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# Dictionnaire des maladies éponymiques et des observations princeps : Zahorsky (syndrome de)

## ZAHORSKY, John. - Herpangina. (A specific infectious disease)

*In : Archives of pediatrics, 1924, Vol. 41, pp. 181-4*

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# HERPANGINA.*

## (A SPECIFIC INFECTIOUS DISEASE.)

By JOHN ZAHORSKY, M.D.
St. Louis.

There are many mild diseases of childhood which do not come to autopsy, but nevertheless are important from a clinical standpoint. Many of these, especially infections of the intestinal canal and respiratory tract, are still unclassified. Even the throat, a part of the body which is readily examined by inspection, is subject to many diseases all grouped together under the anatomical nomenclature of tonsil or pharyngeal disease. For many years almost every summer I have observed a peculiar throat disease, a description of which is not found in the recent literature, and have formed the opinion that it is a specific disease of unknown origin, the clinical features of which are sufficiently clear to separate this affection from other diseases of the mouth and throat.

A summary of this study was published three years ago (Southern Medical Journal, Volume 13, 1920, p. 871). The opportunity is again seized to bring this subject before the profession and add additional facts collected in the last three years. In the previous report I called the disease herpetic sore throat, but as this may readily be confused with other diseases of the mouth and fauces, the name *herpangina* is suggested in this paper.

Herpangina is a specific febrile disease characterized by the appearance of minute papules, vesicles, and ulcers in the throat. The only reference to a similar affection that could be found in the literature is the name stomato-pharyngitis herpetica which Moro uses in contradistinction to stomatitis maculo-fibrimosa, or aphthosa. The latter disease always involves the anterior part of the mouth, while the site of the former is the posterior part of the mouth and throat. (See Pfaundler and Schlossmann).

*Etiology*. Herpangina occurs only during the summer months. It begins often during the warm weather in June and disappears with the first killing frost. In 82 cases referred to in my previous article, the monthly incidence was as follows: June, 11 cases; July, 24 cases; August, 28 cases; September, 13 cases; and October, 6 cases. In different years the disease occurs in different

*Read before the St. Louis Pediatric Society, Oct. 26, 1923.

months. Thus in 1917, most cases were seen in June and July, in 1920 the majority were seen in August and September, while in 1923 the disease was most prevalent in July and August. In some years very many cases are seen, as in 1917 (37 cases), or 1923 (29 cases).

The disease affects children between 3 and 10 years of age. Several cases were encountered in infants, a few in older children, 12 to 15 years.

The epidemic nature of the disease is very probable since the affection occurs in groups; when one case is found many others will be seen in the subsequent weeks.

The disease is contagious. In family practice it is a common observation that one child after another may contract the sore throat. The stage of incubation in the cases in which this could be studied varied from 4 to 10 days. Isolated cases, the source of which could not be discovered, were very numerous. The impression is clear that the disease is acquired in some other way than direct transmission from one sick child to the other in the majority of instances.

I have made quite a number of smears from the ulcers in this disease and studied stained specimens, and found only the same bacterial picture which is usually obtained from the secretions of the mouth and throat.

*Symptoms.* The disease begins suddenly with a marked febrile movement (102° to 105°). A chill was observed only once. In two cases, a convulsion accompanied the initial symptoms. Vomiting is very common but it does not persist as a rule. The child feels tired and often complains of pains in the back and extremities. Headache and pains in the back of the neck are frequently marked symptoms and lead one to suspect poliomyelitis at times. This impression is often accentuated by the tenderness of the extremities on movement. Anorexia is often annoying. Some complain very much of pain on deglutition.

On physical examination nothing is discovered except the characteristic appearance of the fauces.

*The Throat.* On inspecting the throat the diagnostic features are discovered. These are minute vesicles about the size of a millet seed to a small pea situated on the anterior pillars of the fauces, or along the free margin of the soft palate. These vesicles are

occasionally discovered on the posterior part of the buccal mucous membrane or the roof of the mouth. Much more frequently the blisters are found on the tonsil itself or on the pharyngeal mucous membrane.

The vesicle seems to begin as a small papule which undergoes vesiculation in 24 hours. This often ruptures and leaves an ulcer having a punched-out appearance and surrounded by a distinct inflammatory areola about the size of a pea. The ulcer often becomes covered with a thin exudate and its edges are undermined. It differs thus from the superficial erosion of an ulcerative stomatitis.

The lesions are not usually very numerous, two to six being most frequently seen. In one case I counted fourteen.

Associated with these vesicles a marked general angina is present. The tonsils in most cases show considerable inflammatory reaction and a slight pultaceous exudate often protrudes from the tonsils. Indeed, many cases are mistaken for a follicular tonsillitis on superficial examination. The blood shows a slight leucocytosis.

*Course of the Disease.* The fever continues irregularly for two to four days and drops by lysis. The other symptoms disappear with the fall in temperature. The ulcers may persist for several days longer and often show a slight scarring after healing; at least a minute depression is discovered on the site of the ulcer and I have been able to assume the previous existence of this disease two or three weeks after the fever subsided. There are no complications nor sequelae. A permanent immunity seems to follow this infection, since I have not encountered a second attack.

*Diagnosis.* As mentioned, the disease is most commonly mistaken for tonsillitis, which mistake can be avoided by a careful inspection of the fauces. Much more difficult is the exclusion of an ulcerative stomatitis, an infection by the fusiform bacillus. This disease also begins with an acute fever and the original grayish white spots may be found on the palate and posterior part of the buccal mucous membrane.

While at the first visit some doubt may be present, the subsequent course of the disease is quite different, for there is always a marked tendency for this affection to invade the mucous mem-

brane surrounding the teeth and to spread over a great part of the mouth.

The aphthous, or maculo-fibrinous stomatitis, occurs in the anterior part of the mouth and the lesions are quite different.

The disease should not be confused with common or epidemic grippe as the course and sequelae are quite different.

*Nature of the Disease.* We can only conjecture as to the nature of the disease. It has all the clinical features of an infectious origin. Its relation to the foot and mouth disease of cattle must naturally be considered. I also desire to call attention to its possible source of acute poliomyelitis, since faucial vesicles are not unknown in this sporadic or epidemic disease and it has been my experience in a few families to find one child with herpangina and another later with typical poliomyelitis. I have asked the question, may not herpangina be the throat reaction of a poison which sporadically invades the nervous system. However, my experience may be only a coincidence and it would be folly to push this point any further.

### CONCLUSION.

The name herpangina is proposed for a singular group of symptoms occurring in children during the summer months. The disease shows clinical features which suggest that it is a specific disease and can be readily recognized in the sick room.

*536 North Taylor Avenue.*

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HERNIA OF THE BLADDER IN CHILDREN. (Archivio Italiano di Chirurgia, Bologna, Jan., 1923.) Oliva gives the details of sixteen cases of hernia in children under 12 with the bladder included in the hernial sac, published by Pott in 1790 and others since. The hernia in these cases was inguinal. He then describes two cases in his own practice in a girl of 10 and a boy of 8. The hernia was of the femoral type. All the eighteen children recovered after the operation. In all but two of the cases the hernia was on the right side, and the patients were all boys but one. He warns that when a toughness of the tissues or a lipoma is found deep in the hernia, the possibility of involvement of the bladder should be borne in mind, especially when traction on the hernial sac induces a desire to urinate.—*Journal A. M. A.*