Medical Memoranda

Tuberculosis of the Adenoids

In 1945 fifteen cases of tuberculous cervical adenitis were treated at the country branch of the Hospital for Sick Children. Shortly after admission the tonsils and adenoids were removed and examined microscopically. The incidence of tuberculous infection of the tonsils was about 70%, as might be expected from a study of the literature, but it was surprising to find that in this short series three cases showed infection of the adenoids. They are recorded because tuberculosis of the adenoids is rarely mentioned. In 1924 Crowe and MacCready, in an analysis of the pathology of tonsils and adenoids removed at the Johns Hopkins Hospital, noted that tuberculous lesions were present in 2.5% of 1,000 cases of adenoidectomy. In these cases there was no clinical evidence of tuberculosis. No other record could be found of the incidence of tuberculosis of the adenoids in children. One case in an adult was described by Pegler in 1911.

CASE REPORTS

Case 1.—A male child aged 15 months was admitted to hospital on Aug. 10, 1945, with many enlarged glands in both sides of the neck and a discharging sinus in the left side. He had had cervical adenitis since the age of 3 months. His general condition was fairly good, and his weight and height were normal. The tonsils and adenoids were removed on Sept. 25, 1945. Section showed tubercles with giant cells in both tonsils and in the adenoids. At no time was there any clinical or x-ray evidence of tuberculosis of the chest or elsewhere.

Case 2.—A female child aged 11 months was admitted to hospital on April 18, 1945, with bilateral enlarged cervical glands and a fluctuant abscess below the left mandible. The glands had been enlarging for about a month, and although the child was a little underweight she was plump and looked fairly well. The abscess was immediately incised and expressed. There was a little further glandular enlargement and loss of weight during the next two to three weeks; then she began to improve, and on May 17 was fit for removal of the tonsils and adenoids. This was done, and a second abscess was expressed. Section showed tuberculosis of the adenoids but not of the tonsils. There was no clinical or x-ray evidence of tuberculosis elsewhere.

Case 3.—A male child aged 13 months was admitted to hospital for cervical adenitis in February, 1946. He had a discharging abscess on the right side; this was expressed and the tonsils and adenoids were removed on May 4, 1946. He looked well and was a little above the average weight for his age. Section showed evidence of tuberculosis of the right tonsil and of the adenoids. There was no clinical or x-ray evidence of tuberculosis elsewhere.

COMMENT

In each of these cases there was gross cervical adenitis in a child under 2 years of age, and the tuberculin patch test was positive. There was no evidence of tuberculosis of the chest or elsewhere, the weight was about the average or above the normal for the age, and the general health appeared to be good. Clinically there was very little enlargement of the tonsils and adenoids in the first two cases and no inflammation. In the third case there was some enlargement and inflammation of the tonsils during the early part of the illness. No information was obtained as to the origin of the infection in these cases. In none of them was the condition of the tonsils and adenoids such that their removal would have been advised on ordinary clinical grounds. It is probable that investigation of a larger series would reveal infection of these tissues to be more common than is generally supposed.

Treatment consisted in removal of the tonsils and adenoids, expression of glands in which abscess formation had occurred, and general care in the hospital's country branch. These cases are interesting in comparison with cases of streptococcal cervical adenitis. Here the child is pallid and debilitated, and often acutely ill with enlarged red tonsils and nasal obstruction. In the tuberculous infection many glands may be grossly enlarged, but the child is relatively well and the tonsils and adenoids are small and pale.

Macroscopically the tonsils and adenoids were small and of a soft, firm consistency. Sections showed giant-cell systems and areas of necrosis typical of tuberculosis. In these cases there

was no difficulty in demonstrating the pathology in sections taken from any part of the tissue. No special technique was used.

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Mental Disturbance as the Leading Symptom in Typhoid Fever

The following case of typhoid fever is worth recording because of the prominence of mental symptoms and the indefiniteness of the pyrexial illness in the early stages. It also illustrates the difficulty experienced during the war in interpreting symptoms of psychoses in the Middle East where toxic confusional states occurred far more often than at home. Pyrexia of unknown origin was common and was as likely to occur in a patient in a psychiatric hospital as elsewhere.

CASE REPORT

An Army chaplain aged 36 was admitted because of increasing mental disturbance over the past six days. He was by this time very restless and agitated, banging his head against the wall and crying out that all was lost. No contact could be made with him other than that he begged to be placed before a firing squad. He said voices were accusing him of having turned from God, and were threatening him with eternal torment such as his wife and child, supposedly in the next room, were suffering at the hands of the devil in being boiled in oil and yet unable to die. He had been pyrexial for several days, so a full investigation into this was made after examination by the medical specialist and under his guidance.

Clinically nothing whatsoever pointed positively to typhoid until the last few days of the illness. Blood investigations revealed nothing abnormal, with the exception that after two subcultures a growth of what was identified as *Bact. typhosum* was found. This identification was made on what was estimated as the thirteenth day of the pyrexia. In the meantime the patient's condition deteriorated rapidly, and he died the following day. A post-mortem examination showed typical typhoid changes throughout, though intestinal perforation had not occurred.

During the course of the illness the mental disorder had given considerable concern. The acute symptoms had been of gradual onset and at first appeared to be quite unconnected with any incidental pyrexia. The patient became depressed, stated that he did not feel well, and spent hours looking at family photographs. He had been under a psychiatrist for two months on account of emotional instability, undue activity, and vociferation about his work. He had admitted a previous depressive breakdown; but now he had become disorientated, and lived in a state of continual torment in what he considered to be gaol. He was intensely suicidal and had to be restrained. From the first he was resistive and uncooperative, and was continually whispering hoarsely that he was going through hell. He maintained that he had no physical illness. The same delusions of persecution persisted throughout, accompanied by extreme agitation, until he became comatose through exhaustion the day before he died.

COMMENT

Here the depressed form of acute confusional psychosis occurred in a febrile illness which proved to be a fatal case of toxæmic typhoid fever. Depression began at or just before the onset of pyrexia in a man of known cyclothymic constitution, and progressed, with the development of acute suicidal tendencies, as the pyrexia continued, later being absorbed in a confusional setting of disorientation, imperception, and acute hallucinosis. The persistence of relatively fixed delusions suggested the precipitation of a depressive psychosis. This case illustrates the difficulty of diagnosing the depressed form of confusional psychosis and shows well the resemblance between this disorder and the depressive phase of manic-depressive psychosis, and occasionally the depressed form of katatonia.

I wish to thank Col. O. J. O'Hanlon, late R.A.M.C., for permission to describe this case.

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