

Pocket Picture Guides
to Clinical Medicine

Infectious Diseases

W. Edmund Farrar
Harold P. Lambert



Williams & Wilkins

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W. Edmund Farrar
MD, FACP

Professor of Medicine and Microbiology,
Director, Infectious Diseases
and Immunology Division,
Medical University of South Carolina,
Charleston, South Carolina, USA

Harold P. Lambert
MD, FRCP

Professor of Microbial Diseases,
University of London,
Consultant Physician,
St. George's Hospital,
London, UK



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Infectious Diseases

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The purpose of this series is to provide essential visual information about commonly encountered diseases in a convenient practical and economic format. Each Pocket Picture Guide covers an important area of day-to-day clinical medicine. The main feature of these books is the superbly photographed colour reproductions of typical clinical appearances. Other visual diagnostic information, such as X-rays, is included where appropriate. Each illustration is fully explained by a clearly written descriptive caption highlighting important diagnostic features. Tables presenting other diagnostic and differential diagnostic information are included where appropriate. A comprehensive and carefully compiled index makes each Pocket Picture Guide an easy to use source of visual reference.

An extensive series is planned and other titles in the initial group of Pocket Picture Guides are:

Rheumatic Diseases
Sexually Transmitted Diseases
Skin Diseases
Paediatrics

Introduction

In this book we have collected 164 figures to illustrate a wide variety of infectious diseases. Although most of these conditions are common in one or other parts of the world, we have also included a number of less familiar diseases which present characteristic appearances and have important therapeutic implications.

In addition to clinical photographs and radiographs, we have also included a number of pictures illustrating the results of easily available laboratory investigations. We hope that this collection will provide a valuable and easily used guide for both clinicians and laboratory workers.

A more extensive pictorial account of infectious diseases, including more than 700 photographs and line drawings with an integrated text, is available in "Infectious Diseases Illustrated" also by H. P. Lambert and W. E. Farrar.

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Infections of the Upper Respiratory Tract

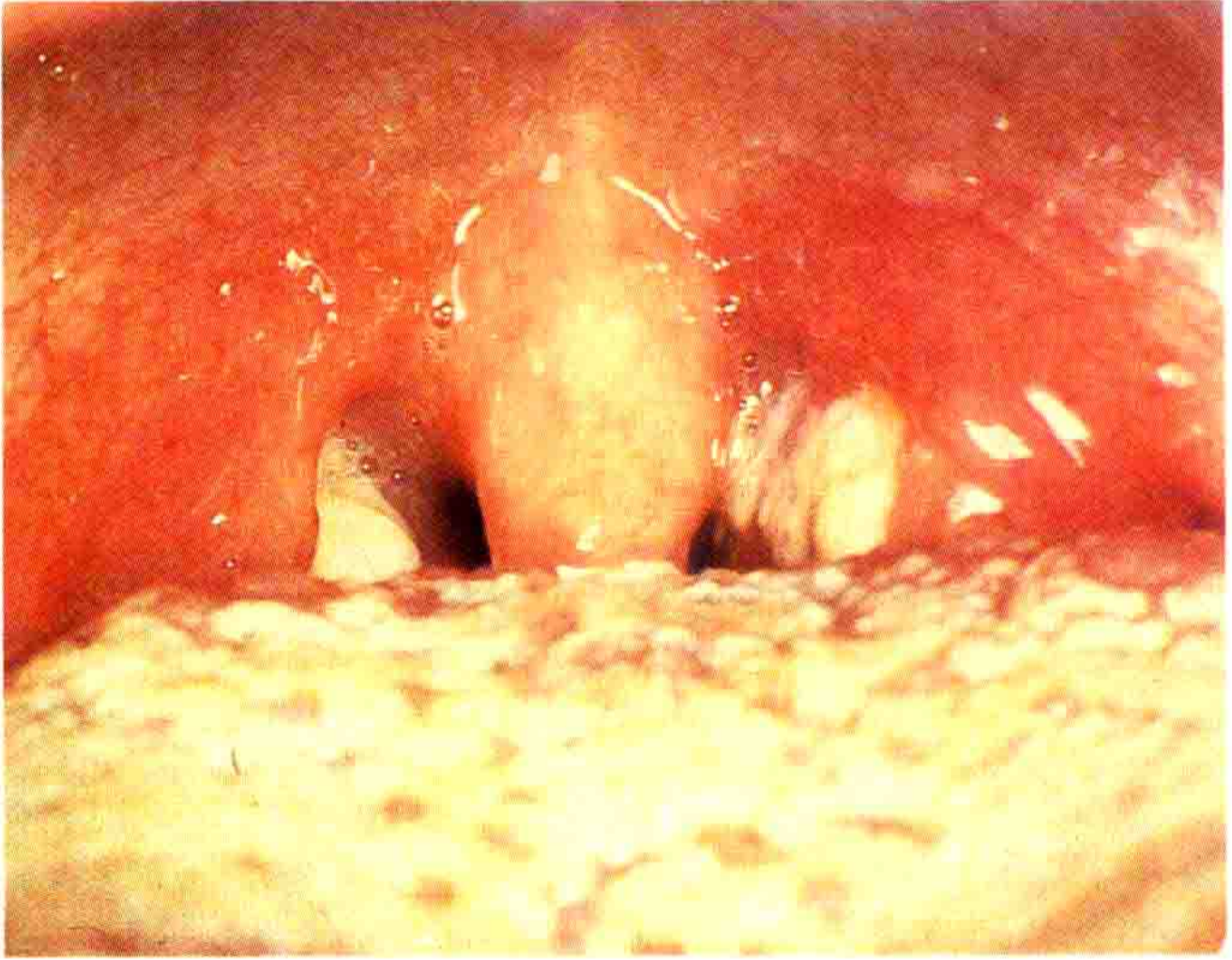


Fig. 1. Infectious mononucleosis. The tonsils are swollen and covered with uniform white exudate. The uvula looks swollen and the patient's speech is nasal.

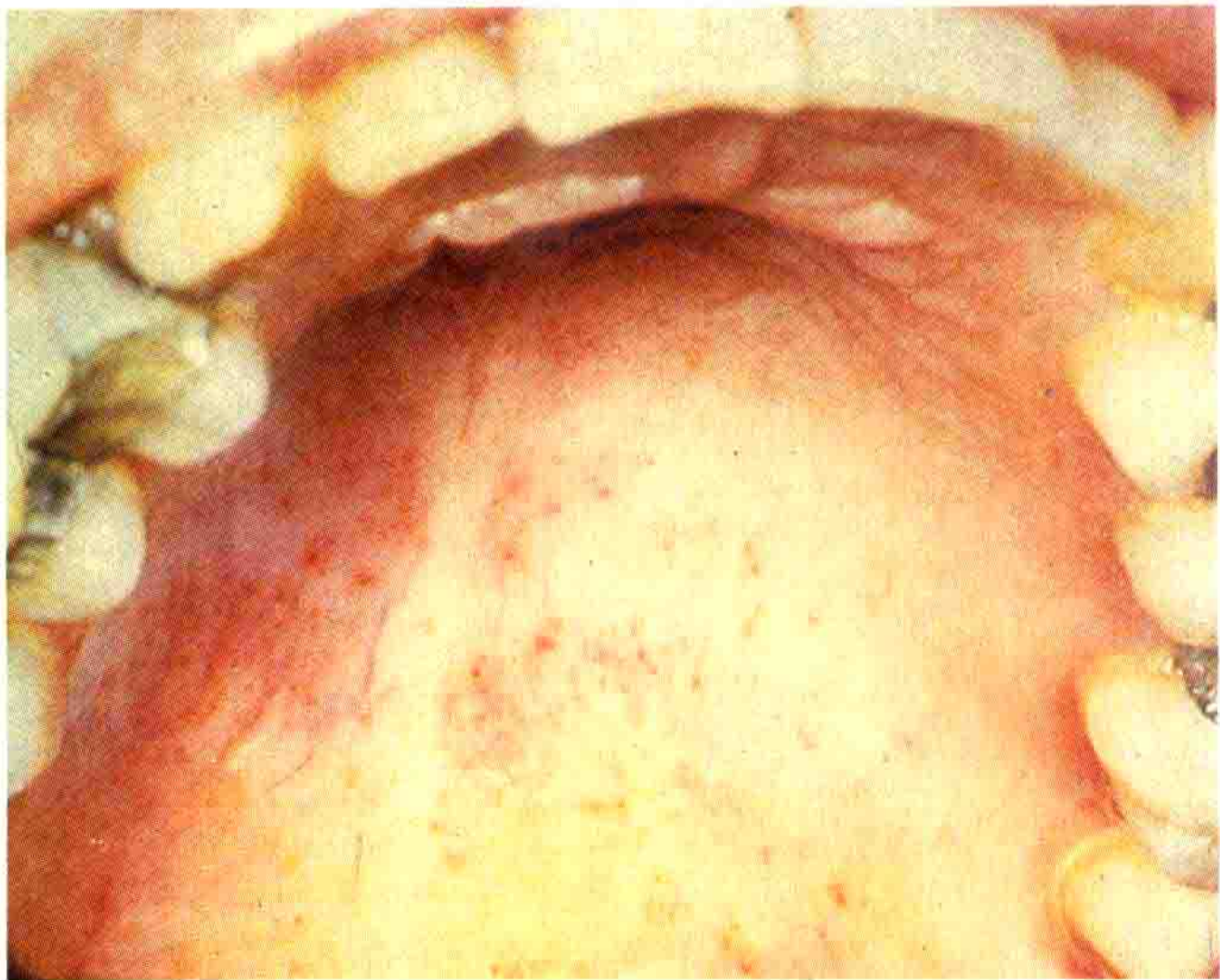


Fig. 2 Infectious mononucleosis. Groups of palatal petechiae, as seen in this picture, are common in infectious mononucleosis, but are not specific for this diagnosis, nor are they always seen even in severe forms of this illness.

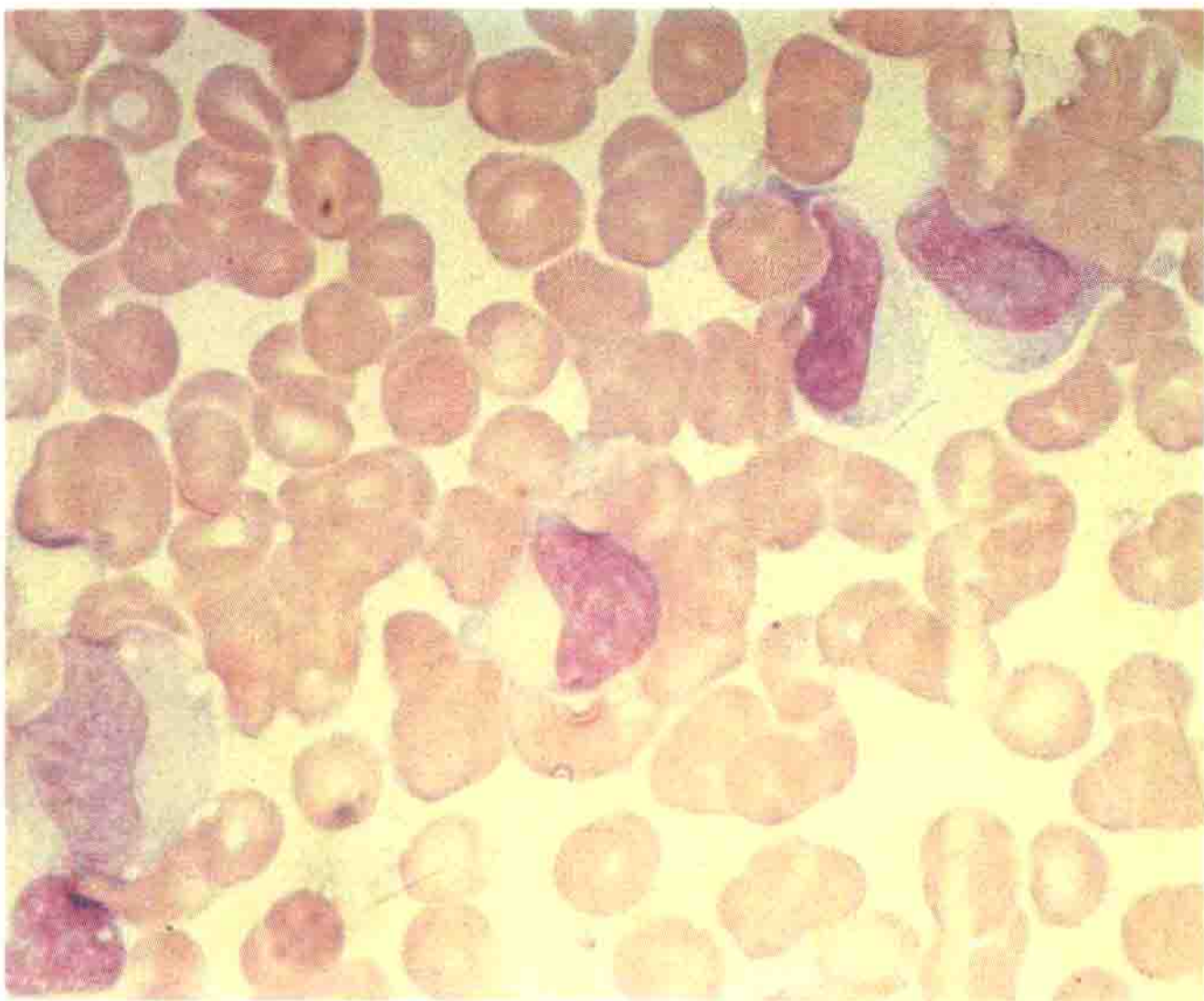


Fig. 3 Infectious mononucleosis. Blood film showing atypical lymphocytes. These are larger than normal lymphocytes with a higher ratio of cytoplasm to nucleus. The cytoplasm is basophilic and the nucleus indented or lobulated.



Fig. 4 Acute ulcerative gingivitis (Vincent's infection). Ulceration of the gingival margin is associated with accumulation of bacterial plaque. The gums are swollen with areas of necrosis and the breath fetid. *Borrelia vincentii* (a spirillary organism) and fusiform anaerobic bacteria are found in the plaque.

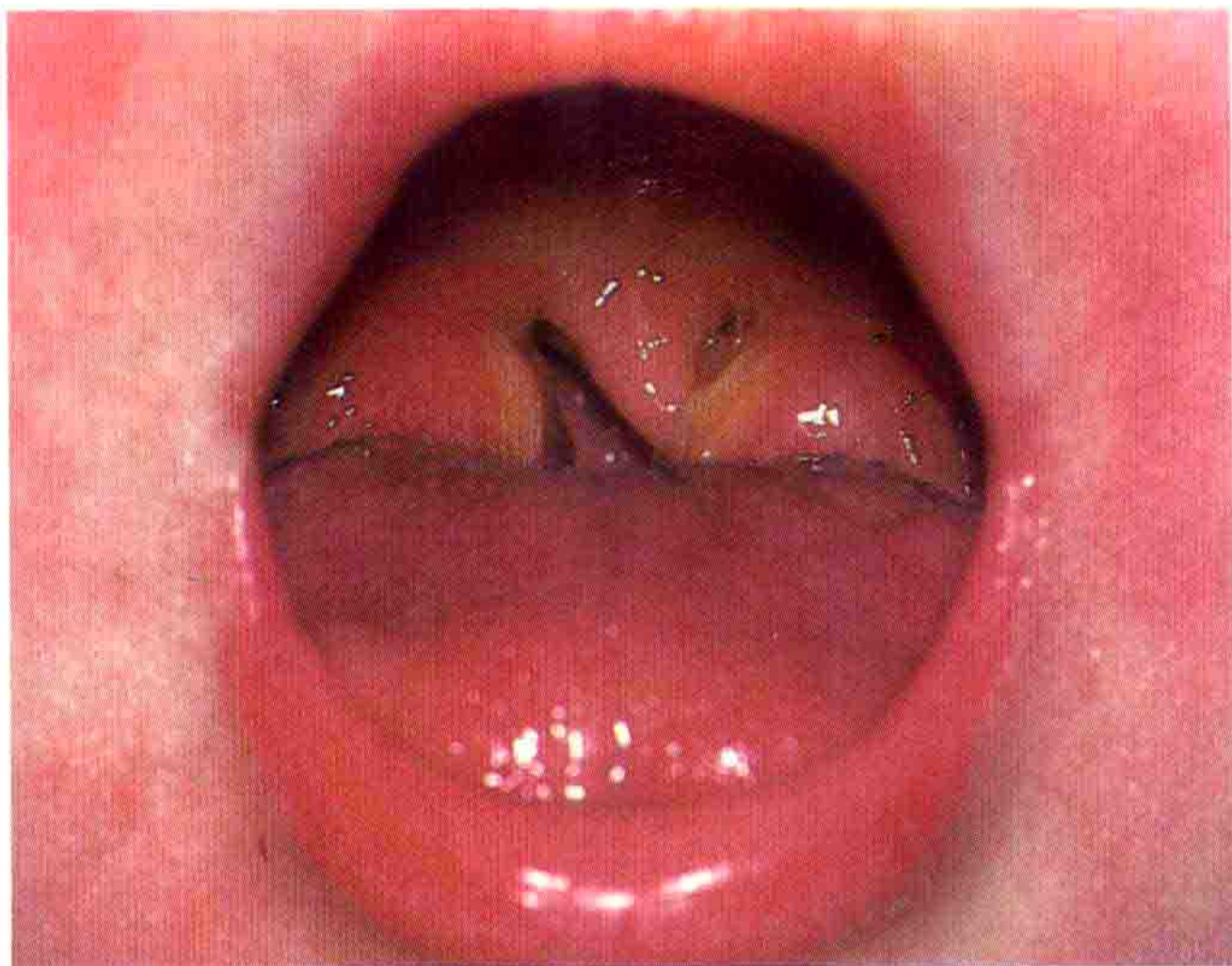


Fig. 5 Scarlet fever. The throat is generally red and the tonsils swollen and dark red with spots of exudate. If the organism is a producer of the erythrogenic toxin, the local signs are accompanied by the punctate erythematous rash of scarlet fever (see Fig. 64).

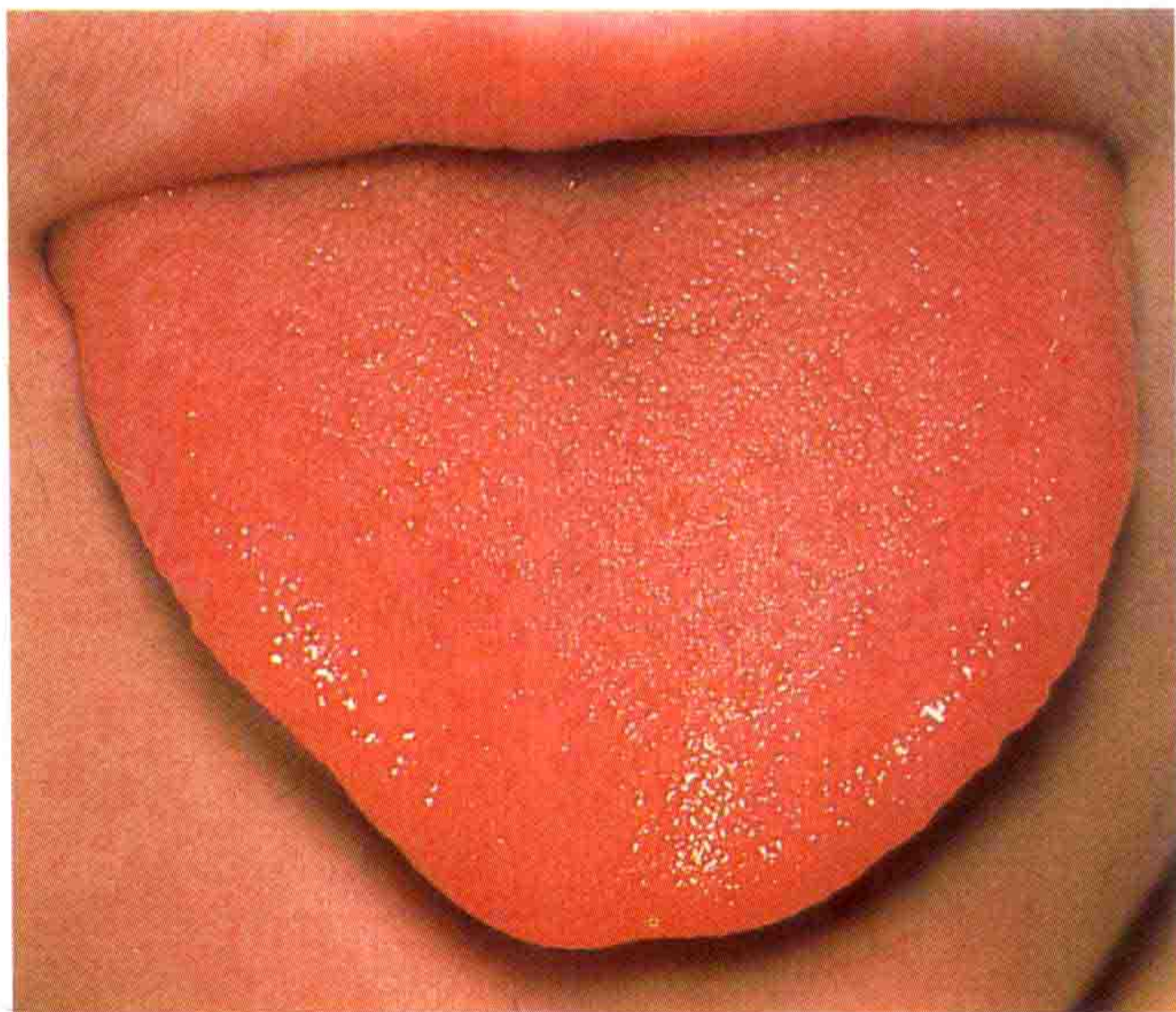


Fig. 6 Scarlet fever. In the early stages there is a dense white coating. Later this peels off leaving a raw red surface, with prominent follicles, the 'strawberry tongue'.

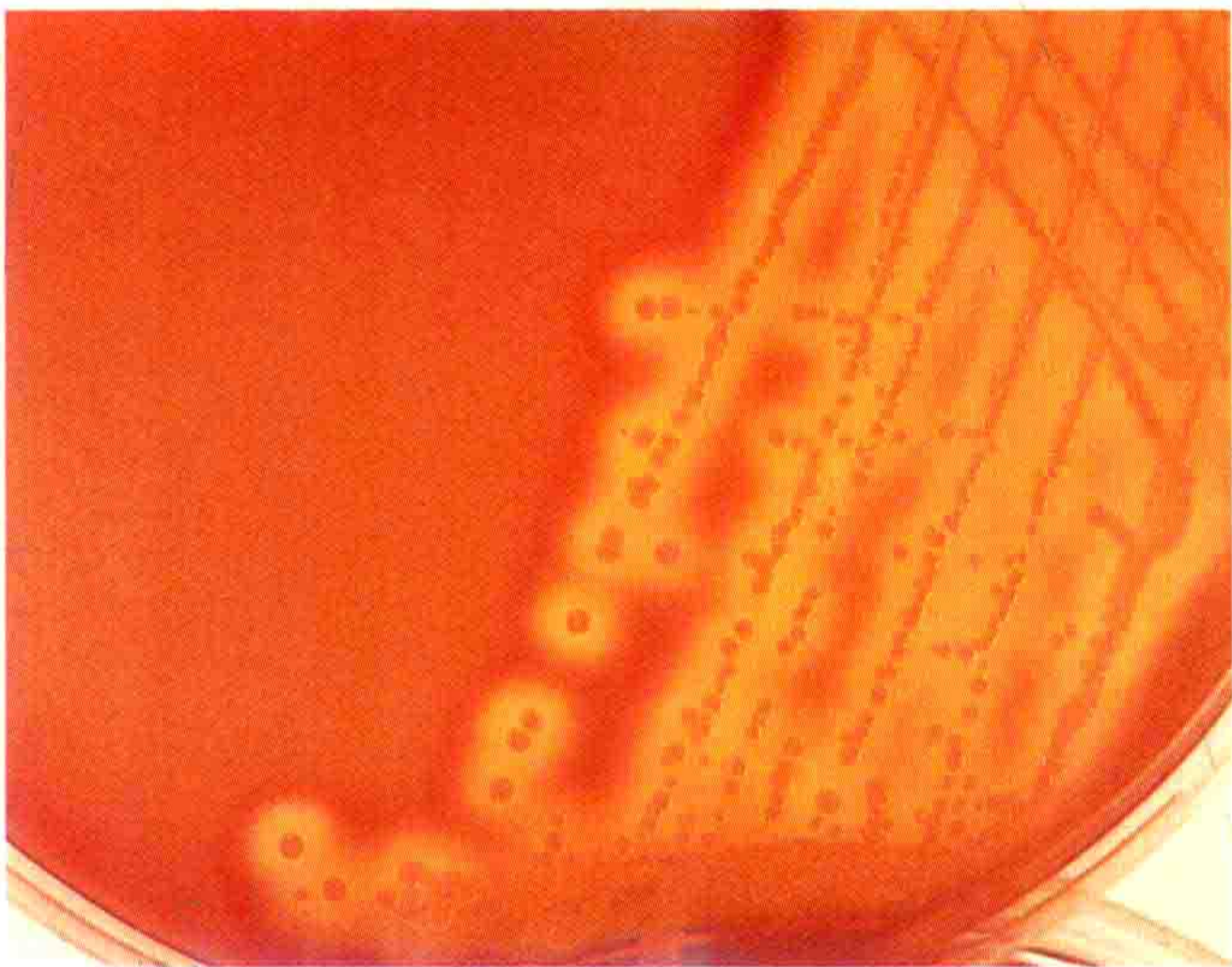


Fig. 7 Scarlet fever (*Streptococcus pyogenes*). The causal organism grows on blood agar giving small colonies surrounded by a clear zone in which the blood has been completely lysed (β haemolysis).



Fig. 8 Actinomycosis. A common site is the cervicofacial region, arising from a dental source. The initial swelling is followed by a chronic discharging sinus, as seen in this picture. Other sites of actinomycosis are the lungs and thoracic wall, and the ileocaecal region. By courtesy of Dr. T. F. Sellers, Jr.

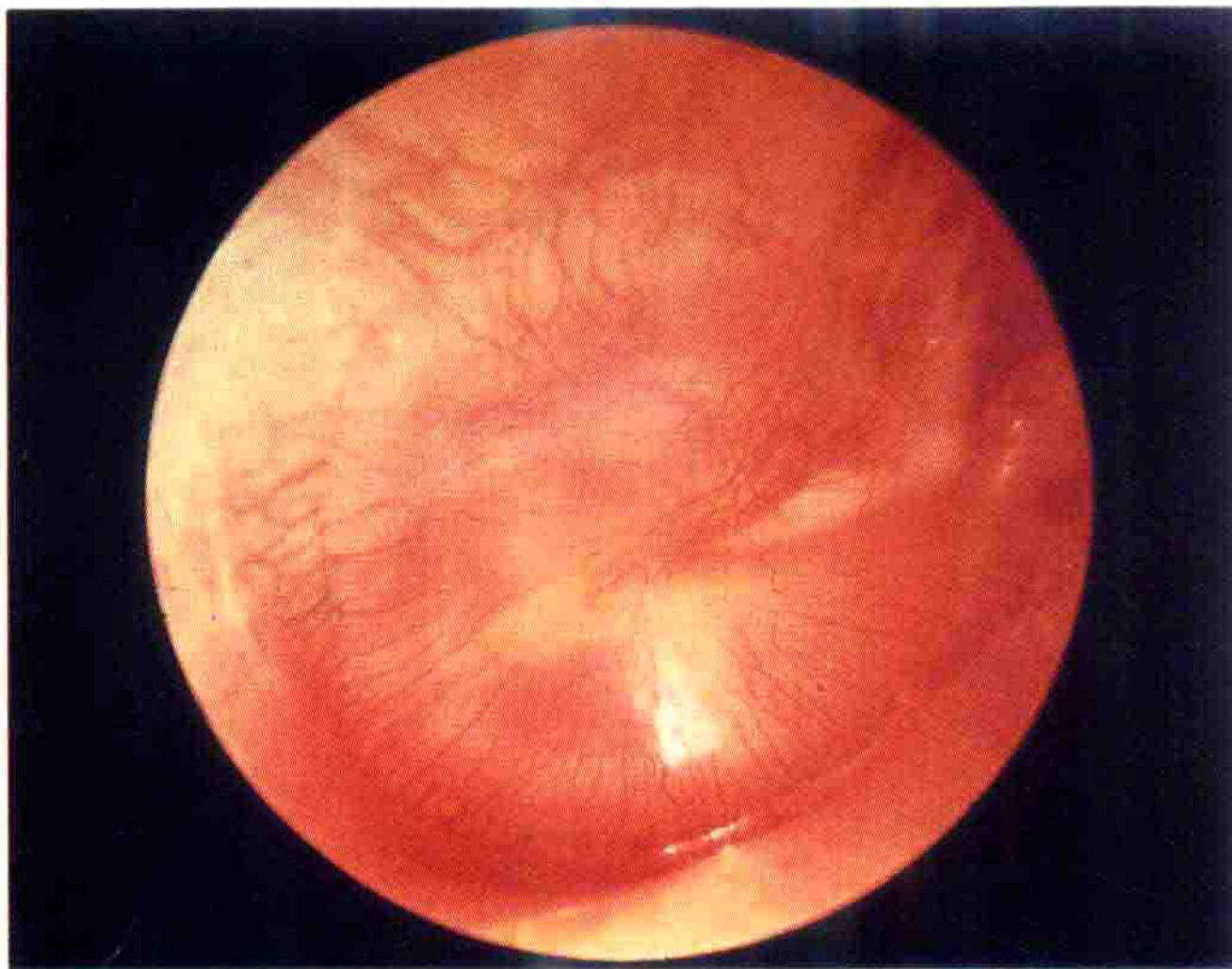


Fig. 9 Otitis media. In the early stages the redness is most prominent in the region of the malleus. The most common bacterial causes are *Streptococcus pneumoniae* and *Haemophilus influenzae*, with *Streptococcus pyogenes* less commonly found. A small proportion of cases are caused by *Neisseria catarrhalis*. By courtesy of Dr. M. Chaput de Saintonge.

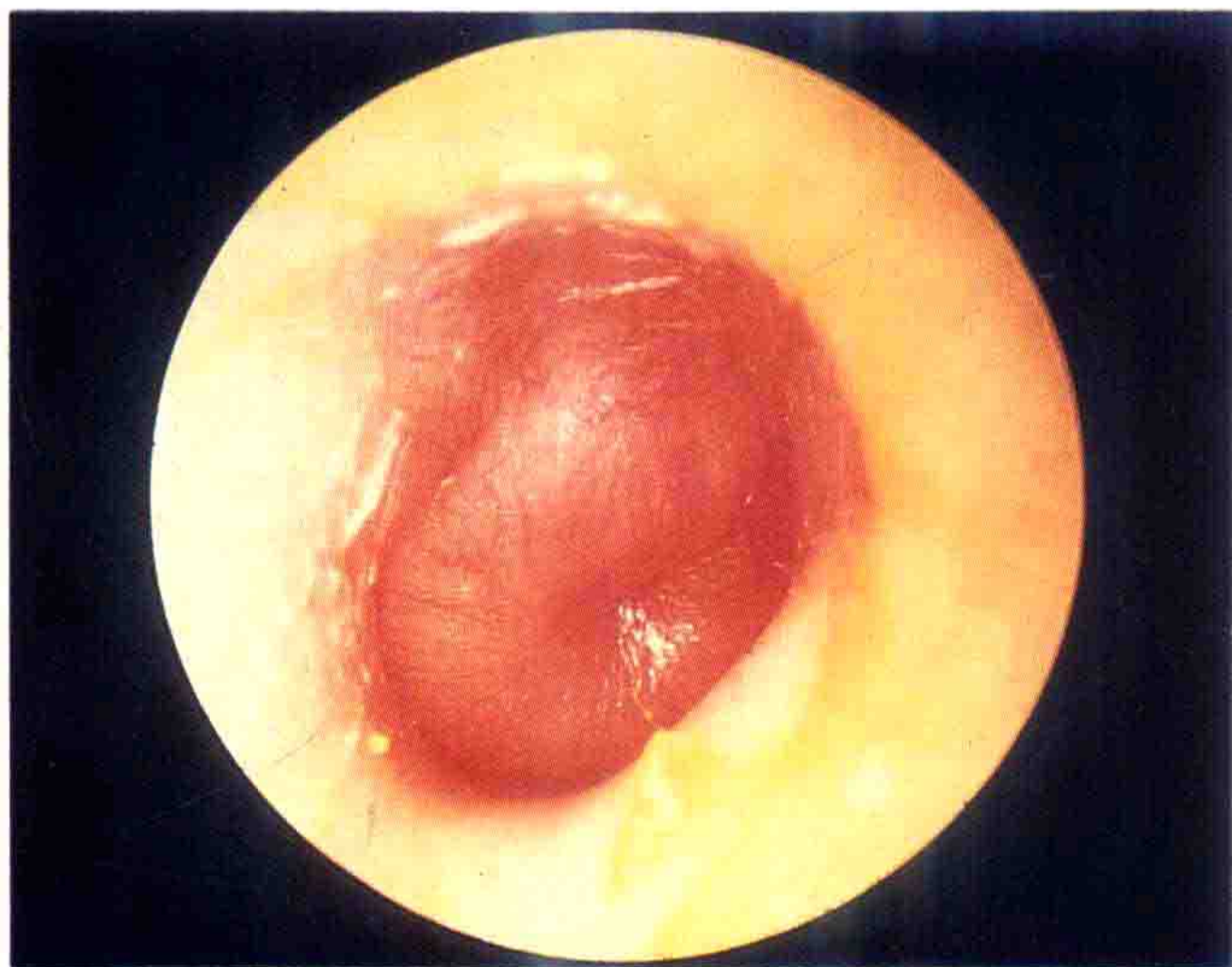


Fig. 10 Acute otitis media. Advanced stage with bulging drum. These appearances are seen just before the drum perforates. By courtesy of Dr. M. Chaput de Saintonge.

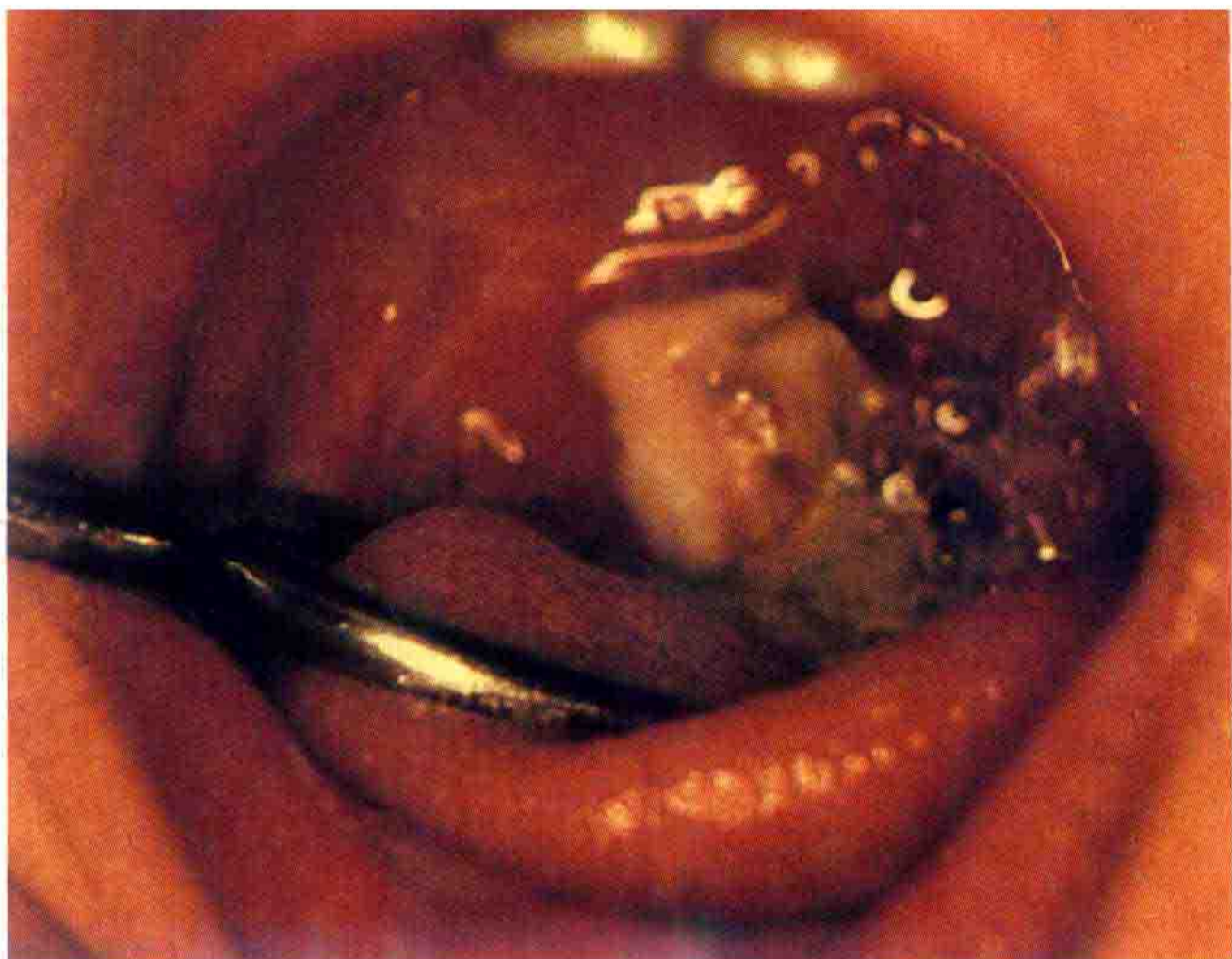


Fig. 11 Diphtheria. Infection by *Corynebacterium diphtheriae* is still common in some developing countries. Clinical manifestations vary between carrier state and life-threatening illness. This photograph shows severe diphtheria with gross swelling and congestion of the whole pharynx and tonsillar area. Dirty white exudate covers both tonsils and is spreading to the posterior pharyngeal wall. By courtesy of Dr. I. Zamiri.



Fig 12 Mumps. Bilateral non-suppurative parotitis is the characteristic syndrome. Submandibular gland enlargement often follows that of the parotids. The common complications of mumps are meningoencephalitis, pancreatitis and, in the post-pubertal male, orchitis. By courtesy of Dr. G. D. W. McKendrick.

Infections of the Lower Respiratory Tract

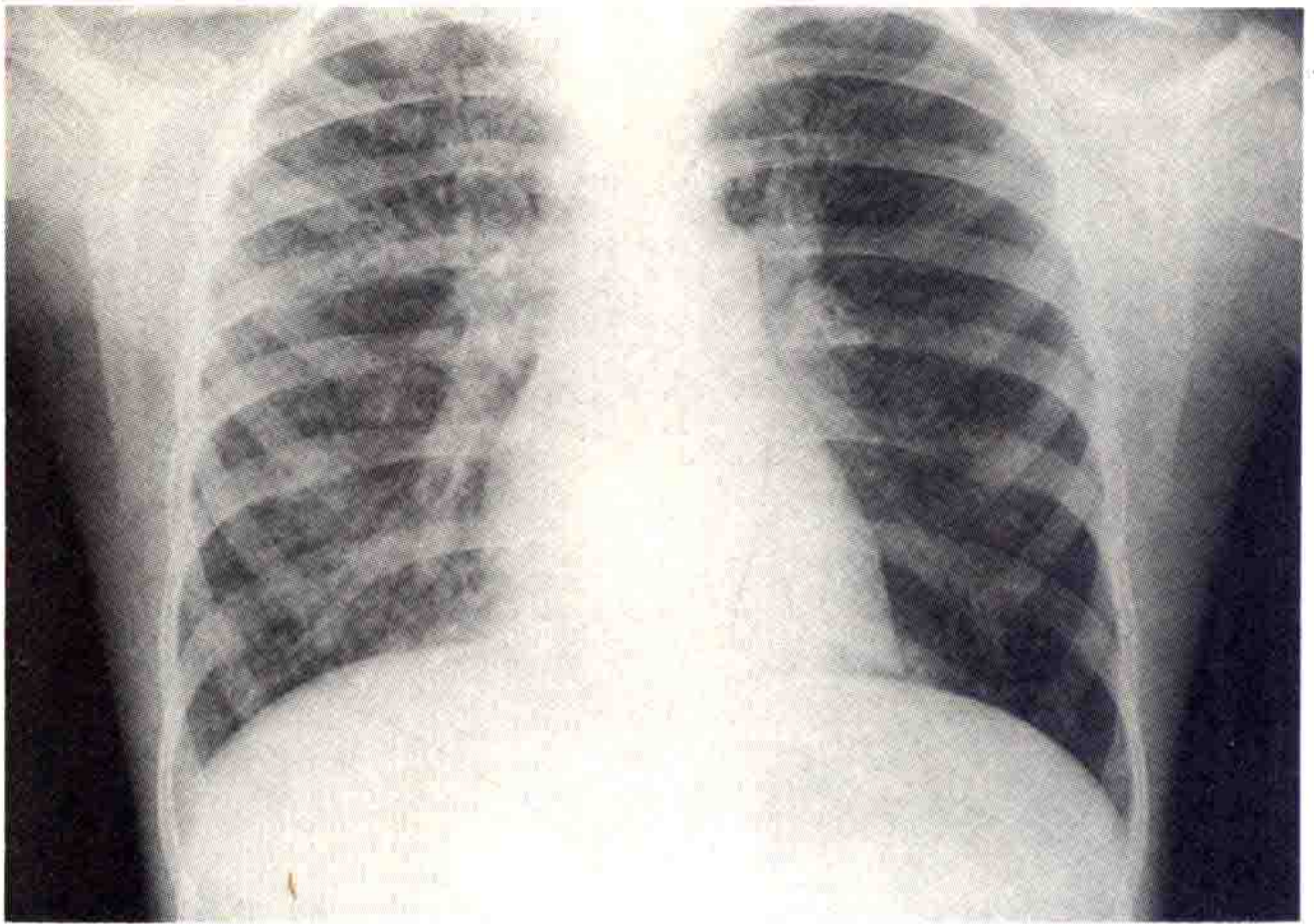


Fig. 13 Viral pneumonia. Some viruses, such as influenza, can cause pneumonia in the normal host while others, such as cytomegalovirus cause lung disease mainly in the immunosuppressed. The radiograph, as here, usually shows diffuse bilateral abnormalities and this appearance could be caused by a number of different viral and other pathogens.

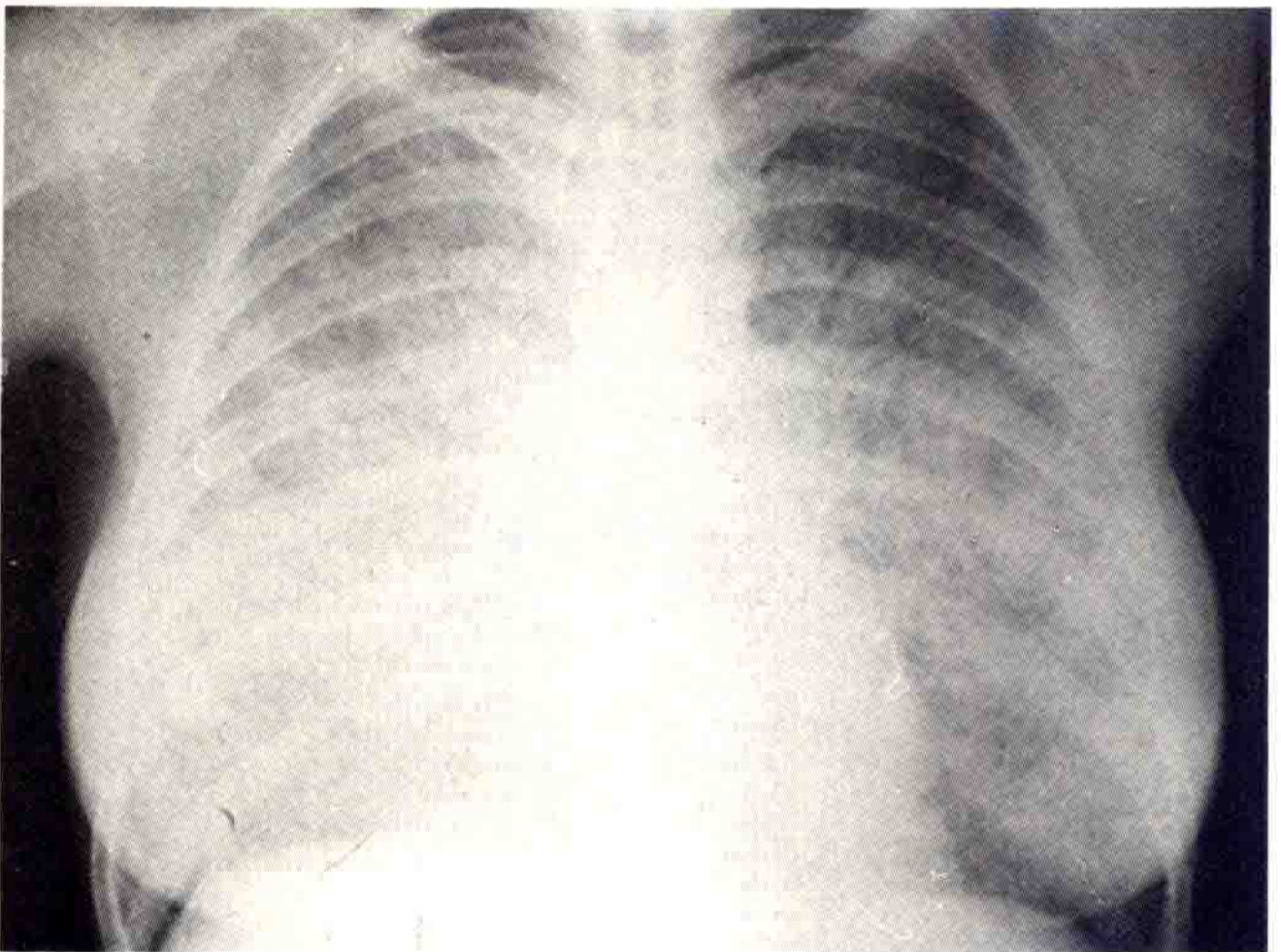


Fig. 14 Viral pneumonia – varicella. This may occur in previously healthy patients or in the immunosuppressed. The patient may be very ill with severe hypoxia. The individual nodular shadows are sometimes larger than in this example, and recovery is sometimes followed by calcification in the residual nodules.

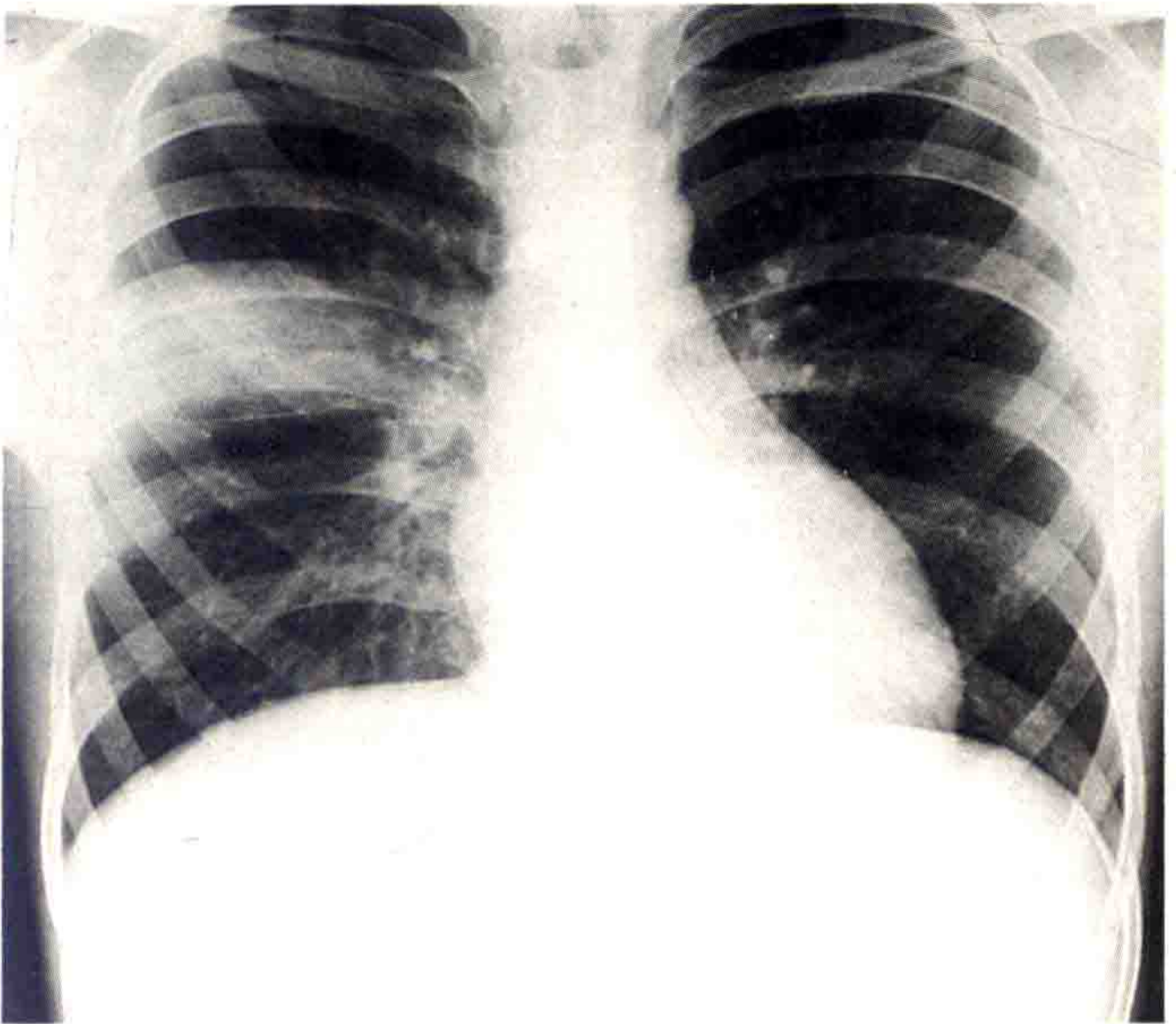


Fig. 15 Pneumococcal pneumonia is characterized by its sudden onset accompanied by rigors, high fever, pleural pain, rusty sputum and neutrophilia. This 'classical' form is now uncommon in wealthier countries. Nevertheless, *Streptococcus pneumoniae* remains the dominant cause of community-acquired pneumonia and is common also in nosocomial pneumonia. Consolidation may involve a complete lobe or, as in this radiograph, a segment.

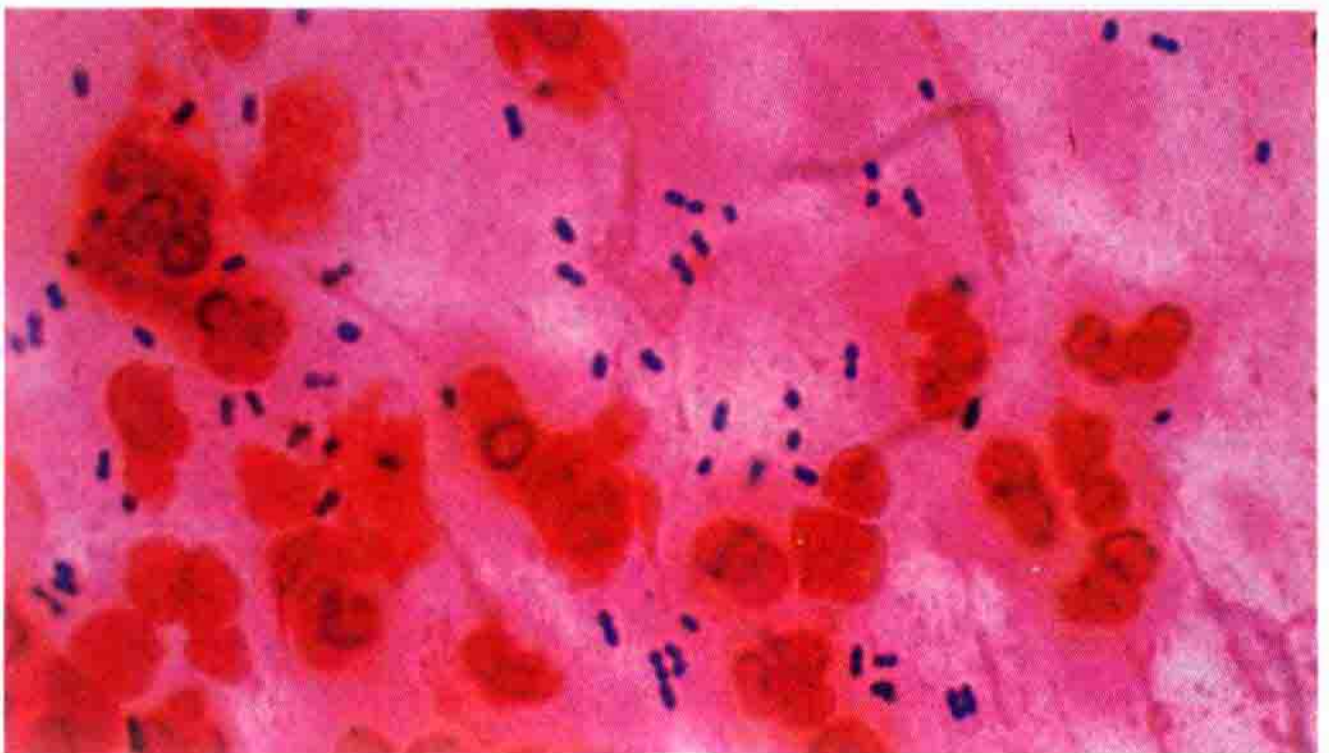


Fig. 16 Pneumococcal pneumonia. A Gram stain film of the sputum shows pneumococci seen mostly as lanceolate diplococci. Other organisms are seen among the leucocytes but pneumococci predominate and are likely to represent the significant pathogen. By courtesy of Dr. J. R. Cantey.

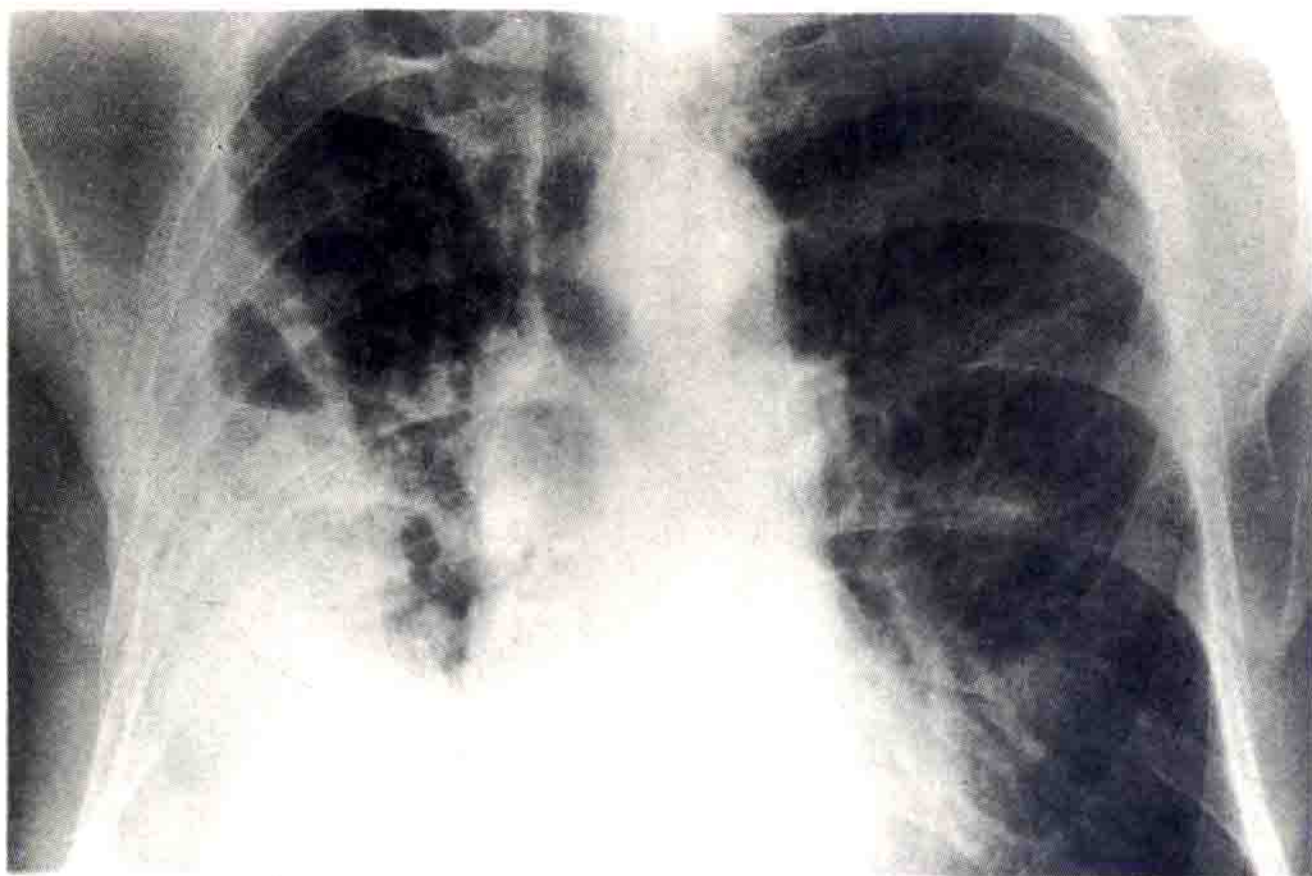


Fig. 17 Empyema. Transient pleural effusion is common in pneumonia and sometimes the effusion becomes purulent. This radiograph shows a large right pleural effusion with an air-fluid level. This pyopneumothorax or hydropneumothorax could result from insertion of air during aspiration or from the formation of a bronchopleural fistula.

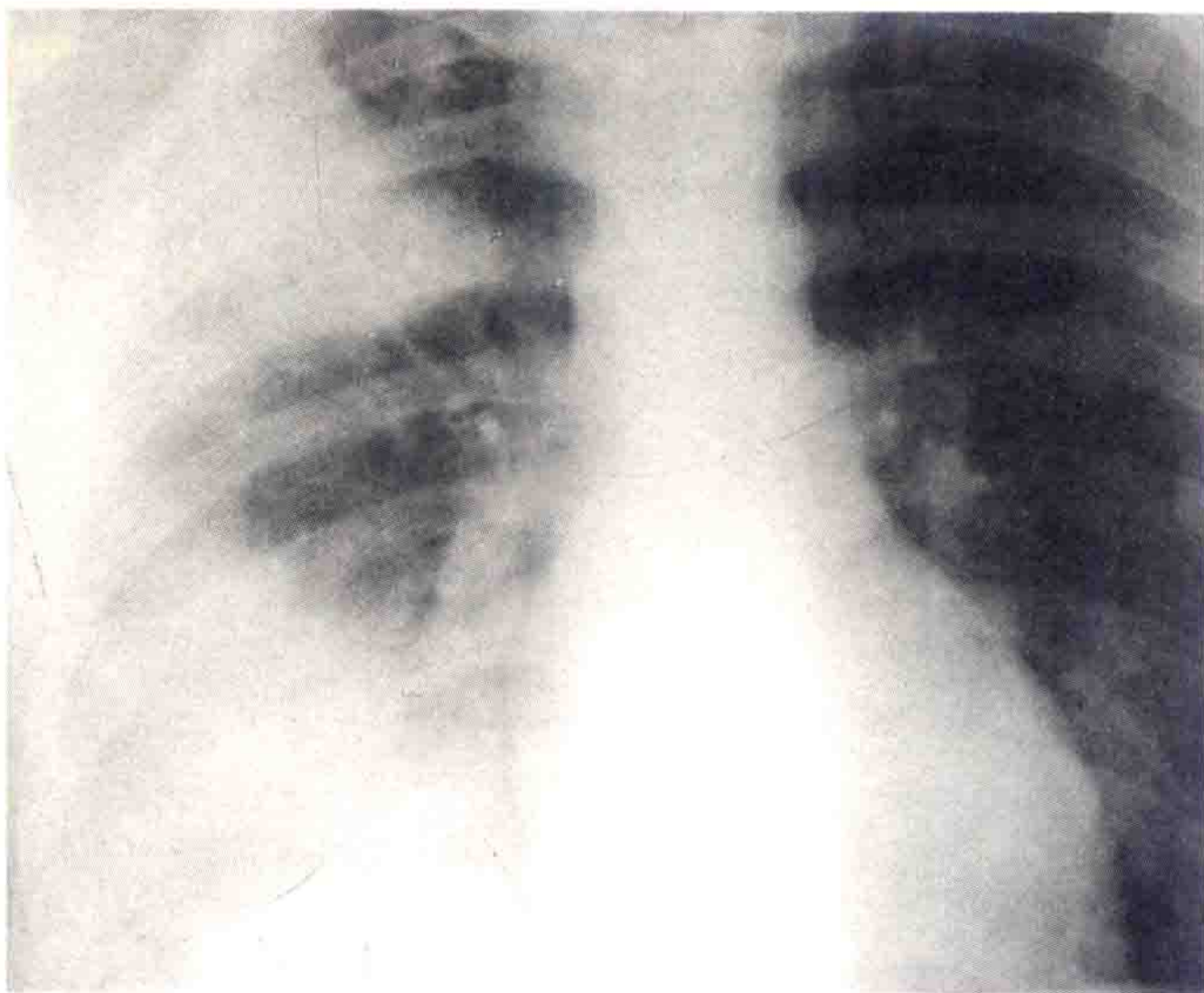


Fig. 18 Legionnaire's disease. This patient, a previously healthy man aged 43 years, became infected in Spain. He had a stormy course with prolonged high fever, severe pneumonia and, in the early stages, diarrhoea and a toxic confusional state. This chest radiograph shows his predominantly right lower and right upper lobe pneumonia. *Legionella pneumonophila* infection was proved serologically.

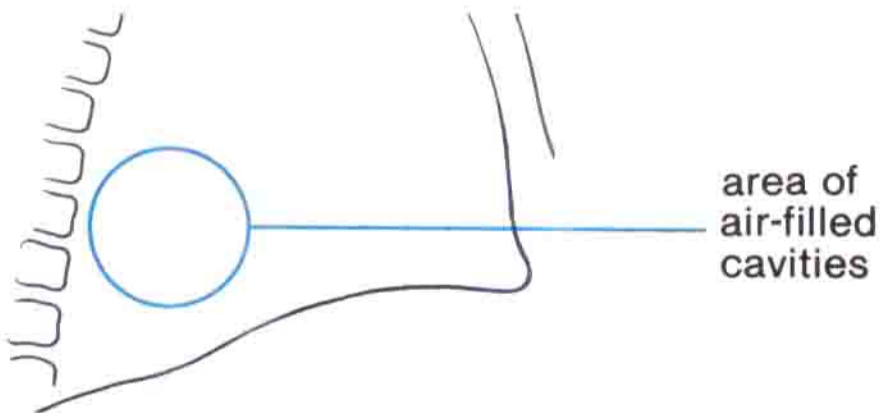
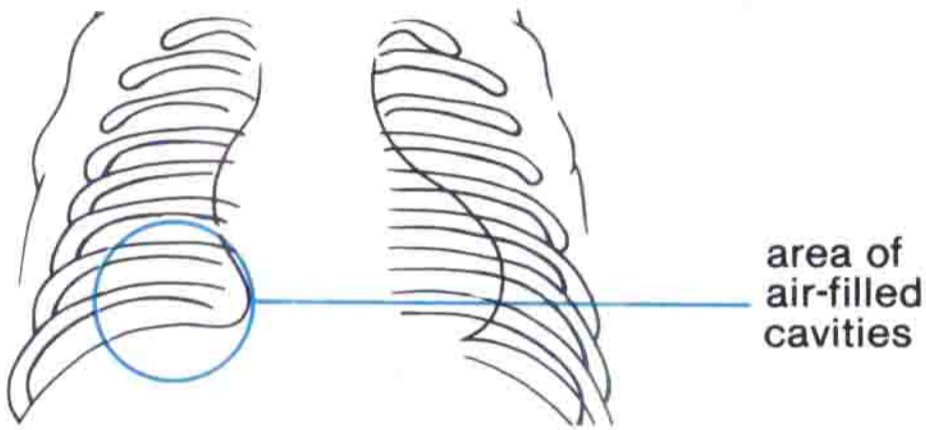
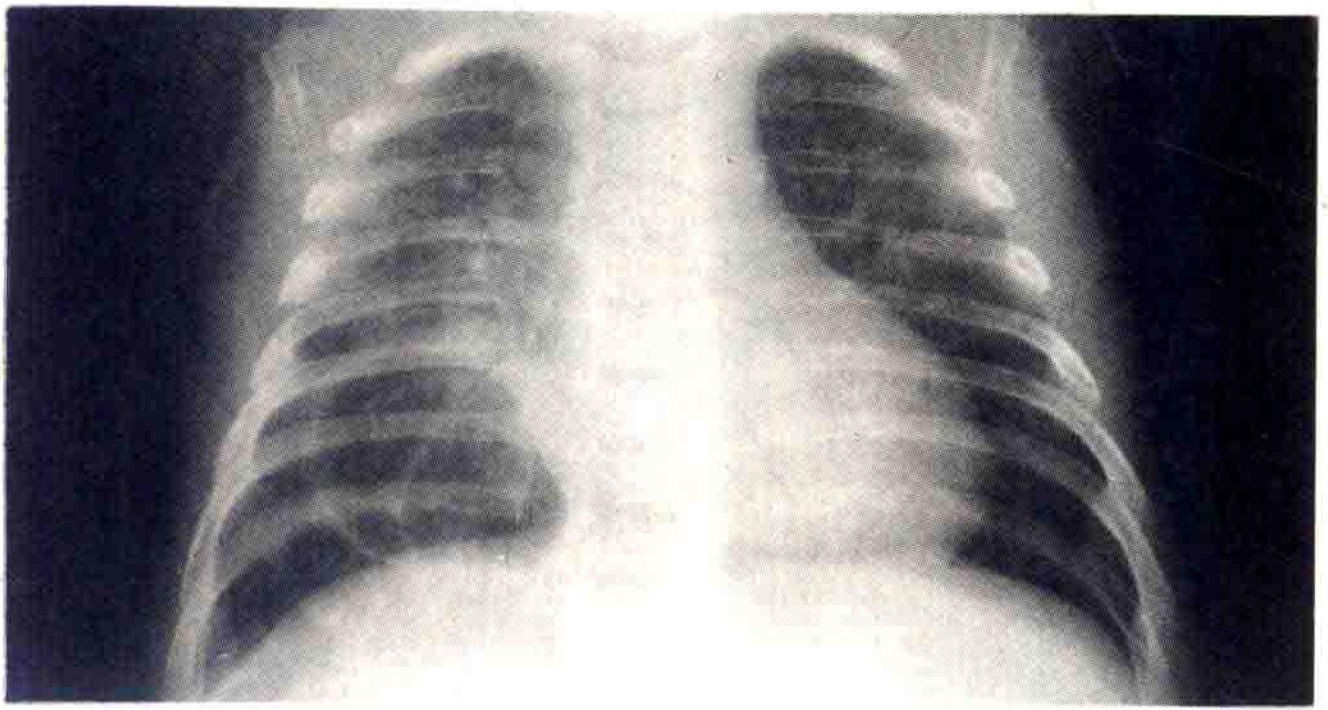


Fig. 19 Staphylococcal pneumonia. The syndrome of staphylococcal pneumonia in childhood is characterized by the formation of pneumatocoeles as seen in these radiographs, which may form abscesses and have a tendency to rupture to give a staphylococcal pyopneumothorax.