CASE REPORT

The case is that of a girl aged 16 who complained of a small discharging sinus in her neck. She stated that to her knowledge it had been present since birth, and that periodically it became more noticeable and discharged a clear coloured fluid for several days.

FIG. 1.—Opening of branchial cyst in neck.

On examination a barely noticeable papule was present over the anterior border of the left sterno-mastoid and situated about 2 in. (5 cm.) above the suprasternal notch (Fig. 1). There was no discharge at the time, and it was found impossible to get a very fine probe into what was apparently a closed punctum. However, extending upwards from this towards the angle of the jaw was a slight but just visible cord-like thickening comparable in diameter to an ordinary lead pencil. On asking the patient to open her mouth and upon milking this thickening upwards, a good teaspoonful of whitish fluid was seen to exude from the region of the suprastonsillar fossa.

Under anaesthesia and after packing off the pharynx, a large ureteric catheter was passed with ease through a visible ostium opening above the left tonsil. Lipiodol was injected, and a subsequent radiograph (Fig. 2) confirmed the provisional diagnosis of a complete branchial fistula communicating with the pharynx.

FIG. 2.—Lateral view of fistula after injection of lipiodol.

COMMENT

Surgical ablation of such a fistula entails a moderate-sized incision and a careful dissection in the region of the internal carotid artery, due respect being given to the proximity of both the glosso-pharyngeal and the facial nerves. Access to the pharyngeal closure of such a fistula is best aided by lateral displacement of the tonsil by means of a finger in the mouth. The mere presence of a branchial

fistula is in my opinion no indication for surgical intervention, and certainly before the latter is contemplated the extent of the tract at least should be investigated.

I wish to thank Dr. G. A. Borthwick, superintendent of the Northern Hospital, N.21, for permitting me to publish this case.

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Hyperpyrexia Complicating Infantile Eczema

Cases of sudden death in patients suffering from infantile eczema have been reported from time to time. Schwartz (1934) reviewed 10 such cases, and Feer (1904) reported others. These deaths seem to have been due to intercurrent infections, such as septicaemia, bronchopneumonia, or gastro-enteritis, which have run a more rapid course in these children than is usual. None of these appear to resemble the following case.

CASE REPORT

The patient, a boy aged 13 months, had suffered from eczema since birth. On admission he had large patches of eczema, partly impetiginized, covering the greater part of all four limbs, the trunk, the face, and the scalp. The skin was treated with compound zinc ointment, and chloral was given by mouth to allay restlessness. The eczema improved greatly during the first week. The skin, however, became dry and showed powdery desquamation.

On the eighth day after admission a convulsion occurred, together with vomiting, pin-point pupils, and the passage of faeces. The skin felt extremely hot, and on taking the temperature in the rectum the mercury reached the end of the thermometer. Repetition with a second thermometer produced the same result. Both were subsequently tested, and the temperature required to bring the mercury to the end of the thermometers was found to be 110° F. (43.3° C.). Tepid sponging was started immediately, and the temperature was plotted every fifteen minutes. After half an hour the temperature was 106° F. (41.1° C.), and after one hour 104.8° F. (40.45° C.). Consciousness was regained four hours from the onset of the convulsion. The temperature was then 100° F. (37.8° C.).

Investigations were carried out to exclude intercurrent disease. The E.S.R. was 12 mm. in one hour. The urine showed a trace of albumin, but no abnormality was found in the C.S.F., the differential white cell count, or in the x-ray picture of the chest.

Progress was uneventful. A low-grade pyrexia persisted, but the eczema cleared except for a small patch on the shoulder. At the time of writing, eleven months later, the child is still attending as an out-patient. His skin remains dry and there are a few eczematous patches.

COMMENT

Hyperpyrexia is a possible and dangerous complication of infantile eczema in which a large proportion of the body surface is involved. In this case the combination of hyperpyrexia, pin-point pupils, convulsions, and unconsciousness also raises the possibility of a pontine lesion. Vasomotor spasm in the pons offers a reasonable explanation of the transitory nature of the signs.

Gratitude is expressed to Dr. F. A. Bryning, medical superintendent of Hackney Hospital, for permission to publish this case, and to Dr. F. L. Lydon, consultant dermatologist, for advice on its presentation.

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