and dysphagia due to esophageal obstruction. Deaths have been reported due to extrinsic compression of mediastinal structure(2,3). In chest radiograph, CT or MR imaging, the lesion usually appears as a well-defined solitary parenchymal nodules(3), rarely as ill-defined mass and occasionally cavitation may occur. Right lung is more commonly affected and the size can vary from 0.5 to 36 cm. Plasma cell granulomas are non-neoplastic and often locally invades the mediastinum, diaphragm, chest wall, vertebral bodies and major vessels(1). Primary hilar adenopathy may also be present, however metastatic spread has not been reported. The natural course is usually either a slow growth or spontaneous resolution. As preoperative imaging and intraoperative biopsy are indistinguishable from that of malignancy, surgical resection of the mass or lobectomy is done depending on diagnostic uncertainty and anatomical position. Diagnosis is usually confirmed by frozen section biopsy. Histopathologically, pulmonary pseudotumor demonstrates a mixed inflammatory infiltrate with a preponderance of plasma cells; evaluation shows varieties of inflammatory cells including lymphocytes, fat laden macrophages and other types of lung parenchymal cells. Recurrences after resection are rare but have been reported(2). Although benign, they have the capacity for local invasion; rapid growth and few of these tumors are also known to undergo sarcomatous transformation(4).

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Shortage of Tuberculin in India: Reason and Remedy

In recent months several doctors have complained that tuberculin is not available from the usual source, namely the BCG Laboratory in King Institute, Guindy, Chennai. Many of us suspected that its manufacture had been suspended for some reason and that sooner than later production will be resumed. A few days ago this matter was discussed with the current director of Tuberculosis Research Institute (Chennai) in the presence of the previous director Dr. S. P. Tripathy. Dr. Tripathy clarified the situation and the details came as an eye-opener to me and I will be failing in my duty if they were not brought to the attention of our Academy members, the concerned

Academy office-bearers and Chapters, for which purpose this communication is being made. Individually and collectively we must impress upon the Government that India must become self-reliant for tuberculin.

All of us were under the impression that tuberculin was being produced in the King Institute, (1). Dr. Tripathy said that the BCG Laboratory had received bulk supply of purified protein derivative (PPD) RT 23 tuberculin prepared in Copenhagen, Denmark and it was being packaged and distributed from Guindy, Chennai. That stock has been exhausted and Copenhagen apparently does not have enough stock to replenish our supply. Years ago the Statens Serum Institute in Copenhagen had prepared a huge batch of PPD RT 23 and standardized the tuberculin content through elaborate tests and that was stocked under the belief that it would be sufficient for the entire world's needs by the time tuberculosis was controlled. That was not to be. He further stated that the production of PPD is easy and the BCG Laboratory can make it quickly if directed by the Union Ministry of Health and Family Welfare. However, standardizing the dose of tuberculin is quite a different matter and it will take time and effort and that was the constraint for its indigenous production and supply.

This is perhaps not the time, nor the forum, to ask the obvious questions as to how a nation with very high incidence of tuberculosis could come to this embarrassing predicament, why it was not anticipated and remedial measures taken *etc.* Such questions can be asked after the emergency is solved through indigenous manufacture and standardization of tuberculin. It is urgently needed for clinical use. As for the national tuberculosis control program, it cannot assess the annual rate of infection without tuberculin testing.

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