SYNDROME OF ACUTE INFLAMMATION OF MUCOUS MEMBRANES of RESPIRATORY TRACTS TONSILLITISES

- **SYNDROME OF ACUTE INFLAMMATION OF MUCOUS MEMBRANES of RESPIRATORY TRACTS**

- Among diseases developing with inflammation of upper respiratory tracts (URT), acute respiratory diseases (ARD) that is characterized by inflammation of mucous membranes of respiratory tracts are most widespread.
- On occasion term of ARD is concrete disease, but this nosology form does not exist although. Undifferentiated ARD is syndromal diagnosis and widespread in pediatric practice.
- In every case we must set etiology if it is possible, that it is very important for adequate therapy.
- Laboratory serologic researches allow to put a correct diagnosis retrospectively.

- Term «acute respiratory viral infections» (ARVI) is a group of viral diseases without concrete nosology.
- ARD include not only viral but also mycoplasm and bacterial diseases.
- Consequently, the term «ARD the undifferentiated» includes diagnosis undeciphered etiology during special researches or without it.
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- **ARD are united by:**
- common way of transmission (respiratory),
- primary damage of respiratory tracts.

- **ARD is most widespread diseases.**
- **Annually over 25% of population is sick and morbidity rises considerably during epidemic of flu.**
- **Much other infectious diseases without signs of damage of URT are wrongly taken to ARD in practice.**
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- **Order of realization of differential diagnostics.**
- To distinguish damage of respiratory tract.
- To decide a question, whether this disease belongs to the group ARD.

- To find out etiology.
- If etiology is not succeeded a diagnosis is formulated as «ARD undifferentiated» or ARVI.
- To define a presence, character and intensity of inflammation in the different parts of respiratory tract, primary localization of pathological changes.
- The syndrome of inflammation of respiratory tract includes next subsyndromes:
- rhinitis,
- pharyngitis,
- laryngitis,
- tracheitis,
- bronchitis
- it’s different combinations.

- **Rhinitis is inflammation of mucous membrane of nose.**
- stuffiness in nose and by difficult breathing through a nose,
- sneezing,
- excretion from a nose (watery or mucous, mucous-purulent, bloody),
- the mucous membrane is oedematous, hyperemic, sometimes covered by crusts or fibrinous films.
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- **Pharyngitis is inflammation of mucous membrane of pharynx.**
- tickle in throat,
- moderate pains rarer burning at swallowing,
- hyperemia of back wall of pharynx,
- edema, grittiness and sometimes hemorrhages of mucous membrane

- Character of exudate is mucous, mucous-purulent, purulent.
- good light is important.
- White films are possible (diphtheria, burning of mucous membrane, candidiasis).
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- **Laryngitis is inflammation of mucous membrane of larynx.**
- It is frequent component of ARD in combination with inflammation of other parts of URT, rarely – isolated.
- It pesents at infectious diseases (flu, parainfluenza, adenoviral diseases, measles, whooping-cough and other)

- It appears under influence of some noninfectious factors – overcooling, chemical irritation and other
- tickle in throat, cough.
- Change of voice (hoarse or aphonia).
- Sometimes – small pain at swallowing.
- Special «barking» cough.
- Laryngoscopy shows hyperemia and edema of mucous membrane of larynx and vocal cords.
- Stenosing laryngitis can be false croup or true croup (diphtheria of larynx).

- ***4 degrees of stenosis :***
- I − short breathing difficulty, no respiratory insufficiency;
- II − attacks of breathing difficulty are frequent, indrawing of areas of thorax (jugular fossa, supra- and subclavicular space, epigastric area), noisy breathing, moderate respiratory insufficiency.
- III − II + cyanosys of lips, extremities, uneasiness of patient, acutely expressed respiratory insufficiency.
- IV − asphyxia.
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- ***Stenosing laryngitis is observed mainly at children.***

- ***Chronic laryngitis at noninfectious pathology – hoarseness and rapid fatigueability of voice, tickle in throat, dryness.***
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- **Tracheitis.**
- dyscomfort behind breastbone,
- objectively – at fibrobronchoscopia.
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- **Bronchitis and bronchiolitis.**

- As a component of ARVI if it combines with the damage of URT.
- For ARD an acute bronchitis is characteristic only.
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- ***Exacerbation of chronic bronchitis is not ARD.***
- At ARD a bronchitis combines with the manifestations of inflammation of URT.
- At some ARD (RS-virus) symptoms of bronchitis are on the first plan.
- Clinical manifestations of acute bronchitis are cough in the beginning usually dry, mucous or mucopurulent sputum, general intoxication; objectively: dry or moist rales.
- Disorders of bronchial passableness manifest by lengthening of exhalation.

- ***A bronchiolitis*** is more severe form of acute bronchitis.
- Bronchioles are involved in a process.
- The signs of general intoxication and disorder of bronchial passableness are more expressed: breathlessness, development of obstructive emphysema, respiratory insufficiency, painful cough with a scanty sputum.
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- **For differential diagnostics of syndrome of acute inflammation of respiratory tracts it is very important to educe carefully a prevalence of inflammatory changes in one or another part.**

- ***Next groups of diseases with inflammatory changes of upper respiratory tracts are possible:***
- ARD;
- inflammation of respiratory tracts as sign of other infectious disease;
- inflammation of respiratory tracts as a result of chemical influence;
- exacerbation of chronic inflammatory diseases of respiratory tracts (chronic rhinitis, nasal asthma, chronic laryngitis, chronic bronchitis of and other).

- **For an infectiologist first two groups of diseases have main practical value.**

- ***Acute respiratory diseases:***
- adenoviral diseasees;
- bacterial nasopharyngitis (streptococcus, staphylococcus and other);
- herpetic respiratory diseasees;
- flu;
- coronaviral respiratory diseasees;
- meningococcal nasopharyngitis;

- respiratory syncytial infection (RS-virus disease);
- rhinovirus disease;
- enterovirus nasopharyngitis;
- mycoplasm inflammation of upper respiratory tracts;
- parainfluenza;
- other ARD (undifferentiated).

- ***Infectious diseases developing with the signs of inflammation of respiratory tracts:***
- herpangina;
- diphtheria;
- whooping-cough;
- measles;
- rubella;
- Q-fever;
- chickenpox;
- smallpox;
- paratyphoid A;
- anthrax (pulmonary form);

- **Toxicochemical inflammatory changes of URT :**
- develops without the expressed fever and signs of general intoxication;
- possibility of poisoning (breathing in steams and toxic gases);
- professional character of disease;
- short latent period.
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- **Exacerbation of chronic inflammatory changes of respiratory tracts :**
- ARD can imitate it sometimes;
- it is necessary to study anamnesis carefully;
- more protracted development is characteristic.
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- ***Main task of differential diagnostics of the diseasees of the first group is to try to detect nosology (clinical, epidemiology and laboratory data).***

- **Flu.** A diagnosis is not difficult during epidemics.
- At the beginning of epidemic flu develops more heavily with typical clinical manifestations and at the end of epidemic mild forms begin to prevail.
- The acute start: temperature of body with a chill at the first day arrives at a maximal level (39-40 °C).
- A headache is acutely expressed with localization in a frontal area, superciliary arcs, in eyeballs.
- Lacrimation and photophobia.
- Pains in muscles and joints.

- General intoxication is expressed (meningism, encephalopathy).
- Hypotension.
- 85% cases last 3-5 days.
- The presence of the expressed tracheitis is characteristic.
- rhinitis, pharyngitis, laryngitis are possible.
- Laboratory confirmation: PCR, IHT, Immunofluorescence.

- **Parainfluenza**
- Unlike a flu does not have such clear clinical presentation.
- There are not large epidemics.
- Latent period 3-6 days.
- 20% of all ARD at adults and 30% at children arecaused by viruses of parainfluenza.
- Seasonality is cold period of year with an increase at the end of winter and at the beginning of spring.
- It usually begins gradually, maximal expressed clinical symptomatology arrives in 2-3 days.

- The temperature of body, as a rule, is subfebrile.
- The symptoms of general intoxication are expressed poorly.
- Rhinitis, pharyngitis and **especially laryngitis** are typical. Inflammatory changes are most expressed in a larynx at children (false croup).
- A tracheobronchitis develops rarely.
- Complication pneumonia arise up rarer than at flu.
- Conjunctivitis at 50% of patients.
- Diagnostics: immunofluorescent method, PCR, IHR.

- **Adenoviral of disease**
- Frequency is same as flu and parainfluenza.
- Epidemic (up to 50% ARD) is possible.
- Epidemic are marked during the first 3 months in new formed collectives.
- Latent period protracted (more frequently 5-7 days).
- Seasonality is cold season.
- Beginning of disease is usually acute, a temperature rises to the feverish level (over 38° C).

- Duration of temperature is saved more protractedly (to 10-20 days).
- General condition is moderate, high fever, general intoxication are expressed weaker than at flu.
- Part of patients has a twowave temperature curve (even in default of complications).
- At adults disease usually develops in mild form.
- Mainly rhinopharyngitis, sometimes is laryngitis (at children) are typical.
- The most frequent form is pharingoconjunctival.
- Increase of peripheral lymphonoduses, conjunctivitis (more frequent follicle).
- Stomach-aches, diarrhea are possible.

- Pneumonias develop rarely.
- Diagnostics - immunofluorescent method, PCR, IHT.

- **Respiratory syncytial infection.**
- It meets mainly at children (30-70% bronchitis and bronchiolitiss and 10-30% acute pneumonias).
- At adults sporadic cases develop relatively easily but are frequently (about 25%) complicated by pneumonias at elderly.
- A characteristic feature is a rapid damage of bronchial tubes and bronchioles, other parts of URT are damaged mildly.

- Development is more protracted than at other ARD.
- Diagnostics - immunofluorescent method, PCR, IHT.
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- **Rhinovirus disease.**
- Absence or poorly expressed general intoxication and expressed rhinitis with rhinorrhea are typical.
- Complications from the side of ENT-organs only.
- Diagnostics - immunofluorescent method, PCR, IHR.

- **Enterovirus (EVI) nasopharyngitis.**
- Among the different manifestations of EVI it can develop as rhinopharyngitis.
- General intoxication and signs of inflammation of URT.
- The inflammatory changes of mucous membranes of respiratory tracts show up at most patients as rhinitis or rhinopharyngitis.
- 20% − hyperemia of conjunctiva.
- Rarely − laryngitis.
- A tracheitis and bronchitis do not almost develop.
- A peak of morbidity is on the end of summer and beginning of autumn.
- Along with the typical manifestations of ARD other clinical forms are marked: epidemic myalgia, enterovirus exanthema, herpangina and other

- These manifestations are original indicators of EVI. Sporadic cases is difficult to recognize clinically.
- Diagnostics - immunofluorescent method, PCR, IHT, ELISA.

- **Herpetic respiratory diseases.**
- HSV-1 causes from 5 till 7% all ARD.
- Children are ill mainly.
- Signs of inflammation of URT are present at a primary infection; in future virus is saved as a latent infection and at relapse skin damages appear.
- It develops as usual pharyngitis.
- Intoxication is expressed poorly.
- Diagnostics - immunofluorescent method, PCR, IHT, ELISA.
- A herpetic rash does not have a substantial differential diagnostic value.

- **Mycoplasm inflammation of upper respiratory tracts.**
- *M. pneumonie,* experiments on volunteers show possibility of exsudative pharyngitis
- About 5% all ARD.
- Epidemic are marked during the first 3 months in new formed collectives (educational centers, recruits of and other).
- Clinically it have a lot in common with ARD of other etiology, therefore differential diagnostics is difficult.
- Some features – start is subacute or gradual, more long development and most expressed toxicosis on the 4-11th day of disease are typical.

- **Bacterial ARD.**
- Streptococci, staphylococci and other cause isolated damages of some part of URT.
- Antibiotic therapy is very effective.
- Severe generalised forms can develop after meningococcal nasopharyngitis and rhinitisatism, myocarditis, nephritis and other - after streptococcal pharyngitis.

- ***Streptococcal pharyngitis***.
- Beta-haemolytic streptococcustococcus group A is characteristic for pharyngitis and other streptococcus diseases (scarlatina, quinsies, erysipelas).
- In a acute period bright hyperemia of pharynx, soft palate, amygdales presents. Mildly expressed rhinitis, laryngitis, hemorrhages and oedema can appear.
- Antibiotic therapy already results by normalization of temperature and reduction of general intoxication during 24 hours and during 72 hours- by changes in pharynx. CBC – moderate leucocytosis

- ***Meningococcal nasopharyngitis (rhinopharyngitis*).**
- Inflammation of mucous membrane of nose and pharynx.
- At some patients the signs of meningitis or meningococcemia can appear in a few days.
- It is very important to recognize disease and begin therapy to avoid development of generalised forms in good time (expresstests and microscopy).
- It has a lot of common with viral nasopharyngitis.
- General weakness, a moderate headache, stuffiness in a nose, excretions from a nose (from the beginning mucous-purulent, quickly become purulent, sometimes with the admixture of blood) are typical.
- Cough and moderate pains at swallowing can appear.

- The temperature is normal (40%) or subfebrile.
- Edema and hyperemia of mucous membrane of epipharynx, mucous-purulent exudation.
- CBC – small neutrophilic leucocytosis.
- Penicillins quickly result in the improvement of the general state.
- Etiologic diagnosis is bacteriologicexamination of mucus from epipharynx before use of antibiotics.
- It is necessary to take into account epidemiology data (cases in a collective).
- There are no laryngitises, tracheitiss, bronchitis, but specific meningococcal pneumonias are possible.

- **INFLAMMATION of MUCOUS MEMBRANES of RESPIRATORY TRACTS AT the DISEASEES not INCLUDED In GROUP of ACUTE RESPIRATORY DISEASES –** one of other manifestations of disease.

- **Diphtheria of nose.**
- It is manifested by ichor excretions from nose with maceration of skin around and upper lip.
- Hyperemia, bulge of mucous membrane, fibrinous tapes with bleeding after removing of it.
- Usually it combine with diphtheria of pharynx(widespread diphtheria).
- A diagnosis must be necessarily confirmed by bacteriologicexamination.

- **Whooping-cough and parapertussis.**
- These diseases are differentiated only bacteriologically.
- Initial period – catarrhal (rhinitis and laryngotracheitis).
- Common state is satisfactory, temperature is usually normal or subfebrile.
- Rhinitis and cough in the beginning are small, increase later, typical fits of the convulsive coughing appear only at the end of 2th week.
- Later – signs of bronchitis.
- For diagnostics epidemiology data are important (absence of vaccination, contact with a patient).
- Specific diagnostics – bacteriologicexamination or serologic.

- **Measles.**

- Before appearance of characteristic exanthema it is frequently interpreted as ARD.
- Fever, pharyngitis.
- Expressed conjunctivitis with bright hyperemia.
- Filatov-Koplik spots on the mucous membrane of mouth.
- Typical morbillous exanthema appears on the 4th day.

- **Rubella.**
- Signs of acute rhinopharyngitis, small hyperemia of conjunctiva, subfebrile temperature of body are possible at atypical rubella (without an exanthema).
- Moderate increase of neck lymphatic nodes (similar at a parainfluenza and adenoviral disease).
- Growth of titles of antibodies in 4 times and more confirms rubella.
- Atypical rubella takes 25-30% of all cases.
- It is especially important at pregnancy.
- Diagnostics - IHT, ELISA.

- **Herpangina.**
- Pharyngitis, intoxication.
- Enanthema: hyperemia – small red spots (2-3 mm) - vesiculas (4-5 mm) - aphthae (to 5-7 mm).
- Total about 20 elements of enanthema develop one week and disappear without trace.
- Diagnostics bases on only clinical data.

- **Q-Fever.**
- Bronchial tubes are damaged mainly, but moderate inflammation of upper respiratory tracts as pharyngitis and laryngitis with the expressed intoxication are marked.
- Hyperemia of face, neck, injection of vessels of sclera like at flu.
- Seasonality is summer-autum while ARD meet rarely.
- Increase of liver and spleen appearss fom 3-4th day (not characteristically for the flu and other ARD).
- Diagnostics – CFR with an antigen of Rickettsia Burnetti.

- **Chicken-pox.**
- Pharyngitis, laryngitis, sometimes specific viral pneumonia can develop.
- A diagnosis is not difficult due to typical polymorphic vesicular rash.
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- **Paratyphoid A.**
- There are rhinopharyngitis, tracheobronchitis, conjunctivitis at initial period.
- It develops more gradually with growth of fever.
- Intoxication fall short of to the inflammatory changes of respiratory tracts.

- Diagnostics is bacteriological and serologic.

- **Anthrax (pulmonary form).**
- Acutely expressed rhinitis, pharyngitis, laryngotracheitis, bronchitis and conjunctivitis.
- Symptoms of hemorragic pneumonia, quickly developing shock.
- Diagnostics is bacteriologic, bacterioscopic and serologic.

- **TONSILLITISES (inflammation of palatal tonsils).**
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- ***Tonsillitis can be manifestation of quinsy or one of signs of other infectious disease.***
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- ***Quinsy*** (acute bscterial tonsillitis) **–** ***inflammation of palatal tonsils and regional lymphatic nodes is basic manifestation of disease.***
- ***Tonsillitis is inflammation of tonsils at other infectious and noninfectious diseases as one of signs of these diseasees.***
- ***Chronic tonsillitis* – *is the chronic inflammation of palatal tonsils and regional lymphatic nodes, quite frequent with development of manifestations of chronic general intoxication and specific complications.***

- **For diagnostic of tonsillitis it is necessary to observe certain rules:**
- Good illumination at examination for correct perception of color.
- Medical careful examination of fauces (by means of two spatulas).
- Sizes, color, relief and state of palatal handles, soft palate, tongue, back wall of pharynx are estimated.
- Presence of mucus, pus, fibrinous films is marked

- **Quinsy.**
- It can be caused by haemolytic streptococcus (85%), staphylococcus aureus (10%), fusobacteria (necrotic Vincent's quinsy).
- Clinically the expressed intoxication corresponding to the inflammatory changes of palatal tonsils, pain at swallowing present.
- Diagnostics is bacteriological.

- **Features of necrotic Vincent's quinsy:**
- absence of the expressed symptoms of general intoxication,
- pharyngalgia at swallowing is not present or expressed poorly,
- process is usually one-sided, in the first twenty-four hours moderate hyperemia, after the rounded greyish-white spot (about 10 mm), from the 2-3th day greyish film, at the removal of that defect (ulcer) is marked, from a 4-5th day ulcer is crateriform
- putrid smell from mouth,
- confirmation — bacterioscopy.

The group of symptomatic tonsillitises includes a number of diseasees of infectious and noninfectious nature :

- ***Infectious:***
- adenoviral diseases;
- anginal-bubonic form of rabbit-fever;
- anginal-septic form of listeriosis;
- diphtheria of pharynx;
- infectious mononucleosis;
- candidiasis of fauces;
- parainfluenza, flu and other ARD;

- ***Noninfectious:***
- agranulocytosis
- radiation disease;
- acute leucosises;
- cytostatic disease;
- chronic tonsillitis.

- **Adenoviral of disease.**
- Adenoviruss can save long time in tissue of tonsils and adenoids without inflammatory changes.
- At acute forms rhinopharyngitis and system damage of lymphoid tissue (generalised lymphadenopathy) are marked.
- Changes in the palatal tonsils are symptomatic tonsillitis and is not quinsy.

- **Anginal-bubonic form of rabbit-fever.**
- Process always is one-sided.
- It has necrotizing character.
- Diagnostics – skin allergic test with tularin, serologic reactions.

- Film on the tonsil has greyish color and deep ulcer appears after sloughing.
- After repairing of ulcer scars on an tonsil appear.
- Unlike necrotic Vincent's quinsy high fever and intoxication are typical.
- A characteristic feature is formation of bubo (upper and anterior neck)
- A bubo is not soldered with surrounding tissues, movable, a skin above it is not changed, fluctuation and fistula usually appear at the end of 3th week from the beginning of illness.
- A feverish period proceeds 10-15 days, but cicatrization of ulcer on an tonsil and reverse development of bubo take place considerably slower.

- **Anginal-septic form of listeriosis.**
- **Tonsillitis** develops on a background a severe general (septic) disease with the varied clinical manifestations.
- Quite frequent rash (erythema with the figure of «butterfly» on face).
- Generalised lymphadenopathy, constantly – hepatosplenomegaly, and at some cases purulent meningitis.
- Clinical diagnosis is difficult.

- Diagnostics – bacteriologic (from blood, neurolymph, pharynx), serologic (CFR and IHR).
- A listerious allergen is produced for skin test – passing of negative to positive.

- **Diphtheria of pharynx.**
- Damage of palatal tonsils is obligatory.
- Differential diagnostics is especially laboured at development of streptococcus quinsy at the bacillicarrier of toxigenic C.diphtheriae.
- The catarrhal form of diphtheria of pharynx is differentiated with a catarrhal quinsy; island-like – with lacunar, membranous – with a necrotizing quinsy, and toxic – with quinsy complicated by abscess.
- Diagnostics – bacteriologic examination (toxigenic C.diphtheriae), serologic, bacterioscopy.

- ***Catarrhal form of diphtheria of pharynx.***
- Atypical form, without fibrinous films on tonsils.
- The temperature of body is normal or subfebrile.
- A pharyngalgia at swallowing is absent or expressed poorly.
- The mucous membrane of tonsils is mildly hyperemic and on the 2-3th day small edema and cyanochroic colouring is possible.
- It can pass to membranous in future.
- Specific characteristic complications are possible.

- ***Island-like form of diphtheria of pharynx.***
- The small areas of fibrinousого film (small «islands») on tonsils are easily taken off by a spatula, thin.
- Lacunar quinsy develops with a high fever, expressed symptoms of general intoxication, great pains in a throat.
- Island-like a form develops with subfebileой temperature of body, pains at swallowing are absent or expressed poorly.
- Without specific treatment illness passes to the membranous form.

- ***Membranous diphtheria of pharynx.***
- Expressed continuous fibrinous films keeping indoors outside tonsils.
- A film is taken off hardly, in place of it bleeding surface appears. The taken off film sinks in water.
- Intoxication is expressed and does not correlate with the temperature of body.
- High probability of specific complications characteristic for diphtheria.
- ***Widespread diphtheria of pharynx.***
- fibrinous film goes across and on the surrounding areas of mucous membrane − back wall of pharynx, soft palate, uvula.

- ***Toxic diphtheria*** is characterized by appearance of edema of neck cellular tissue.
- At toxic diphtheria false diagnose of quinsy complicated by abscess is possible.
- The expressed pharyngalgia is not present (diphtherin has anaesthetic action).
- Grey-brown films can cover both palatal tonsils and surrounding tissues.
- Edema on a neck, high fever, expressed symptoms of intoxication are typical.

- Appearance of paratonsillar abscess is characterized by a rapid fervescence, chill expressed by a toxicosis.
- Trismus of masticatory musculature limits opening of mouth.
- One-sided edema and infiltration are marked in default of films on the mucous membrane of tonsils.
- The diagnosis of diphtheria is confirmed by the selection of causative agent.
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- **Infectious mononucleosis.**
- **Almost** always develops with the damage of pharynx.
- Acute beginning, high fever, intoxication.

- Appearance of tonsillitis is possible after ferver, general intoxication and other signs of mononucleosis.
- It can imitate lacunar quinsy, necrotizing changes of tonsils and even fibrinous films.
- A fever and toxicosis are saved protractedly, and changes in a pharynx do not grow and keep indoors outside tonsils.
- Generalised lymphadenopathy appears early (from the first days of illness).
- Hepatosplenomegaly appears at the 3-5th day, a spleen ise considerably increased and painful at palpation.

- Acute hepatitis can develop.
- CBC – leucocytosis, neutropenia, lymphomonocytosis, atypical mononuclears.
- The changes of blood appear early and saved long time (sometimes few months).
- Diagnostics is an serologic, PCR.

- **Candidiasis of fauces.**
- Arises up as a result of dysbacteriosis and immunodeficit.
- The temperature of body remains normal, rarer subfebrile.
- Film related to the mycosis, greyish-white color, usually by separate areas, not only at tonsils but also mucous membrane of cavity of mouth, back walls of pharynx.

- Inflammation of tonsils is not actual it is not tonsillitis but widespread candida damage of mucous membrane of fauces.
- Diagnostics is mycologic research.
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- **Flu, parainfluenza and other ARD –** cataral tonsillitis is included in clinic of inflammation of respiratory tracts.
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- **Syphilis.**
- At the primary syphilis original primary syphiloma at gate of infection.
- Increase of one tonsils, mucous membrane is hyperemic.

- A regional lymphatic node is mildly increased, dense consistency, painless.
- Pains at swallowing is not marked.
- General condition is normal.
- Small erosion on tonsils (5-10 mm is in a diameter) with clear dense edges and clean bottom.
- Abundant exanthema and/or enanthema present at second stage of disease.
- A diagnosis is confirmed by specific laboratory methods.

- **Scarlatina**
- Like quinsy it is caused by haemolytic streptococcustococcus group A.
- Along with a clinic signs of quinsy, influence of erythrogenic toxin manifests by skin hyperemia, rash with, tachycardia.
- Unusually bright hyperemia of mucous membrane is a «blazing pharynx».
- Clean hyperemic language with increased papillae («raspberry language»).
- Laboratory confirmation of diagnosis is absent.

- **Typhoid fever.**

- Palatal tonsils and archs are edematous, small ulcers covered by a greyish films are possible.
- Other manifestations of main disease have prevalence.
- Diagnostics is bacteriological, serologic.
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- **Noninfectious illnesses.**
- **Tonsillitis *presents at haematological diseases (different forms of leucosises), neutropenia (acute radiation illness, immune agranulocytosis and other), changes of tonsils have necrotizing character.***

- **Chronic tonsillitis.**
- Character of development is decompensated and subcompensated.
- Periodic exacerbation and remissions are typical.
- Exacerbation is provoked by supercooling or ARD.
- In remission signs of chronic toxicosis (general weakness, fatigueability, irritability, subfebrile fever), vasoneurosis (lability of pulse, orthostatic hypotension, dyscomfort in heart area) present.
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- ***Chemical burns can also cause the inflammatory changes of mucous membrane of tonsils, sometimes with formation of films and do not cause diagnostic difficulties.***

The End!