**Diphtheria :**

**Epidemiology:** Diphtheria was controlled for a time by active immunization, but lately its incidence has been rising due to low vaccination numbers, especially in immigrants from Eastern Europe, and secular fluctuations in the virulence of the toxin .All instances of the disease must be reported to health officials.

**Causative organism:** The causative organism is Corynebacterium diphtheriae, which is transmitted by droplet inhalation or skin-to-skin contact. The incubation period

is 1–5 days.

**Pathogenesis:** The bacterium produces a special endotoxin that causes epithelial cell necrosis and ulcerations.

**Clinical manifestations:** Two main forms are distinguished based on their clinical presentation:

• Local, benign pharyngeal diphtheria

• Primary toxic, malignant diphtheria

The disease begins with moderate fever and mild swallowing difficulties. The clinical picture becomes fully developed in approximately 24 hours, characterized by severe malaise, headache, and nausea.

**Diagnosis:** Mirror examination of the pharynx reveals typical grayish-yellow pseudo membranes that are firmly adherent to the tonsils and may spread to the palate and pharynx. The underlying tissue bleeds when the coatings are removed. A slightly sweet breath smell is also characteristic. The diagnosis is confirmed by the overall clinical impression, combined with smear findings.

**Treatment:** First, the patient should be isolated. Whenever diphtheria is suspected, even before it is confirmed by smear results, **diphtheria antitoxin** (200–1000 IU/kg body weight) should be administered by intravenous or intramuscular injection. Allergy to the antitoxin should be excluded (with a skin test) before it is administered .Penicillin G should also be administered.

**Discharge** from the hospital is contingent upon test results :three smears taken at 1-week intervals must all be negative. Two percent of patients continue to carry the bacterium and should undergo tonsillectomy.

**Complications:** Dangerous complications, which occur mainly in association with the primary toxic malignant form, are toxic myocarditis (which may terminate fatally in 10–14 days) and interstitial nephritis. The more severe the diphtheria, the earlier these complications may arise. Electrocardiography and urinalysis follow-ups should be continued for at least 6weeks after the onset of the disease.

**Glandular fever**

Glandular Fever is also known as infectious mononucleosis or Epstein-Barr virus infection. It is common in teenagers and young adults. Patients with glandular fever may present a similar picture to patients with acute bacterial tonsillitis, but with a slightly longer history of symptoms. Diagnosis relies upon a positive monospot or Paul-Bunnell blood test, but early in the course of the disease this test can still show up negative.

Signs and symptoms

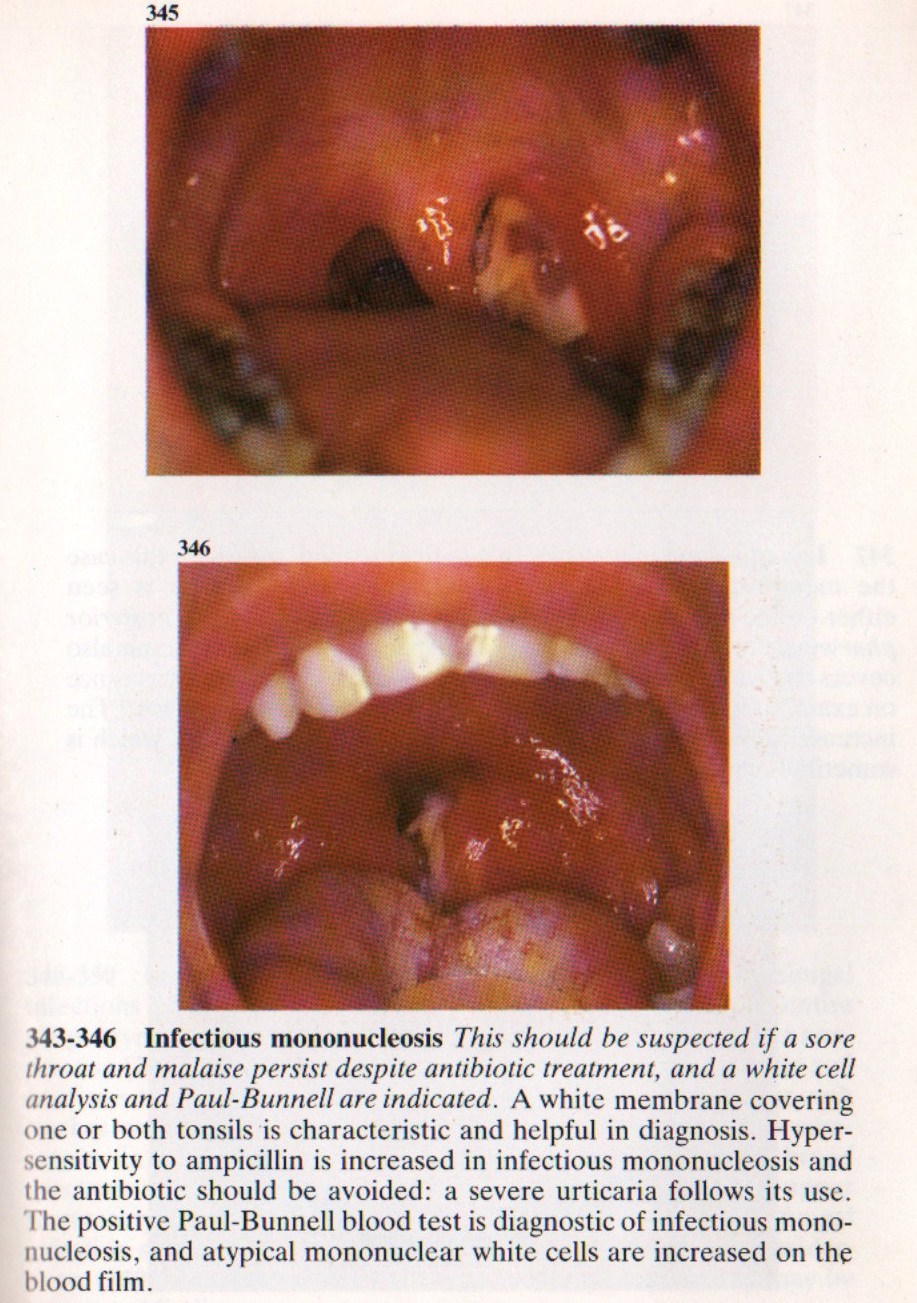
* Sore throat
* Pyrexia
* Cervical lymphadenopathy
* White slough on tonsils
* Petechial haemorrhages on the palate
* Marked widespread lymphadenopathy
* Hepatosplenomegaly.

**Treatment**

This is a self limiting condition for which there is no cure as such. Treatment is largely supportive with painkillers, although patients may appreciate a short course of corticosteroids to decrease swelling. IV fluids may be necessary if they cannot drink enough.

Complications

Patients should be advised to refrain from contact sports for six weeks because of the risk of a ruptured spleen. This can lead to life threatening internal bleeding.

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