Letters to the Editor

Re: Unified European higher medical degrees

Sir,

The authors of this paper¹ rightly appeal for more equitable standards of eligibility and assessment for higher medical degrees amongst European universities.

The premise, implicit in their argument, that a thesis of published work is superior to a written thesis deserves comment. A written dissertation allows assessment not only of the method of research but also of the literary style and standard that the candidate has, or has not, achieved. A successful written thesis is an indication that the candidate has satisfied the examiners in both respects. Surely for this reason, the submission of a written thesis should be encouraged, not abandoned.

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Stridor, the presenting symptom of a thyroid abscess

Sir,

A 69 year old black woman developed weakness, fever, cough and sudden dysphagia with drooling. This rapidly progressed to inspiratory stridor and respiratory distress, necessitating intubation. Past medical history included hypothyroidism, hypertension, Parkinson's disease and diabetes mellitus.

Physical examination showed: rectal temperature, 37.5°C; blood pressure 196/90 mmHg; pulse rate, 112/minute, regular; plethoric face; engorged neck veins; soft warm, tender, anterior mass on neck, without bruit, measuring 10 × 5 cm; left submandibular lymphadenopathy; and oropharynx without exudate. The rest of the examination was unremarkable. Laboratory evaluation revealed: leucocytosis of $11.7 \times 10^9/l$ with 75% neutrophils (20% band cells); blood cultures, negative; thyroid function, normal. Chest X-ray: lung fields, clear; peritracheal mass impinging on the trachea above the carina. Computerized tomographic scan of neck and mediastinum revealed a right-sided cystic mass extending from the subglottic larynx into the anterior mediastinum, with left tracheal deviation encompassing the right internal jugular vein and right common carotid artery.

Aspiration, irrigation and catheterization of the mass yielded a litre of purulent, malodorous fluid that grew *Escherichia coli* (also grown in the urine). Antibiotics ceftazidime and clindamycin were given but were changed to cefuroxime. A repeat CT scan showed diminution of the mass. Biopsy of the cyst demonstrated necrotic thyroid tissue with acute inflammation. Oesophageal

gastrograffin study demonstrated no fistula. Tracheostomy and percutaneous endoscopic gastrostomy were necessary. Explorative neck surgery revealed the mass was contiguous with the right lobe of the thyroid. The mass and entire thyroid were excised. Biopsy of the thyroid tissue showed involutional and focal chronic inflammation with fibrosis.

Infections of the thyroid gland are rare due to its isolated anatomic location, rich blood supply, generous lymphatic drainage and high concentrations of iodine.¹ An infection may result from haematogenous or lymphatic seeding, or may spread directly from the oropharynx, contiguous cervical tissue, oesophageal perforation, foreign bodies or patent thyroglossal fistula. Pre-existing thyroid disease is a known predisposing factor.²

Our patient was at risk because of hypothyroidism and a urinary tract infection. The stridor and subsequent airway obstruction were beyond the usual presentation of swelling, pain, fever, hoarseness and dysphagia. Large abscesses may cause intrafascial tension leading to dysphagia and dysphonia.

Organisms commonly responsible for bacterial thyroiditis are those that typically colonize the skin and oropharynx;³ however, mycobacteria, fungi, and pneumocystis carinii have also been documented. Reports of *E. coli* thyroiditis are few,^{4,5} the mechanism of which is transient bacteraemia from a urinary tract infection with seeding.

Suppurative thyroiditis must be considered in the differential diagnosis of stridor. Untreated cases may lead to septicæmia, osteomyelitis or septic thrombophlebitis. Early biopsy and cultures are needed for prompt antimicrobial therapy. Surgical drainage is required for large abscesses.

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