ADENOIDS

AETIOLOGY

- Adenoids are subject to physiological enlargement in childhood. Certain children have a tendency **to generalized lymphoid hyperplasia** in which adenoids also take part.
- **Recurrent attacks of rhinitis, sinusitis or chronic tonsillitis** may cause chronic adenoid infection and hyperplasia.
- **Allergy of the upper respiratory tract.**

SYMPTOMS

1. ***NASAL SYMPTOMS***

- ***Nasal obstruction*** *is the commonest symptom. This leads* to mouth breathing. Nasal obstruction also interferes with feeding or suckling in a child.

- ***Nasal discharge****. It is partly due to choanal obstruction,* as the normal nasal secretions cannot drain into nasopharynx and partly due to associated chronic rhinitis. The child often has a wet bubbly nose.

- ***Sinusitis.*** *Chronic maxillary sinusitis is commonly associated* with adenoids.

- ***Epistaxis****. When adenoids are acutely inflamed, epistaxis* can occur with nose blowing.

- ***Voice change****. Voice is toneless and loses nasal quality due* to nasal obstruction

2. AURAL SYMPTOMS

- ***Tubal obstruction***. *Adenoid mass blocks the eustachian* tube leading to retracted tympanic membrane and conductive hearing loss.

- ***Recurrent attacks of acute otitis media***

- ***Chronic suppurative otitis media*** *may fail to resolve in the* presence of infected adenoids.

- ***Serous otitis media***.

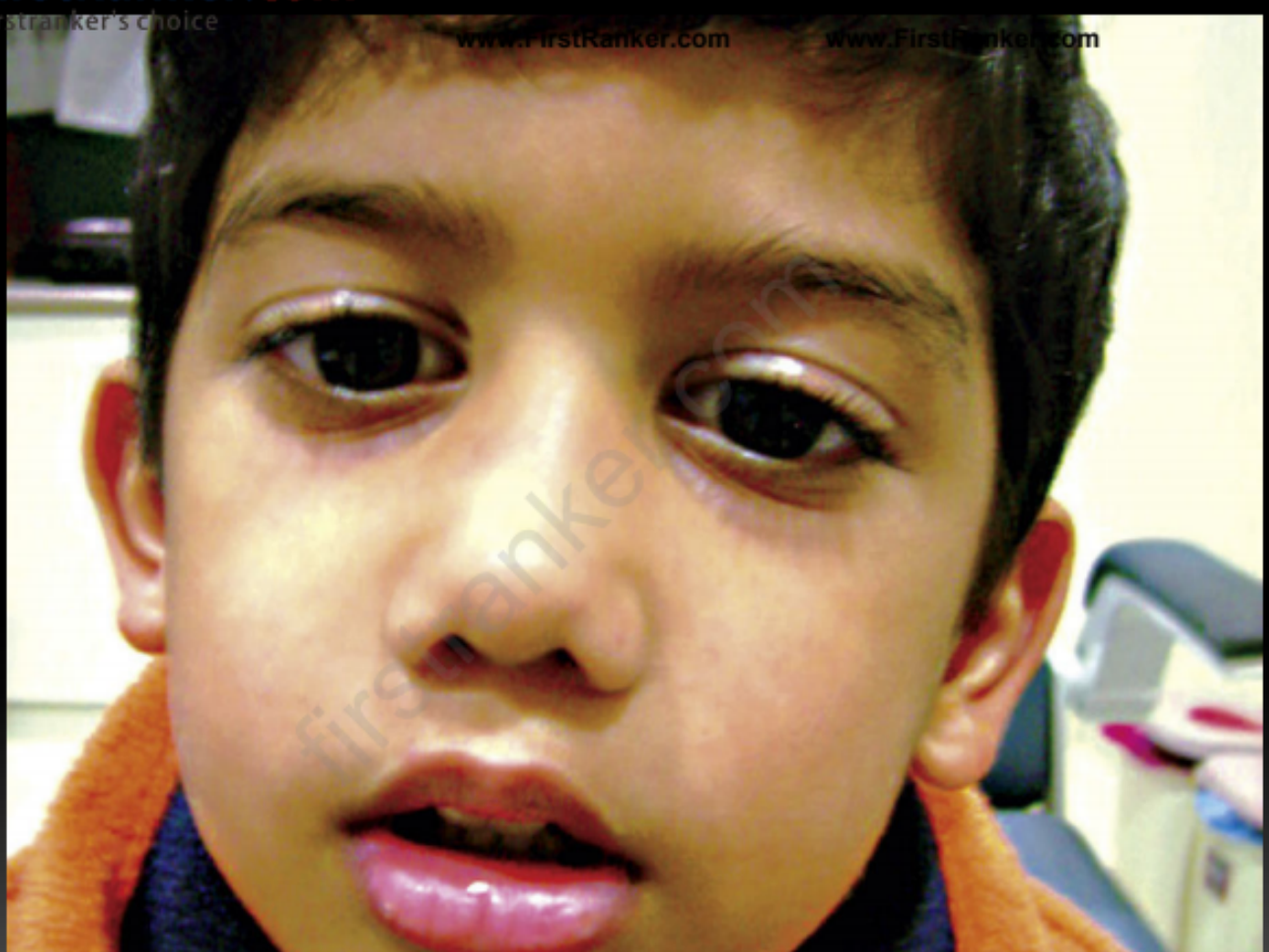
3. GENERAL SYMPTOMS

- ***Adenoid facies.***

- *Chronic nasal obstruction and mouth* breathing lead to characteristic facial appearance called *adenoid facies.*
- *The child has an* ***elongated face*** *with* ***dull*** **expression, open mouth, prominent and crowded upper teeth and hitched up upper lip**.
- Nose gives a **pinched in appearance** due to disuse atrophy of alaenasi.
- Hard palate in these cases is **highly arched** as the moulding action of the tongue on palate is lost.

- ***Pulmonary hypertension***. *Long-standing nasal obstruction* due to adenoid hypertrophy can cause pulmonary hypertension and cor pulmonale.

- ***Aprosexia***, *i.e. lack of concentration*



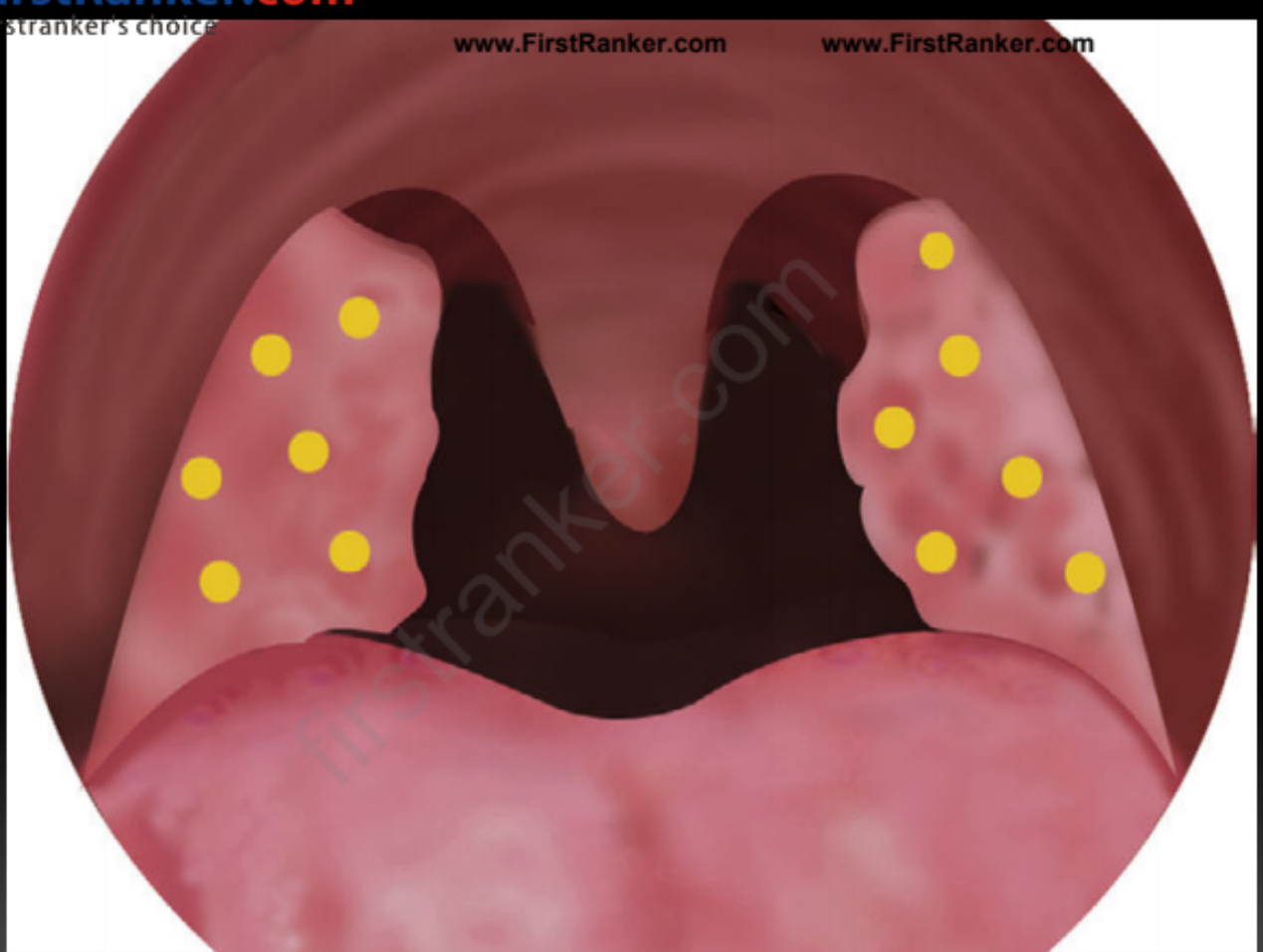
ADENOID FACIES. PATIENT IS A MOUTH BREATHER.

ACUTE TONSILLITIS

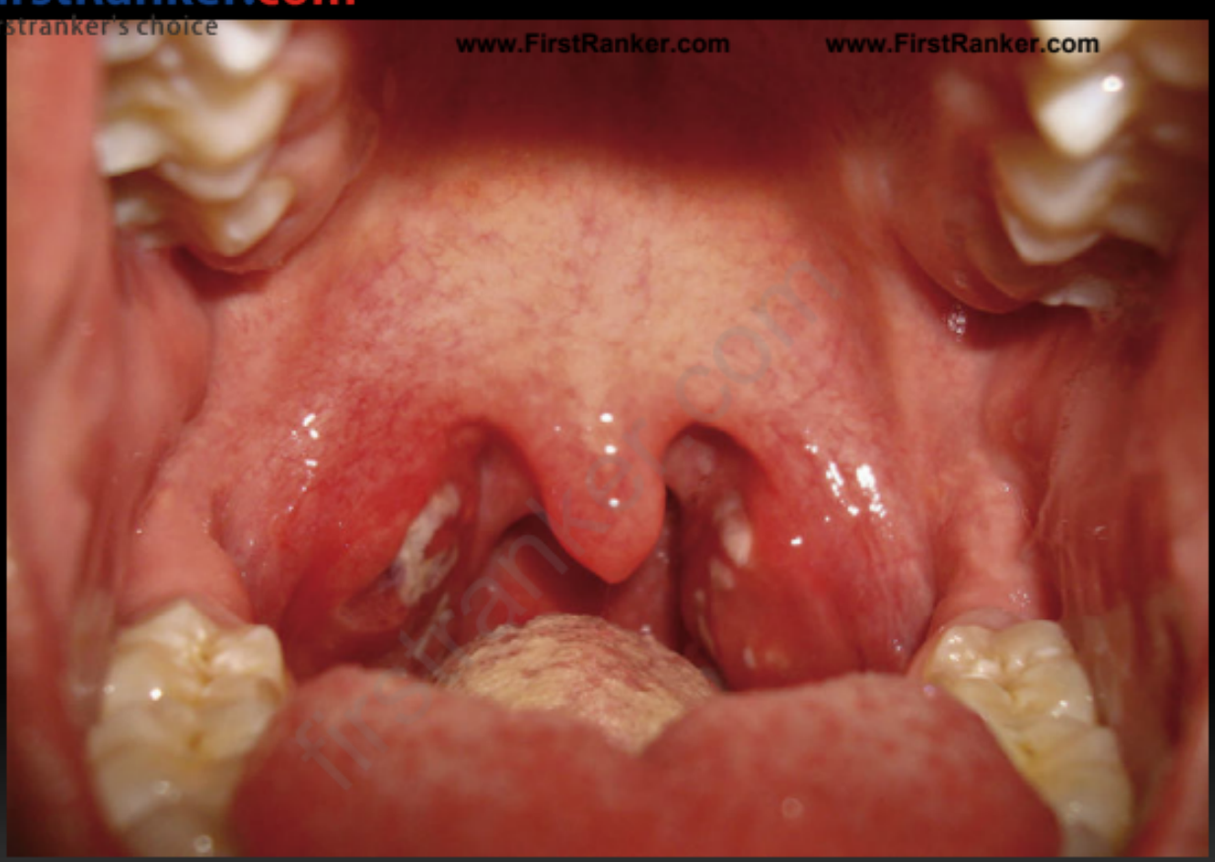
- CLASSIFICATION
- **1. Acute catarrhal or superficial tonsillitis.** Here tonsillitis is a part of generalized pharyngitis and is mostly seen in viral infections.
- **2. Acute follicular tonsillitis**. Infection spreads into the crypts which become filled with purulent material, presenting at the openings of crypts as yellowish spots

- **3. Acute parenchymatous tonsillitis**. Here tonsil substance is affected. Tonsil is uniformly enlarged and red.

- **4. Acute membranous tonsillitis.** It is a stage ahead of acute follicular tonsillitis when exudation from the crypts coalesces to form a membrane on the surface of tonsil



ACUTE FOLLICULAR TONSILLITIS.



ACUTE FOLLICULAR TONSILLITIS. NOTE PUS BEADS ON THE SURFACE OF LEFT TONSIL. ON THE RIGHT PUS BEADS HAVE COALESCED TOGETHER TO FORM A MEMBRANE.

AETIOLOGY

- Acute tonsillitis often affects **school-going children**, but also affects adults. It is rare in infants and in persons who are above 50 years of age.
- ***Haemolytic streptococcus*** *is the most commonly infecting* organism. Other causes of infection may be staphylococci, pneumococci or *H. influenzae*.
- *These bacteria may* primarily infect the tonsil or may be secondary to a viral infection.

SYMPTOMS

- **Sore throat.**
- **Difficulty in swallowing. The child may refuse to eat anything** due to local pain.
- **Fever. It may vary from 38 to 40°C and may be associated** with chills and rigors.

- **Earache. It is either referred pain from the tonsil or** the result of acute otitis media which may occur as a complication

- **Constitutional symptoms. They are usually more marked** than seen in simple pharyngitis and may include headache, general body aches, malaise and constipation. There may be abdominal pain due to mesenteric lymphadenitis simulating a clinical picture of acute appendicitis

SIGNS

- Often **the breath is foetid and tongue is coasted.**
- There **is hyperaemia of pillars, soft palate and uvula.**
- Tonsils are red and swollen with yellowish spots of purulent material presenting at the opening of crypts ***(acute follicular tonsillitis)***
- *or there may be a whitish membrane* on the medial surface of tonsil which can be easily wiped away with a swab ***(acute membranous tonsillitis)***

- The tonsils may be enlarged and congested so much so that they almost meet in the midline along with some oedema of the uvula and soft palate ***(acute parenchymatous tonsillitis).***

- The jugulodigastric lymph nodes are enlarged and tender.

CHRONIC TONSILLITIS

AETIOLOGY

- It may be a complication of acute tonsillitis.
- Subclinical infections of tonsils without an acute attack
- Mostly affects children and young adults. Rarely occurs after 50 years.
- Chronic infection in sinuses or teeth may be a predisposing factor.

CLASSIFICATION

- **1. Chronic follicular tonsillitis. Here tonsillar crypts are full** of infected cheesy material which shows on the surface as yellowish spots.

- **2. Chronic parenchymatous tonsillitis. There is hyperplasia** of lymphoid tissue. Tonsils are very much enlargedand may interfere with speech, deglutition and. Attacks of sleep apnoea may occur. Long-standing cases develop features of cor pulmonale.

- **3. Chronic fibroid tonsillitis. Tonsils are small but infected**, with history of repeated sore throats.

CLINICAL FEATURES

- Recurrent attacks of sore throat or acute tonsillitis.
- Chronic irritation in throat with cough.
- Bad taste in mouth and foul breath (halitosis) due to pus in crypts.
- Thick speech, difficulty in swallowing and choking spells at night (when tonsils are large and obstructive).

PARENCHYMATOUS TONSILLITIS. THE TWO TONSILS ARE ALMOST TOUCHING EACH OTHER CAUSING PROBLEMS OF DEGLUTITION, SPEECH AND RESPIRATION.