SYMPTOMATIC PURPURA FOLLOWING TUBERCULIN TEST
(A case report)

PRANESH NIGAM * AND V. K. VERMA †

The tuberculin skin tests (Mantoux Test) is one of the most reliable test in medicine (Stead[4]) and occurrence of purpura following it is exceedingly unusual and hardly it is seen in literature. In fact intracutaneous (Mantoux) test is considered to be most reliable and safe (Stead[4]). Rarely the occurrence of tubercular eye disease was noted shortly after the test. Here we report a case of Thrombocytopenic (symptomatic) Purpura following Mantoux Test.

Case Report

A 20 year old Hindu male was admitted in this hospital in October, 1971 with purpuric spots all over the body with bleeding per rectum, gums and subconjunctival haemorrhage for the last six days. He said that he had cervical lymph nodes enlargement last year and Mantoux Test was performed this year at Kanpur. Four days after test he developed fever with itching, blister formation at the site and later on he noticed purpuric spots all over the body with epistaxis and malena. He also noted red patch in his eyes (subconjunctival haemorrhage) and bleeding from gums. He had frequent motions 5-6 per day with fresh blood without any pain in abdomen. There was no history of such purpuric spots in his family members or in his past illness.

On Examination

The young man of average build, anaemic showed multiple purpuric spots, petaechiae on the trunk and all the four limbs of varying size from pin head to 2 x 1 cms. At the site where Mantoux test was performed there was dark blue necrotic area 2 x 1.5 cms with area of redness around it. Subconjunctival haemorrhage was present with bilateral enlargement of posterior and anterior cervical lymph nodes which were firm and matted. Vital signs were within normal range and systemic examination could not reveal any abnormality.

Invesitgations

Haemoglobin 9.8 gms% total leucocyte count 11,800/cu. mm. with polymorph 64% lymphocytes 26% eosinophils 8% and monocytes 2% with normocytic hypochromic general blood picture. Bleeding time 1 hour 55 mts. platelet count 42,000/cu. mm. Urine showed microscopic haematuria and fresh blood in stool. Liver function test was within normal range.

Response to Treatment

He was given betamethasone sodium phosphate (Betnesol) 0.5 mg. tablet two tablets every six hourly and fresh blood transfusion with other supportive measures. Bleeding from various sites continued for 6–8 days but gradually decreased in amount. After 15 days platelet count came to 1,72,000/-cumm. and bleeding time to 1 mt. 20 sec. Sternla puncture was done when no bleeding was seen from various sites for 6-7 days. The bone marrow showed normocellular pattern with erythroid myeloid ratio of 1 : 5. Platelet formation appeared to be less than normal and few mega-karyocytes seen which were apparently normal.

Patient was discharged after three weeks with platelet count of 1,98,000/ cumm. and cortisone therapy was tapered off over a period of a week and advised to attend the out-patient department for check up.

* Medical Officer, I/C VD Clinic District Hospital, Jhansi (UP)

† Medical Officer, I/C Mobile Hospital Unit, District Hospital, Faizabad (UP)

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Discussion

Thrombocytopenic purpura has been reported after the immunisation against small pox (Metindersma)[2] poliomyelitis, tetanus, diphtheria (Britton[1]) and pertussis (Wintrobe[6]). Symptomatic purpura has also been described in tuberculosis (Britton[1]). Purpura appears as a result of foreign agent which may either be a vascular or a thrombocytopenic variety or both.

Symptomatic thrombocytopenic purpura may be differentiated from an idiopathic thrombocytopenic purpura on the basis of accompanying anaemia, changes in leucocytes and decrease in number of mega karyocytes in bone marrow in the former as compared to the characteristic changes of dormancy decreased granularity and nuclear lobulation in the megakaryocytes in idiopathic thrombocy-to-penia (Wintrobe[6]). According to Weisfuse et al[5] the bone marrow examination is not much helpful in differentiating thrombocy-to-penia due to sensitivity from idiopathic thrombocy-to-penic purpura. Clinically one can diagnose I. T. P. by history of reccurrence and persistent low platelet count. Metindersma et al[2] could not demonstrate antibodies in thrombocy-to-penia following immunisation with whooping cough, tetanus, poliomyelitis etc. The present case probably belongs to symptomatic thrombocy-to-penic purpura.

The evidence for regarding a particular agent as a cause of selective or generalised bone marrow depression is largely circumstantial (Saxena et al[3]). It is difficult to differentiate an induced from an idiopathic dyscrasia (Wintrobe [6]). The infrequency of the occurrence of an ill-effect and its unpredictability necessitate the assembling of data on the occurrence of such relations in order to make the clinician aware of the possibility of adverse reaction to a certain agent.

In order to establish definite relationship between the Tuberculin test and occurrence of purpura four days later, it would be essential to expose the patient again to attempt to elicit a similar response to the causative agent which will not be ethically justifiable.

Summary

A case of generalised thrombocy-to-penic (symptomatic) purpura in a young man following Mantoux Test is described with its clinical course and response to treatment.

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