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The Kveim test – a stain on your character?

Sir,
I should like to draw your readers' attention to three patients recently referred to the Mersey Regional Plastic Surgery Centre from different hospitals within an 18 month period who had had Kveim tests performed. In order to identify the site of the test innoculum, the doctor involved had used a needle and syringe to inject a quantity of blue dye, probably ink, into the skin. This had resulted in a large blue stain on the forearm of each patient, which was both unsightly and permanent. Each was referred for plastic surgical eradication of this blemish.

Leaving aside the question as to the usefulness of the Kveim test and its place in medical practice an accurate method for identifying the site of innoculum must be used. Some practitioners use a convenient mole on the skin of the patient, others a measured distance from the wrist crease in the mid-line of the forearm and the use of a tattooed mark has also been advocated. A simple prick of a needle coated with ink will suffice, so that a needle first rubbed dry and then coated in ink can puncture the skin transferring the ink to one small spot. This can then be removed along with the innoculate at the time of biopsy. Thus, no further blemish apart from the scar of the biopsy, will be apparent.

In this regard also, much can be done to reduce scarring. Olsson¹ pointed out that his young female patients disapproved of an ugly scar on the forearm and suggested the thigh might be a more useful place to situate the test. Sanders² in a discussion on BCG vaccination marks, has suggested that the inner aspect of the arm could be a suitable hidden site.

When suturing a biopsy site, it is suggested that small bites of small needles with thin suture material be used and that a two layer closure be effected. Thus, the resultant scar and stitch marks can be kept to a minimum.

It is hoped that by presenting the plight of these three patients, similar occurrences might be avoided. The eradication of these stains will require excision with grafting, serial excision or the embarkation on a programme of tissue expansion. Inevitably the resultant scars will be much larger than originally intended.

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Anal burning and peppermint oil

Sir,
Enteric-coated peppermint oil capsules are widely used in the treatment of abdominal colic, particularly in the irritable bowel syndrome,¹ because of their effects on intestinal smooth muscle activity.² I wish to record a significant side effect.

A 28 year old medical registrar contracted Salmonella enteritis, with bacteraemia, following the ingestion of contaminated food at a medical conference. He was admitted to hospital where on the third day, his stool frequency was 20 liquid motions per day. There was perianal soreness but no other anal pathology. A peppermint oil capsule was taken orally. Within three hours severe burning pain was experienced in the anus on defaecation persisting for 20 minutes before gradually subsiding. A strong odour of peppermint was evident. The following day a further capsule was ingested with the same result. On this occasion the partly destroyed capsule was easily identified in a bedpan 2 hours 40 minutes after ingestion.

The patient has recovered and with a stool frequency of 1 formed motion per day and on a normal diet has been able to tolerate peppermint oil capsules with no ill effects.

This severe but short lived side effect has not been specifically reported before though mention is made of similar symptoms at high dosage.³ It is felt that the unusual severity in this patient was due to a combination of the poor state of the anal mucosa after frequent bowel actions and the delivery of a high concentration of unabsorbed menthol to the anus as a result of rapid whole-bowel transit time.

This case has been reported to the Committee on the Safety of Medicines.

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