SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF LARYNGOLOGY

May 3rd, 1965

Discussion on Glandular Fever

MR. GEORGE GOMEZ (London) said that as an unsophisticated general practitioner, possibly the only one present, he would like to emphasize the rarity of Glandular Fever. In 17 years' experience of general practice he had probably not seen more than 17 cases. He easily remembered them as he felt so foolish when he found that the acute sore throat with cervical lymphadenitis was not being cured by antibiotics. The patient was usually a child, quite severely ill.

The speaker and his wife had carried out a survey of acute sore throat in general practice, throat swabs being taken at the onset, and on the fifth and tenth days of the illness. Out of 200 cases, 57 per cent. were found to be due to bacterial infection—usually the hæmolytic streptococcus—the rest were presumably viral. Out of these cases only one was due to glandular fever.

May 7th, 1965

Discussion on Respiratory System in Health and Disease

PROF. I. FRIEDMANN (London) said that he was very interested in Dr. Pepys's remarks on nasal polyps containing lymph follicles or similar accumulations of large lymphocytes. It has been suggested that such cells synthesized macroglobulins and macroglobulin antibodies and have been found to contain macroglobulin in patients with macroglobulinæmia.

He also asked for Dr. Pepys's comments on the probable immunological processes operating in midline granuloma of the face and polyarteritis nodosa.

He congratulated him on a masterly review of a complex field.

MR. S. W. ALLINSON (Boston) said that it was important to teach patients how to breathe through the nose and how to blow the nose. In this way many respiratory infections could be prevented or ameliorated.

MR. H. ZALIN (Liverpool) said that he disagreed with a number of points made by Mr. Munro Black in his paper and deplored the tendency to perpetuation of meaningless medical clichés. Post-nasal purulent discharge in a child is not pathognomonic of sinusitis and does not, *per se*, call for an attack on the sinuses. It can and does occur as part of any acute or subacute upper respiratory tract infection and is frequently phasic, present one week and absent the next. Mr. Black advocated enlisting the aid of the Pædiatrician and the

https://doi.org/10.1017/S0022215100065488 Published online by Cambridge University Press

Thoracic Surgeon in the treatment of the bronchiectasis found to be associated with purulent sinusitis in childhood, but this is not surgical bronchiectasis. The lung involvement starts before the age of three and is diffuse and bilateral. It does not call even for bronchoscopic aspiration, let alone lobectomy and there is some evidence that it is spontaneously reversible. There is no place for the Thoracic Surgeon in this condition and the Pædiatrician has nothing to offer either. Antibiotics, postural drainage and vitamins can be prescribed by the Rhinologist.

With regard to desensitization techniques in the treatment of upper respiratory tract allergy he would welcome some information on the rationale of building up a high antibody titre to a specific antigen when the standard conception of allergy is an explosive reaction between antigen and antibody resulting in histamine release. If this conception is to be believed how is the allergic reaction suppressed merely by increasing the amount of available antibody? Theoretically an increase in the amount of circulating antibody must expose the patient to considerable risk of more intense and dramatic allergic reaction.

Discussion on the Syndrome of Respiratory Suppuration in Children

MR. KENNETH G. MALCOMSON (Bristol) said that Mr. Munro Black has championed the recognition of diffuse respiratory suppuration in children for many years.

Suspicions about lower respiratory infection either recurrent bronchitis or particularly bronchiectasis must be entertained in any patient with recurrent or relapsing nasal infection involving the sinuses. During the last 6 months he had requested bronchographic examination in eight such patients who had the characteristic chest rattle on coughing or laughing as well as sinusitis; bronchiectasis was demonstrated in seven. It should be emphasized that in none of these patients had the diagnosis been suspected by their own doctor even when the disease had been present for as long as 40 years. He now makes it a practice to request a bronchogram during in-patient treatment for sinusitis whenever lower respiratory symptoms of consequence are present.

In addition to respiratory suppuration and keratosis obturans attention should also be drawn to the concomitant presence of mucus in the middle ear which can only be detected by paracentesis for the appearance of the drum has been altered by keratosis. If this is omitted a double cause for deafness may be overlooked.

In discussing respiratory infection it is unfortunate that the word "catarrh" is used; generally we understand it to mean an inflammation of a mucous membrane and any discharge derived therefrom. We know only too well that the term as used by our patients has lost its true meaning and may be employed to describe any infective, irritative or mechanical disturbance of any part of the upper or lower respiratory tract (including the ears, and even headaches) and may also be applied to lesions of the foregut such as hiatus hernia. If we are to be precise we should reject all nebulous and imperspicuous expressions from our clinical vocabulary.

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