However, we would like to share our experience with childhood tuberculosis.

The Group has rightly recommended the dose of tuberculin unit for Montoux test (MT) that it should not exceed 5TU. In developing country, such as