Parapharyngeal Abscess: An Unusual Complication of Measles

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Measles is still a common exanthematous illness in our country which affects about 14 million children annually and accounts for 0.2 million deaths occurring due to its various complications(1). Significant morbidity and wide variety of complications occur during acute stage or shortly thereafter(2). Otitis media, laryngotracheobronchitis and pneumonia are the common respiratory complications of measles(3). We are reporting for the first time an interesting case of parapharyngeal abscess occurring after an attack of measles.

Case Report

A two-year-old girl presented to us with a two days history of high grade fever, cough and one day history of dysphagia and swelling on the left side of the neck. These symptoms developed two days after the disappearance of measles rash. Physical examination revealed toxic, sick and febrile (axillary temperature 39.5°C) child with continuous drooling of saliva. There was a soft tissue swelling on the left side of the neck extending from the angle of mandible to the middle of the neck. The swelling was soft, fluctuant and extremely tender. Examination of the throat revealed mild congestion, normal epiglottis and a bulge on the lateral pharyngeal wall on the left side. A diagnosis of post measles parapharyngeal abscess was considered and therapy was initiated with antibiotics (penicillin, cloxacillin and gentamicin), intravenous fluids, oxygen inhalation and the child was prepared for surgical drainage. A re-examination by ENT surgeon just before the surgical drainage resulted in rupture of the abscess in the pharynx. The pus was suctioned out quickly and oropharynx was cleared. The child was kept under closed observation and airway patency was maintained by frequent suctioning.

Hemogram revealed polymorphonuclear leukocytosis (WBC count 24 × 10^9/dl; 84% polymorphs) and moderate anemia (Hb 7.5 g/dl). The pus examination showed Gram positive cocci on direct smear and a pure growth of *Staph. aureus* on culture. Blood culture was sterile. Antibiotics were continued for two weeks and the child recovered completely.

Discussion

Parapharyngeal abscess is a potentially serious condition and usually occurs as a complication of tonsillitis or peritonsillar abscess. There is a risk of spread of infection to the neighboring structures(4). The local complications include respiratory obstruction and rupture of abscess leading onto aspiration, respiratory arrest and death. This child had rupture of the abscess at the time of throat examination and timely intervention prevented aspiration and respiratory arrest. The outcome of this potentially serious condition thus depends on early recognition, prompt drainage of the pus and appropriate antibiotic therapy.

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Measles is a totally preventable disease. In view of large number of children developing measles and its potentially life threatening complications in our country, it is further emphasized to strengthen the measles immunization programme. Till then early recognition and prompt medical intervention of postmeasles complications remain the only modality to cope up with this vaccine preventable disease.

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Unusual Presentation of Tuberculous Peritonitis

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Spontaneous primary peritonitis (SPP) is an infection of the peritoneal cavity without demonstrable intra abdominal source(1). Impaired immunological status as in protein energy malnutrition, nephrotic syndrome, and cirrhosis of liver may predispose to development of the condition. We describe a case of tuberculosis presenting with acute peritonitis.

Case Report

A 7-year-old girl was admitted with fever, pain abdomen and cough of four days duration. Clinical examination showed a malnourished, febrile, and toxic child. Generalized lymphadenopathy involving cervical, axillary and inguinal groups was present. Abdominal examination revealed distension, tenderness, guarding, non tender hepatomegaly (5 cm), splenomegaly (1 cm), evidence of free fluid, and exaggerated peristaltic sounds. Investigations showed hemoglobin 10 g/dl; total leucocyte count-12600/cu mm, polymorphs 85%, positive cocci, on Gram stain, and culture grew *Staphylococcus aureus*. A clinical diagnosis of bacterial peritonitis was made. Other investigations revealed a negative Mantoux test, *X*-ray chest showed miliary mottling, *X*-ray abdomen showing multiple fluid levels.

The case was managed with injection cloxacillin, gentamicin, and metronidazole (100 mg/kg/day; 5 mg/kg/day; 5 mg/kg/dose, respectively) and parenteral fluids. However, clinical signs deteriorated with increasing abdominal distension, absent bowel sounds, and persistent multiple fluid levels on *X*-ray abdomen despite 72 h of

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