A severe case of undiagnosed dysphagia caused by scleroderma

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Dysphagia is a symptom observed in about half of the patients admitted to an acute clinic of geriatric medicine. Dysphagia can be caused by a multitude of illnesses and its consequences such as malnutrition, cachexia, dehydration and aspiration pneumonia are noted in a high percentage of geriatric in-patients. The male patient (80 years old) presented in this case study was admitted to our geriatric clinic because of a persistent cough and severe weight loss. He had had a 16 months long history of consultations at several hospitals and medical specialists: A bronchoscopy, an X-ray of the lungs and a laryngeal examination including stroboscopy at an ENT clinic had been conducted. Finally the patient had been diagnosed with a beginning fibrosis of the lungs and compulsive throat clearing. The latter was treated to little effect by a speech and language therapist. Bedside evaluation of the patient's swallowing performance including the Daniels Test suggested severe dysphagia which was confirmed by a video endoscopic evaluation of swallowing. The endoscopy revealed great amounts of pharyngeal residues with a high risk of post deglutitive aspiration of pudding and silent aspiration of fluids. Further medical diagnostic procedure comprised a neurologic examination, an MRT of the brain stem and blood tests which suggested scleroderma as the underlying pathology. This was later confirmed by a clinic for entorology. Severe dysphagias caused by reduced opening of the upper esophagus sphincter and beginning fibrosis of the lungs were the first symptoms of scleroderma in this patient. In general, an examination of persistent cough should include screening for dysphagia and scleroderma should be considered as differential diagnosis.

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The effect of performing investigations on the management of tonsillitis and quinsy patients

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Background: Tonsillitis and quinsy remains a common acute in-patient admission into an Otolaryngology unit. Nevertheless, there is lack of specific guidelines for secondary care. Resource utilization within the secondary care remains puzzling.

Aim: The primary aim was to assess our centre 2014 practice regarding throat swabs/pus sample (TSPS) and Monospot test (MT) for tonsillitis and quinsy. The secondary aim was to analyze the effect of the investigations on the management.

Methodology: Retrospective data collection from the year 2014 was performed from a single ENT unit. List for patients admitted and diagnosed with 'Tonsillitis', 'Quinsy', 'Peritonsilar Abscess' or 'Glandular Fever' was obtained from the Hospital Information Office. The Electronic Care Record system was used to obtain the data needed. Fisher’s Exact were performed to analyze the data.

Results: 69 patients accounting for 72 episodes of admission occur in the year 2014. Mean age was 27.87 years old with Male: Female ratio of 38:31. Overall, 35.2% did not have any investigation. 64.8% had at least more than one investigation accounting for 25% of TSPS and 48.6% MT. The amount of investigations perform did not change the management (Fisher’s exact F=0.5973). The estimated overall cost to detect one positive monospot test per 100 patients was 911.76gBP and 450gBP to grow a positive throat swab/pus sample per 100 patients.

Conclusion: MT should only be performed in those within a high risk group patient. TSPS are not routinely sent as it will not alter the management in 48 hours.

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