Immigrants and tuberculosis

The article by Neil Heywood and associates[1] presents an algorithm for tracking potential cases of tuberculosis (TB) in recent arrivals to Canada, but it should not give Canadians a sense of security.

In my experience of practising in northwest metropolitan Toronto for over 20 years, I have seen many immigrants and refugees with TB that was probably active at the time of their arrival in Canada. However, the medical examination before arrival and the screening after arrival were inadequate to identify the disease.

The implication that skin testing would yield too many false-positive results is indefensible. If the test result is positive and the patient is deemed a "low-risk reactor," at least the information will be in the patient's dossier. Should the person become ill, this information should alert medical personnel of possible reactivation of TB. We must also be aware of the possibility of anergy. In Ontario, all health care workers are required to undergo skin testing for TB.

Heywood and associates[1] also discuss surveillance for pulmonary TB; however, no provision is made for identifying extrapulmonary disease, of which I have seen many cases. For example, patients have been referred to me with a tentative diagnosis of inflammatory bowel disease or a "funny skin swelling." The former had gastrointestinal TB, the latter classic "cold abscesses." Like syphilis, TB is a great mimic of other diseases and conditions.

Immigrants and refugees from areas where TB is endemic should be thoroughly screened, and a skin test is essential for people from regions such as the Indian subcontinent and Somalia.

W. Wallace Watson
Surgeon
William Osler Health Centre
Etobicoke Hospital Campus
Etobicoke, Ont.

Reference

1. Heywood N, Kawa B, Long R, Njoo H, Panaro L, Wobeser W, on behalf of the Immigration Subcommittee of the Canadian Tuberculosis Committee. Guidelines for the investigation and follow-up of individuals under medical surveillance for tuberculosis after arriving in Canada: a summary. *CMAJ* 2003;168(12):1563-5.

The article by Neil Heywood and associates[1] draws attention to an important aspect of the health management of adult immigrants and refugees. However, the authors do not make clear that infants and young children (those under 5 years of age) who have been exposed to TB should be managed differently, as they are at much higher risk of progression to active disease. In contrast to adults with recent latent TB infection, among whom the risk for progression to active disease within 5 years is less than 2%, the likelihood of such progression in an infant is up to 40%.[2] Furthermore, infants and young children are much more likely than older children and adults to experience life-threatening forms of TB such as TB meningitis and miliary TB.[2] TB meningitis occurs in approximately 0.5% of children with untreated primary infection;[3] if left untreated this condition is often fatal. In contrast, TB meningitis in adults is much rarer after untreated primary infection.

I am curious as to why young children were omitted from the discussion (in the first full paragraph on page 1564) of giving greater priority for identification and management to those at greater risk of progression to active disease; young age is not even mentioned as a major risk factor for progression.

Readers might be left with the erroneous impression that these guidelines are appropriate for immigrants and refugees of all ages, whereas they really apply only to adults. Nonetheless, physicians also need information about