Acute epiglottitis in adults

Sir,

Acute epiglottitis, usually caused by *Haemophilus influenzae* type B occurs only rarely in adults.¹ We have treated 15 such patients (18–60 years; 8 < 35 years) over a period of 6 years (1986–1991) in Medical College & Hospital, Rohtak, India.

All were males. Ten presented within 48 hours of onset of symptoms while five had had symptoms for 3–4 days before reporting. Pain or difficulty in swallowing was the main symptom (14 cases). Pain in the throat (six cases), respiratory distress (five cases) and change in voice (four cases) were other presenting symptoms. All were febrile and had a red swollen epiglottis. Inflammation of aryepiglottic folds and arytenoids was observed in seven cases and tonsillopharyngitis in six. In five cases vocal cords could not be visualized. The important differential diagnosis included tubercular epiglottitis and malignancy, excluded by history and relevant examination. X-ray soft tissue neck showed the swollen epiglottis producing a 'thumb sign' in 14 patients. In 10 cases where throat swab and blood culture was done, the blood culture was sterile in all, while throat swab showed *Klebsiella pneumoniae* (sensitive to ampicillin, gentamicin and kanamycin) in three. All patients improved with parenteral ampicillin. The mean hospital stay was 5.2 days (3–10 days).

As in the present study, acute epiglottitis has been reported to have a greater preponderance among males.² The incidence of the 'thumb sign' seen in the present study is also similar to that reported earlier.³ Other radiological findings reported include prevertebral swelling with obliteration of the vallecular space and ballooning of the hypopharynx. These were, however, not seen in present series.

It has been said that acute epiglottitis is associated with septicaemia. The isolation of an organism from both blood and epiglottis is a better indicator of its pathogenic role than cultures from epiglottis alone, where many incidental throat commensals are to be found.⁴ In the present study *K. pneumoniae* was isolated in three cases only. The possibility of a viral aetiology in the rest cannot be ruled out.

In addition to antibiotics, proper airway management is the mainstay of treatment. Endotracheal intubation should be done when obstruction is imminent.⁴ Acute epiglottitis runs a much more benign clinical course in adults as compared to children⁵ and unlike children no respiratory distress occurs due to examination. None of our patients required tracheostomy/endotracheal intubation and no complication or recurrence was seen over a follow-up period of 3 months.

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Pharyngeal pouch presenting as dysphagia after a stroke

Sir,

We report a patient who developed dysphagia following an acute stroke, in whom a diagnosis of a previously asymptomatic pharyngeal pouch was made and in whom normal swallowing returned when the pouch was resected.

An 83 year old previously fit man developed sudden onset of weakness and speech disturbance. On examination he was drowsy, dysphasic, dysarthric with an absent gag reflex and he had an incomplete right hemiparesis. A stroke was diagnosed, food and oral fluids were withheld and he was hydrated intravenously. On the third day he had sitting balance and was continent of urine, but a speech therapist felt that he was still at risk of aspiration. By day 8 his hemiparesis had improved and he was mobile with the aid of one person, but considerable dysarthria and dysphasia persisted and when tested he was still unable to swallow safely. On the 10th day a fine bore nasogastric tube was passed (on the first attempt) and feeding was commenced. On the 24th day the nasogastric tube had become dislodged and it was not possible to pass it satisfactorily again because it became coiled in the oesophagus at each attempt. By this time he had become independently mobile on the flat with a stick, his dysarthria and dysphasia had improved, but when his swallowing was tested he appeared to aspirate then regurgitate. It was decided to perform a percutaneous endoscopic gastrostomy on the 26th day. However, the endoscope could not be passed beyond a large pharyngeal pouch, the extent of which was subsequently confirmed by a barium swallow. Even at this stage no history of any swallowing disturbance before the stroke could be obtained. He was operated upon 7 days later when the pouch was approached externally and a diverticulectomy and cricopharyngeal myotomy was performed without problems. By 6 days postoperatively he was eating and drinking normally and was fully independent in the activities of daily living.

Dysphagia due to a pharyngeal pouch is not common but, like stroke, predominantly affects the elderly.¹ In our patient it remains a matter of speculation whether the stroke merely unmasked a pre-existing but previously asymptomatic pouch, or permitted a small, asymptomatic, pouch to enlarge sufficiently to become symptomatic. Percutaneous endoscopic gastrostomy is a safe and effective procedure² and would have been our initial