GLANDULAR FEVER*

By BRIAN PICKARD (London)

THE laryngologist is called upon to identify and sometimes treat the complications of the disease. Rarely is the initial sore throat brought to his attention but the stage of secondary infection will provide an inflamed red pharynx covered by a pseudo-membrane and the temperature which had begun to fall, rises again. This false membrane bears a slight resemblance to that of diphtheria. There is much less surrounding inflammation and the false membrane may be stripped easily from the underlying epithelium, which is intact and not bleeding.

The usual site of this false membrane is the tonsils or posterior pharyngeal wall, but it may be seen on the palate, on the buccal mucosa or as a gingivitis on the mucus membrane of the alveolar process of upper and lower jaws surrounding the teeth.

The microscopic examination of the membrane shows no specific features. It does not display the breaking down epithelium of a diphtheritic membrane and there are no specific organisms. It is usual to find the mouth commensals including the spirochaete of Vincent.

Turning from the usual case we find rare cases in which the throat condition is more frightening. Hammond and McBrien (1962) recorded the story of one of their own nurses who during the course of infective mononucleosis, developed bilateral parapharyngeal abscesses, the first of which ruptured spontaneously and the second was incised.

Mosonyi and Rusvai (1961) describe a case of subacute thyroiditis during this illness.

As with other inflammatory conditions of the respiratory tract, particularly when laryngitis is a feature, respiratory obstruction is a rare but frightening emergency. Parsons and Dodds recorded in 1958 a case in which tracheostomy was necessary.

The enanthem of mononucleosis is quite typical and pathognomonic. It was first described by Holzel in 1954 and consists of a large number of small petechial hæmorrhages, around the junction of hard and soft palate. These petechiae appear between the thirteenth and the twenty-first day and last from 5 to 7 days. The arrival of the petechiae usually coincides with the height of the first wave of pyrexia before the remission and return of pyrexia.

---

* Précis of the paper read at the Section of Laryngology, Royal Society of Medicine, March 5th, 1965.

https://doi.org/10.1017/S0022215100065348 Published online by Cambridge University Press

Glandular Fever

Among the neurological complications is paralysis of the one motor nerve which is of particular interest to the otologist. A VIIth nerve palsy may be unilateral or bilateral and unaccompanied by cerebrospinal fluid changes. I have never seen such a case and would be interested to know whether taste and lacrimation are involved and to know whether this is a diagnostic problem with Bell's palsy.

The diagnosis of glandular fever in the absence of serological confirmation may be difficult, but how much more difficult were the cases in the earlier literature in which this disease coincided with either diphtheria, scarlatina or secondary syphilis!

REFERENCES

BELL, C. (1829) *Phil. Trans.*, **111** (Part II), p. 317. Reprinted (1936) in *Med. Classics*, **1**, 155.

HAMMOND, V. T. and MCBRIEN, D. J. (1962) *Brit. med. J.*, **2**, 1518.

HOLZEL, A. (1954) *Lancet*, **2**, 1054.

MOSONYI, L. and RUSVAI, A. (1961) *Z.ges. inn. Med.*, **16**, 798.

PARSONS, H. M. and DODDS, E. J. A. (1958) *J. Laryng.*, **72**, 910.

55 Blackheath Park,
London, S.E.3.

https://doi.org/10.1017/S0022215100065348 Published online by Cambridge University Press