EPISTAXIS AND TUBERCULOSIS

By R. SCOTT STEVENSON (Gibraltar)

S.F., aged 44, married, a fireman in the City Fire Brigade, Gibraltar, presented himself at hospital on *February 9th, 1965*, because of epistaxis from the right side of his nose. There was a varicosity on the right side of his nasal septum, which I cauterized, but as I felt uncertain that this was the true cause of the epistaxis I told the patient to return that afternoon if there was any more bleeding. He did return, complaining again of epistaxis and as I did not then see any further cause for this in the nose, I looked in his post-nasal space and found it full of blood-clot. Suspecting a neoplasm, I therefore admitted him that evening to hospital.

Next morning, *February 10th*, I examined his post-nasal space under general anæsthesia, and having cleared away the blood-clot, found fresh blood coming from the median cleft of a persistent pharyngeal tonsil (adenoids, or Thornwaldt's bursa), unusual in a man of 44. I removed this with an adenoid curette, and stopped the bleeding from two or three persistent spots with diathermy. This bleeding (and likewise epistaxis) never recurred, and the patient left hospital, quite happily, 3 days later.

I sent the specimen for microscopic examination to the hospital pathologist, Dr. Ernest Imossi, who reported that it was a tuberculoma, showing giant cells.

I therefore had the patient's chest X-rayed, and the film showed opacities in the upper zones of both lungs, more marked on the right side, which Dr. J. J. Giraldi, consultant physician, diagnosed as pulmonary tuberculosis. A few crepitations were present at each apex. The patient was therefore re-admitted to hospital, in a medical ward, on *February 23rd.*

The pathologist reported on a blood specimen, on *February 24th*, that the patient's red blood cells were 4,340,000 per c.mm., hæmoglobin 87 per cent., white cells 11,300 per c.mm. (of which 65 per cent. were polymorphonuclears and 25 per cent. lymphocytes, monocytes 8 per cent. and eosinophils 2 per cent.). More important, he reported on *February 25th* that acid-fast bacilli were present in a specimen of his sputum, and this was confirmed in another sputum specimen on *February 26th.* Wassermann and Kahn tests were negative.

Standard anti-tuberculosis therapy (streptomycin 1 g. daily, PAS, and isoniazid) was begun on *February 26th*, and Prednisone 10 mg. t.d.s. was also begun on *March 24th*, but was stopped on *May 31st.* Sputum examinations were carried out by the pathologist once a week, but all were negative after *February 26th.* Successive X-rays of his chest showed slight but gradual improvement in the appearance.

All the other members of the City Fire Brigade had their chests X-rayed, and also the patient's family and his other contacts, but in every case the result was negative for tuberculosis. Tuberculosis is, in fact, rare in Gibraltar

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nowadays (the tuberculosis sanatorium that was built in 1939 has become the medical department of our Hospital), and such cases as occur have usually a Spanish origin. The patient himself was unable to help as regards history, except that he had lost weight (11 lbs. in 3 months) before admission to hospital. There had been no constitutional upset, no sweats, loss of appetite, or malaise, and there was no fever while in hospital. It is assumed that he had contracted pulmonary tuberculosis when young, that this had healed but had broken down again, possibly after a cold or bronchitis. The patient was discharged to normal life on *July 12th, 1965*, feeling well and having put on weight, but still with opacities on X-ray, though less marked, at both pulmonary apices.

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