Original Article

Pulmonary tuberculosis among political asylum seekers screened at Heathrow Airport, London, 1995–9

M E J Callister, J Barringer, S T Thanabalasingam, R Gair, R N Davidson

Background: Over 50% of cases of tuberculosis (TB) in the UK occur in people born overseas, and new entrants to the country are screened for TB. A study was undertaken to determine the prevalence and disease characteristics of pulmonary TB in new entrants to the UK seeking political asylum.

Methods: A retrospective analysis of the results of screening 53 911 political asylum seekers arriving at Heathrow Airport between 1995 and 1999 was performed by studying Airport Health Control Unit records and hospital medical records. Outcome measures were chest radiograph abnormalities, sputum smear, culture, and drug resistance data for Mycobacterium tuberculosis.

Results: The overall prevalence of active TB in political asylum seekers was 241 per 100 000. There were large variations in prevalences of TB between asylum seekers from different regions, with low rates from the Middle East and high rates from the Indian subcontinent and sub-Saharan Africa. The frequency of drug resistance was high: 22.6% of culture positive cases were isoniazid resistant, 7.5% were multidrug resistant (resistant to both isoniazid and rifampicin), and 4% of cases diagnosed with active disease had multidrug resistant TB.

Conclusions: The prevalence rate of TB in political asylum seekers entering the UK through Heathrow Airport is high and more M tuberculosis isolates from asylum seekers are drug resistant than in the UK population. Extrapolating these figures, it is estimated that 101 political asylum seekers with active pulmonary TB enter the UK every year, of whom about 25 would have smear positive disease.

The overall incidence rate for tuberculosis (TB) in the UK rose throughout the late 1980s and 1990s and was 10.9 per 100 000 per year in England and Wales according to the results of the 1998 National Tuberculosis Survey (Information from Public Health Laboratory Service Communicable Disease Surveillance Centre, December 1999). The incidence rate in London is higher and increasing faster, reaching 31.2 per 100 000 per year in 1998. Most patients with TB are from ethnic minority communities, with 38% in the Indian subcontinent population and a further 13% in Africans. The 1998 national survey revealed that 56% of TB notifications were in persons born outside the UK, and rates were especially high in recent entrants to the UK. In subjects from the Indian subcontinent the rates in those who had arrived in the UK within the last 5 years were three times higher than in those who had arrived more than 5 years before.

Much of the burden of TB is thus borne by a relatively small proportion of the UK population. Screening of people arriving to live in the UK from areas of the world with high TB notification rates is an important part of the UK's TB control programme. Screening allows early identification of active pulmonary TB which, in turn, reduces transmission rates. Such screening can take place in a variety of ways. The USA and Canada screen for pulmonary TB prior to entry, thus circumventing difficulties associated with screening after immigration. For the UK a similar scheme (the XY form) is available at certain centres in a few countries. However, most TB screening is by the port of arrival system where the immigrant is identified at the port of entry with either immediate referral for investigation or with notification to the Consultant in Communicable Disease Control (CCDC) for the eventual area of residence who initiates investigation and follow up at local chest clinics.

Over the last 4 years 224 305 people intending to live in the UK have been referred to the Health Control Unit (HCU) at Heathrow Airport. Of these, 169 029 were immigrants and 55 276 were political asylum seekers. Many new arrivals have addresses in the UK where they intend to stay; others arrive with no intended address. Political asylum seekers usually lack pre-existing arrangements for residence in the UK and rarely have permanent forwarding addresses at entry, making follow up in the community difficult. For this reason the rate of referral for screening at the port of entry is close to 100%, whereas referral of non-asylum seekers is less complete.

In this study we have used a large sample of all political asylum seekers arriving at Heathrow Airport over a 4 year period to estimate minimum prevalence rates at entry into the country of different groups of political asylum seekers. These rate estimates have then been used to estimate the minimum number of cases of TB in all political asylum seekers in the UK.

Methods

We established the numbers of political asylum seekers referred to and seen by the HCU over the period 1 April 1995 to 31 March 1999 and recorded the final diagnosis of patients referred to hospitals in North and West London. Political asylum seekers were categorised according to age group, sex, region of origin, smear and culture status, and sensitivity of the isolate of Mycobacterium tuberculosis. The overall numbers of political asylum seekers entering the UK during the 4 year period from 1995 to 1998 (inclusive) were obtained and the prevalence of the disease in the population screened at Heathrow was extrapolated to estimate the numbers of political asylum seekers with TB who enter the UK annually.

Heathrow HCU screening protocol

Referral to the HCU occurs at the discretion of officers of the Immigration Service who take into account areas of the world where the prevalence of TB is high. A threshold of 40 cases per 100 000 was recommended by the 1994 Joint Tuberculosis Committee guidelines and the 1996 Department of Health recommendations for control and prevention at district level. Nearly all political asylum seekers arriving at Heathrow from

www.thoraxjnl.com
TB endemic areas are therefore referred to the HCU for medical screening by basic clinical examination and a miniature chest radiograph. If the chest radiograph shows possible pulmonary TB, the subject is either transferred by ambulance to hospital for further investigation or allowed to proceed with his/her immigration process with referral to the CCDC for the area of intended residence. This decision is based on the HCU doctor’s judgement of the risk of active TB based on clinical assessment and the radiographic appearances, and the reliability of the forwarding address. All the chest radiographs initially passed as normal are subsequently reviewed by a consultant chest physician. If they are found to be abnormal, the CCDC for the area in which the subject resides is informed and local screening arranged.

**Hospital investigation**

The details of the diagnostic work up vary from hospital to hospital. Most patients are referred to the regional infectious diseases unit at Northwick Park Hospital where they undergo a repeat chest radiograph, tuberculin test, and microscopy, culture and sensitivities of sputum samples and up to three samples of gastric lavage. Patients with smear negative sputum and gastric washing samples then have a broncho-spicographic examination with auramine and Ziehl-Nielsen staining, and mycobacterial culture and sensitivity of the bronchial lavage samples. Patients are diagnosed with active TB if microbiological samples are smear or culture positive, or if the clinical features and radiological appearances strongly suggest active infection in the absence of positive microbiology.

**Data collection**

Records at the Heathrow HCU covering the period 1 April 1995 to 31 March 1999 were examined to identify all political asylum seekers. The country of origin, age, sex, and chest radiographic result were recorded. Those referred to hospital were identified and their medical case notes were examined to establish the

---

**Figure 1** Flow chart showing protocol of tuberculosis screening programme at Heathrow Airport. Numbers refer to number of political asylum seekers between April 1995 and March 1999.
eventual diagnosis, their smear and culture status, and the drug susceptibility of the cultured \( M \) \( \text{tuberculosis} \). The Research, Development and Statistics Directorate of the Home Office provided numbers according to country of origin of political asylum seekers entering the UK from 1 January 1995 to 31 December 1998.

### RESULTS

Figure 1 shows the decision tree used. A total of 55,276 political asylum seekers were referred to the Heathrow HCU during the 4 year study period. Logistical problems prevented 1365 from being examined at the HCU, and follow up in the community was arranged. Of the 53,911 seen in the HCU, 696 were pregnant and 11,745 were below the age of 13. These political asylum seekers were referred to the Heathrow HCU during 1995–99 extrapolated from Heathrow figures

<table>
<thead>
<tr>
<th>Country</th>
<th>No screened</th>
<th>Active TB</th>
<th>Prevalence*</th>
<th>95% CI</th>
<th>Culture +ve</th>
<th>Smear +ve</th>
<th>INH resistant</th>
<th>MDR-TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>3096</td>
<td>11</td>
<td>355</td>
<td></td>
<td>177 to 634</td>
<td>4</td>
<td>0</td>
<td>1 (0)</td>
</tr>
<tr>
<td>Balkans</td>
<td>2295</td>
<td>4</td>
<td>174</td>
<td></td>
<td>47 to 445</td>
<td>2</td>
<td>1</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>533</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0 to 689</td>
<td>0</td>
<td>0</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Central Africa</td>
<td>885</td>
<td>5</td>
<td>565</td>
<td></td>
<td>183 to 1313</td>
<td>3</td>
<td>0</td>
<td>0 (0)</td>
</tr>
<tr>
<td>East Africa</td>
<td>3042</td>
<td>9</td>
<td>296</td>
<td></td>
<td>135 to 560</td>
<td>8</td>
<td>6</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>7249</td>
<td>14</td>
<td>187</td>
<td></td>
<td>102 to 313</td>
<td>10</td>
<td>3</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Far East incl China</td>
<td>1529</td>
<td>3</td>
<td>196</td>
<td></td>
<td>40 to 572</td>
<td>3</td>
<td>1</td>
<td>1 (1)</td>
</tr>
<tr>
<td>India</td>
<td>1060</td>
<td>5</td>
<td>472</td>
<td></td>
<td>153 to 1097</td>
<td>4</td>
<td>3</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Middle East Cy &amp; Tu</td>
<td>6304</td>
<td>2</td>
<td>32</td>
<td></td>
<td>3 to 114</td>
<td>1</td>
<td>1</td>
<td>1 (1)</td>
</tr>
<tr>
<td>North Africa</td>
<td>750</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0 to 490</td>
<td>0</td>
<td>0</td>
<td>0 (0)</td>
</tr>
<tr>
<td>North East Africa</td>
<td>1052</td>
<td>2</td>
<td>380</td>
<td></td>
<td>103 to 970</td>
<td>2</td>
<td>1</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Pakistan</td>
<td>2088</td>
<td>5</td>
<td>239</td>
<td></td>
<td>77 to 558</td>
<td>2</td>
<td>1</td>
<td>0 (0)</td>
</tr>
<tr>
<td>South America</td>
<td>3779</td>
<td>4</td>
<td>106</td>
<td></td>
<td>28 to 270</td>
<td>1</td>
<td>0</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Somalia</td>
<td>2101</td>
<td>22</td>
<td>1047</td>
<td></td>
<td>657 to 1581</td>
<td>9</td>
<td>4</td>
<td>4 (2)</td>
</tr>
<tr>
<td>Southern Africa</td>
<td>406</td>
<td>0</td>
<td>0</td>
<td></td>
<td>0 to 904</td>
<td>0</td>
<td>0</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>2806</td>
<td>6</td>
<td>214</td>
<td></td>
<td>78 to 464</td>
<td>4</td>
<td>2</td>
<td>0 (0)</td>
</tr>
<tr>
<td>West Africa</td>
<td>2254</td>
<td>6</td>
<td>266</td>
<td></td>
<td>97 to 578</td>
<td>4</td>
<td>1</td>
<td>0 (0)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>41,470</td>
<td>100</td>
<td>241</td>
<td></td>
<td>196 to 293</td>
<td>53</td>
<td>24</td>
<td>12 (6)</td>
</tr>
</tbody>
</table>

Calculated using regional prevalences from Heathrow screening data (table 1). Cy=Cyprus; Tu=Turkey.
years, and eight were aged over 50 years. Calculated prevalence rates for these three age groups were 229 (95% CI 180 to 291), 237 (95% CI 163 to 344), and 487 (95% CI 247 to 958) per 100,000, respectively.

For the subsequent analysis we considered all four years and looked at rates of TB among the political asylum seekers who underwent radiographic examination. Geographical areas and countries showed variations in the prevalence of active disease (tables 1 and 2). Prevalence rates per 100,000 cases of active TB were lower among asylum seekers from Eastern Europe (187), the Balkans (174), and the Middle East (32). The highest prevalence rates per 100,000 were in political asylum seekers from Somalia (1047), Central Africa (565), India (472), and Afghanistan (355). During the period of the study the Home Office statistics that most closely corresponded to our study period (1 January 1995 to 31 December 1998), showed that 152,120 people claimed political asylum in the UK. We used the prevalence in each region of our screened population, extrapolated to all political asylum seekers in the UK as a whole, to estimate that 406 (95% CI 313 to 496) political asylum seekers entering the country during the 4 year study period would have been predicted to have active pulmonary TB, of whom 99 (95% CI 54 to 142) would have smear positive disease (table 2).

DISCUSSION

This study is the first to estimate prevalence rates of TB in political asylum seekers arriving in the UK and is based on a large sample of over 41,000 subjects. Because we only have outcomes for the 352 cases referred directly from Heathrow, and that 238 had a radiograph suggestive of TB and, of these, after investigation, 55 were considered to have active TB (2228 per 100,000). These rates were almost 10 times higher than in the UK population, only one case of MDR-TB was detected per year of the study period.

One important finding of our study was the difference between the prevalence of active disease in asylum seekers from various geographical regions. Those from the Middle East (an area of the world considered by the WHO to have a high prevalence of TB) had a prevalence of TB of 32 per 100,000 which is similar to the annual notification rate for London as a whole (31.2 per 100,000) and considerably lower than that for certain London boroughs such as Newham, Brent, and Tower Hamlets (79, 77, and 77 per 100,000, respectively). By contrast, political asylum seekers from sub-Saharan Africa had very high rates of active TB with those from Somalia having the highest prevalence rate (1047 per 100,000).

Assuming that the political asylum seekers presenting to Heathrow are representative of asylum seekers nationwide, we calculated that there would have been 406 cases of active TB in asylum seekers nationally over the 4 year study period of which 99 would have been smear positive. However, there are weaknesses in these assumptions. Some asylum seekers claim political asylum only after they have been resident in the UK for some time, and they may differ in social and economic characteristics from the group claiming asylum at entry. Our data also showed variations in the prevalence of TB among different age and sex groups, and the data provided by the Home Office did not include details of age and sex.

Only two previous reports have specifically studied TB among political asylum seekers. Van den Brande et al. screened asylum seekers on a voluntary basis at the Central Transit Centre in Brussels during 1993 and calculated a prevalence of 396 cases of active disease per 100,000 subjects screened with chest radiographs. However, there was a high drop out rate during this voluntary programme, and the authors advised that screening of political asylum seekers entering Belgium should be mandatory and that follow up of the screened cases should be regulated. Kessele et al. performed a similar voluntary screening project study in North Rhine, Westphalia between 1992 and 1994. They performed chest radiographs on 4058 political asylum seekers and found 48 cases of active tuberculosis (prevalence rate 1183 per 100,000). They too recommended compulsory chest radiographs shortly after arrival with subsequent regulated treatment or prophylaxis programmes.

A number of other studies have looked at the prevalence of pulmonary TB in persons newly arrived in Europe and North America (table 3). Bonvin et al. studied 4512 immigrants to Switzerland between 1988 and 1990. Of 2469 who underwent chest radiography, 238 had a radiograph suggestive of TB and, after investigation, 55 were considered to have active TB (2228 per 100,000 for the population screened).

Two studies in the UK have examined screening of immigrants, not specifically political asylum seekers, using the port of arrival system. Hardie and Wilson estimated that only 36,000 (26%) of the 140,000 immigrants arriving in the UK.
annually were traced and screened and, of the 20,000 who had chest radiographs, 100 per 100,000 were found to have active TB. Ormerod’s review of screening in the Blackburn area found that the port of arrival system failed to identify 60% of new immigrants.

Political asylum seekers and other immigrants differ in a number of ways, and this is reflected in differences in the criteria used by immigration officers to refer them to the port health control units. Whereas it is policy to refer political asylum seekers whenever possible, other immigrants are referred on the basis of country of origin and intended length of stay. Political asylum seekers tend to either have no forwarding address or one is only obtained after a number of weeks or months. They will more often live in shared accommodation and, because of cultural differences and a fear of deportation, may be more reluctant to seek medical help. Transmission of TB is by prolonged close contact. For this reason, political asylum seekers with TB pose a risk primarily to other asylum seekers and those in the new entrant community. When considered with the significantly higher risk of drug-resistant disease in political asylum seekers with TB, this underlines the importance of primary screening for TB in this population in order to ensure that they receive appropriate treatment and that others in the immigrant community are protected.

Screening of political asylum seekers arriving at Heathrow Airport between 1995 and 1999 yielded a diagnosis of pulmonary TB in at least 241 per 100,000 of those who underwent radiography, which is a prevalence 22 times higher than the annual incidence rate for the UK as a whole (10.9 per 100,000 in 1998). The true burden of TB among political asylum seekers is almost certainly higher, as non-respiratory TB is not detected by chest radiography and because follow-up information was only available for 252 of the 564 cases identified by radiographic abnormalities.

ACKNOWLEDGEMENTS

The authors thank the staff at Heathrow Airport Health Control Unit and Northwick Park Infectious Diseases Unit for their help in collecting the data, especially Professor G Pasvol, Dr RA Wall, and Northwick Park Hospital Audit Department.

Authors’ affiliations

M E J Callister, R N Davidson, Department of Infection and Tropical Medicine, Lister Unit, Northwick Park Hospital, Harrow, Middlesex HA1 3UJ, UK

J Barringer, S T Thanabalasingam, R Gair, Health Control Unit, Terminal 3 Arrivals, Heathrow Airport, Hounslow, Middlesex TW6 1NB, UK

All authors contributed equally to the idea of the study and substantially to the writing of the paper. ST and JB collected the data from Heathrow. MC was responsible for the hospital data and performed the data analyses. RD is guarantor for the study.

Funding: None.

Conflict of Interest: None.

REFERENCES


Pulmonary tuberculosis among political asylum seekers screened at Heathrow Airport, London, 1995–9

M E J Callister, J Barringer, S T Thanabalasingam, R Gair and R N Davidson

Thorax 2002 57: 152-156
doi: 10.1136/thorax.57.2.152

Updated information and services can be found at:
http://thorax.bmj.com/content/57/2/152

These include:

References
This article cites 4 articles, 1 of which you can access for free at:
http://thorax.bmj.com/content/57/2/152#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Topic Collections
Articles on similar topics can be found in the following collections

- Drugs: infectious diseases (968)
- Radiology (diagnostics) (812)
- Screening (epidemiology) (366)
- Screening (public health) (366)
- TB and other respiratory infections (1273)
- Tuberculosis (51)

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/