

Misuse of the Wooden Tongue Depressor

Sir,

The purpose of this review is to sound a red alert over the erroneous use of disposal wooden tongue depressor (DWTD) for high risk patients. A literature search was conducted for medical and nonmedical uses of the disposable wooden tongue depressor (DWTD). Search strategy was through Medline and Google.

Besides inspecting throats, medical uses include mixing medications, splinting fractures, securing intravenous fluid lines, handling stool specimens. Nonmedical uses of the DWTD include bookmark, toy, ruler, memo and phone pad, recording housestaff evaluations, spoon for ice cream, mixing hot beverages, and a toothpick. However, use of the DWTD, is not without associated morbidity and mortality, especially in the immunocompromised host. There are scattered reports, in the literature, of nosocomial infection with *Rhizopus microsporum*, the fungus responsible for mucormycosis, particularly after the use of DWTDs in patients with depressed immunity.¹⁻³ Mucormycosis is an opportunistic fungal infection. Innocent as it may seem, inspecting throats of immunocompromised patients with a DWTD, or even using it to mix medications, is a risk factor for fungal spore transmission.^{1,2} In addition to their weak immune defences, premature babies are at high risk because of the use of occlusive dressings, and humidity inside the incubators. In premature infants, DWTDs serve as a vehicle for fungal spore transmission, when used as splints to secure lines for intravenous and intraarterial fluids.³ In a nosocomial mucormycosis infection in an

Intensive Care Unit in Spain, the fungus was even grown from unopened DWTD boxes.⁴

In conclusion, the use and abuse of the DWTD were reviewed. Associated morbidity and mortality occurs in immune deficiency states, which promote fungal proliferation. Prevention of infection includes avoidance of the DWTDs and other wooden instruments, when caring for a patient with depressed immunity. While the DWTD may be used safely in healthy children, it should be avoided in high risk patients, such as the immunocompromised and neonates.

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Retropharyngeal Abscess in the Neonate

Sir,

Retropharyngeal abscess (RPA) is very rare in the neonate.^{1,2} Herein, we report a neonate with RPA who had airway compromise and mediastinitis and was managed successfully.

A 28-day-old male baby was brought to the pediatric emergency services with complaint of fever, neck swelling and lethargy, with refusal to feed. Examination revealed a febrile, lethargic and sick looking neonate with palpable cervical lymph nodes of 1-1.5cm size on the left side. USG of swelling on the left side of neck

showed multiple enlarged hypoechoic lymph nodes. CRP was positive and blood culture was sterile. Clinical diagnosis of lymph node abscess with sepsis was made and injection amoxyclav and amikacin were charted.

On day 3 of admission, baby developed severe respiratory distress. Air entry was markedly decreased on both sides, but there was no stridor. The baby was immediately intubated and showed dramatic improvement in respiratory distress and air entry. A repeat USG revealed retropharyngeal abscess.

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Radiograph of soft tissue of the neck, lateral view showed increased prevertebral space with extension inferiorly into the mediastinum. CT neck and chest revealed extension of retropharyngeal abscess from base of skull into the superior mediastinum till T₃-T₄ vertebrae (Fig. 1) and a compromised and displaced airway. Baby was extubated on day 3 and he became afebrile on day 5. He was discharged home after 14 days of IV antibiotics and was prescribed oral

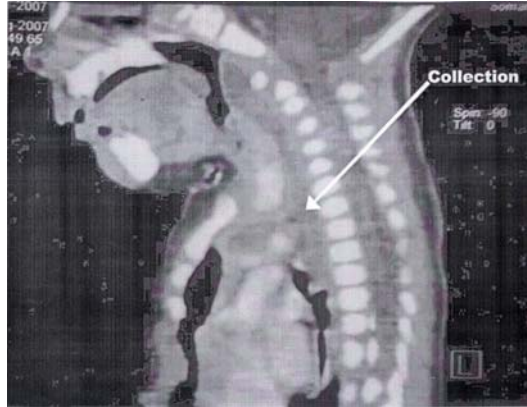


Fig. 1. Reformatted sagittal image reveals poorly enhancing collection in retrpharyngeal space extending from base of skull to posterior mediastinum till T₃-T₄ vertebrae. The collection is also seen in anterior mediastinum.

amoxyclav for another 2 wk. He was doing well on follow up till age of 3 months.

Common presenting symptoms of RPA in infants include fever, neck swelling, anorexia and irritability. The physical signs include fever (100%), cervical adenopathy (69%), retropharyngeal bulge (43%), neck pain (38%) stridor (23%), torticollis (18%) and rarely cyanosis.² The index case presented with fever, cervical lymphadenitis and acute onset severe respiratory distress due to airway obstruction resulting from compression of the trachea due to extension of the retropharyngeal abscess into the retrotracheal space. Diagnosis of RPA is based on clinical suspicion with supportive imaging studies. CT scan, however, is the preferred imaging technique and shows the extension

and stage of abscess (whether cellulitis or true abscess).³ An abscess in the retropharyngeal space may cause compression of airway or rupture into the pharynx with aspiration of pus or it may dissect into esophagus or a major blood vessel or into the mediastinum with resulting high mortality.⁴ In the index case, extension into the mediastinum and airway compromise were observed.

Staphylococcus aureus and β hemolytic streptococcus group A and anaerobes are the commonest causative organisms. The traditional management of RPA has been surgical drainage of pus collection with an intra-oral incision, but upto 58% patients have been treated with antibiotics alone.⁵ The index case was managed successfully with antibiotics alone.

A high index of suspicion in the presence of fever, cervical lymph nodes and airway compromise should suggest the diagnosis. An early and prompt treatment can be life saving.

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