CLINICAL IMAGES

Tuberculous lymphadenitis and Horner's syndrome

Robert Freercks, Mark W Sonderup

Given the significant disease burden of tuberculosis (TB) and TB/HIV co-infection in South Africa, disseminated TB and tuberculous lymphadenitis are common and important causes of morbidity. Despite this relationship, Horner's syndrome secondary to tuberculous lymph node compression of sympathetic nerves is rare.

Case report

A 20-year-old HIV-positive woman, not on antiretroviral therapy, was admitted to Groote Schuur Hospital following a short history of headache, lethargy and night sweats. She had previously started a 6-month course of TB treatment, but defaulted after 2 months.

She had significant meningism and bilateral enlarged, non-tender cervical lymph nodes in the anterior and posterior triangles, but no focal neurological deficit at this point.

Chest radiography revealed confluent opacification of the left upper lobe with areas of cavitation and air-bronchograms (Fig. 1). The working diagnosis was disseminated TB with meningitis owing to incomplete TB treatment, for which she was admitted and treated. A subsequent TB blood culture was positive for drug-sensitive TB.

Within 36 hours of admission she developed left-sided ptosis and miosis with anisocoria (Fig. 2). Facial sweating was preserved and ocular movements were intact with no diplopia or other cranial nerve or long tract deficit, in keeping with a left postganglionic Horner's syndrome. A computed tomography (CT) scan demonstrated enlarged, centrally necrotic lymph nodes bilaterally in the neck (Fig. 3), adjacent to and displacing the carotid artery bifurcation on the left (Fig. 4). Three months after further TB care, her Horner's syndrome had resolved.

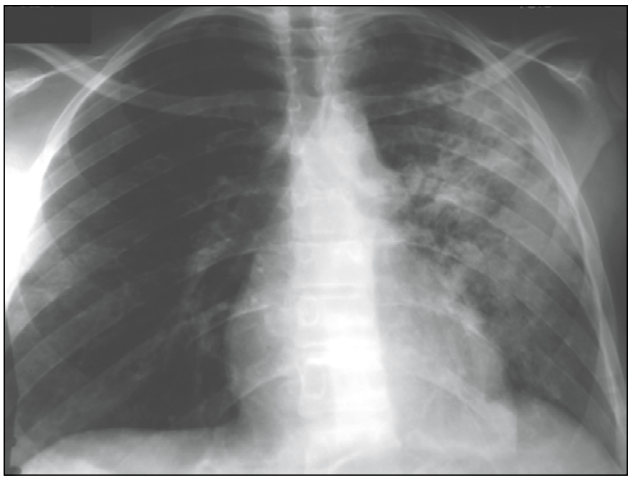

Fig. 1. Radiograph showing predominant left-sided consolidation with cavitation and air-bronchograms.

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Fig. 2. Patient's face demonstrating ptosis of the left eye with maintained conjugate gaze.

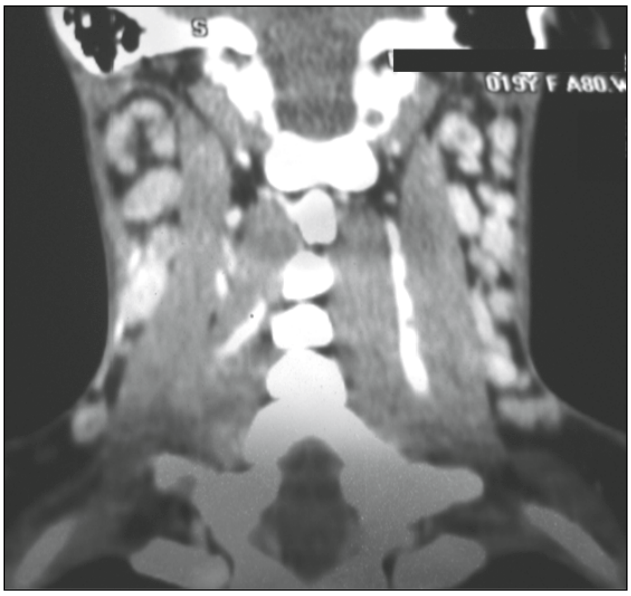

Fig. 3. Coronal CT scan of the neck showing lymph nodes with central caseation.

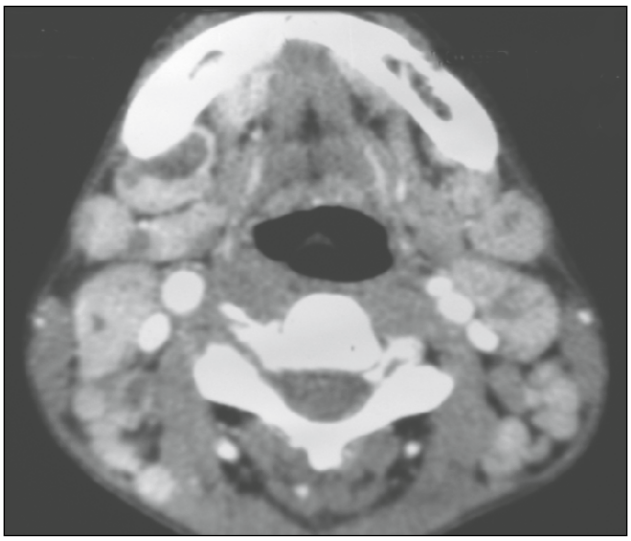

Fig. 4. Axial CT scan through upper neck demonstrating lymph nodes adjacent to great vessels.

Discussion

Two case series[1,2] identified neoplastic disease as the most common cause of Horner's syndrome. Only two case reports in the English literature describe TB as a cause for Horner's syndrome.[3,4] Notably, the first-ever published case was in the *SAMJ* and was thought to be a pre-ganglionic lesion.

Horner's syndrome has many possible aetiologies that can involve a lesion anywhere in the course of the sympathetic tract from hypothalamus to brainstem and upper thoracic cord, sympathetic trunk, stellate ganglion, carotid artery and, finally, long ciliary nerve to the eye. The lack of other focal neurological deficits in our patient vitiates the possibility of a central lesion such as brainstem tuberculoma or tuberculous endarteritis. The preservation of facial sweating, which implies a post-ganglionic lesion as facial sweat gland tracts run along the external carotid artery, localises the lesion to the upper neck and/or internal carotid artery. A neoplastic cause is excluded by the lack of mediastinal or apical lung lesions on the CT scan, the presence of central lymph node necrosis, and the good response to TB treatment.

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ETHICS IN MEDICINE

Breaking bad news – ethical dilemmas for doctors attending to Jewish patients

Maurice Silbert

Breaking news to a patient of an illness feared to be serious or life-threatening has always caused difficulties, both moral and ethical, among doctors and all other health care providers. Moreover, there are distinct differences in the approach to this topic among various religious and cultural groups. In any diverse society, such as that in South Africa, it is helpful for doctors to familiarise themselves with the practices and philosophies of various groups, faiths and cultures, in matters relating to life and death. This article attempts to define a Jewish approach, and hopefully create better understanding of the subject among all doctors and health-care providers. (To avoid clumsy repetition, the term 'doctor' will hereafter be used and will denote all health care providers.)

Although there has been, in keeping with the culture of an open society, a universal shift towards telling the truth and the right to know, there is still a tendency to withhold the full truth of the ultimate prognosis of an illness. 'Reasons include perceived lack of training [of doctors], no time to attend to the patient's emotional needs, fear of negative impact on the patient, uncertainty about prognostications, requests from family members to withhold information, and a feeling of hopelessness regarding further curative treatment.'[1] The traditional view among doctors is that most patients do not want to know of the terminal nature of their illness, and have difficulty in coping with the emotional trauma of such disclosures. Psychologists argue that doctors who withhold the truth are actually projecting their own repressed feelings about death, a topic that causes discomfort and is therefore avoided. Alternatively, some feel that the whole truth, and the way it is often disclosed by doctors, can be seen to be insensitive or even brutal, and so lacks compassion and is therefore morally indefensible. The implication is that withholding some of the truth is felt to be justified.

In a discourse on contemporary medical practice, Rabbi Immanuel Jacobovits, former Chief Rabbi of the United Kingdom and noted bio-ethicist, stated in the context of imparting bad news that '… we are opposed to divulging the whole truth if there is the slightest suspicion that by doing so, we may cause a physical or mental setback to the patient … peace of mind takes priority over truth, and if necessary, for the sake of the health of the patient, we may play down and suppress the truth ... [so that] hope is not ultimately removed from the patient.'[2] Within the ethos of Judaism, this approach fulfils the Jewish recognition that hope for the preservation of life must never be abandoned – every fraction of every second of life being of infinite value. Psalm 71 states '… when my strength faileth, forsake me not … but as for me, I will hope continually …'[3] The sanctity of life, albeit a universal and sacred precept in most faiths, is paramount in Judaism and firmly entrenched.

Providing hope

Providing hope is not unique to Judaism. Christianity and Eastern religions profess their own particular approaches to providing hope, other than only that of preserving life. Relief of pain and suffering, for instance, provide the patient and family with hope and meaning from which they gain strength in the face of fear. Many patients try to re-define their hope when physical life and health wane: how

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will they be remembered, what legacy will be left? Moreover, in the medical context, it is realistic to provide hope in view of the vast improvement in management and prognosis of malignant disease.

Providing hope is therefore universally seen to be a central force between recovery, and belief in recovery. Withholding the truth, however, in providing hope is fraught with problems and dilemmas for the doctor. 'Well-intentioned practices of withholding information may have detrimental consequences for patients, their families and friends, and the health-care team'.[4] There is a distinct possibility that patients may lose trust in the doctor when eventually, and inevitably, they become aware of the true nature of their illness and its ultimate prognosis. Consequently, they may also disbelieve what they are told subsequently, which may seriously impinge on the doctor-patient relationship. It may also be regarded as paternalistic on the part of the doctor who takes it upon him/herself to decide what and how much the patient ought to know, thereby failing to recognise that the patient's autonomy and right to know constitute one of the most important ethical reasons for truthful disclosure. Patient autonomy is recognised by the South African Medical Association as an important ethic in doctor-patient relationships, and is incorporated in the Association's credo and code of conduct. From a temporal point of view, the right to know enables the patient to share in decision-making about treatment, and to attend to matters such as domestic and business affairs. Of equal importance – if not more so – an awareness of the diagnosis and its implications provides opportunities for the patient to express uncertainties and fears, share feelings of depression, anxiety and isolation, and reconcile interpersonal relationships. Acceptance of the diagnosis and its ultimate implications moreover allows preparation for the dying process, and ultimately 'permission to let go'. These issues, apart from the individual's religious beliefs, are intrinsic to the philosophy of preparing for death, as practised by various religions or faiths as well as being fundamental to Hospice philosophy. This philosophy strives towards patients experiencing a 'good death'; in other words, at peace with everything important to them at this crucial stage of their lives. This, Hospice contends, is achievable if patients and their 'significant others' are supported in working through all issues. Awareness of the reality of impending death is important to achieve this.

In caring for Jewish patients, however, the Rabbinical injunction of not abandoning hope for survival, even till the last breath, is in sharp contrast to the acceptance of death and preparing for the dying process. The belief in the preservation of life is so pre-eminent in Judaism that, even in the face of death, it is reinforced; it is evident in the patient's prayers, even when they have accepted their fate. When death is imminent, it is customary to recite the *Vidui*, a confessional prayer seeking atonement from the Almighty. Its opening sentence contains an affirmation of life in the words '... may it be thy will to send me perfect healing ...'.[5] Moreover, the Rabbis caution that the *Vidui* should not be introduced too early as it may 'crush the spirit of the patient, for s/he may perceive this as being told s/he is about to die'.[6]

Resolving the dilemma

How then can the doctor, in caring for Jewish patients, resolve the dilemma between the Rabbinical injunctions for preserving hope for survival, while at the same time fulfilling the ethical commitment to disclose the truth?

Awareness of the approach promoted by Elizabeth Kübler-Ross provides a model or basis for the doctor. In her groundbreaking book *On Death and Dying*, she described the coping or defence mechanisms and the psychological stages which patients, diagnosed with serious or life-threatening illness, experience. She identifies the stages of denial, anger, depression, bargaining and ultimate acceptance.[7] Denial is the strongest human defence. Generally, there is disbelief and resistance, both at conscious and unconscious levels, to accept the diagnosis. By way of example, patients may want to block out the fact that they have a life-threatening illness such as cancer, and it would therefore be initially appropriate for the doctor to use terminology such as 'growth' or 'tumour', be it even for a day or two, or until a definitive diagnosis has been confirmed and communicated to the patient. The doctor thus fulfills the commitment to telling the truth. By initially withholding the whole truth about possible serious implications or prognosis of an illness, the doctor conforms to the universally accepted practice of breaking bad news, using the well-recognised format of the patient-centred approach, 'listening to what the patient knows and wants to know'.[8] In so doing, the doctor respects the patient's defences of denial, and shows compassion.

The general principle of this approach is that it is usually possible to temporise in keeping with the patients' defences. The doctor reveals the information and implication of the illness in stages by withholding some of the truth when necessary, thereby allowing patients time to set their own pace and mobilise less radical defences. Rabbi Jacobovits puts the approach succinctly: '… the patient should be allowed to buy time, gather himself and mobilise his resources …'. In this way, he acknowledges the universality of this approach, an approach which imparts compassion to patients and their families.

The principle embodied in the above not only facilitates the doctor's communication with the patient, but also helps to resolve many of the moral, ethical, and religious dilemmas facing the doctor. Moreover, it demonstrates compassion and is in keeping with humanitarian philosophy.

Conclusion

Although there is general uniformity among various religions, faiths and cultural groups in their approach to breaking bad news, the foregoing highlights some important aspects of the Jewish approach; significantly, the belief that hope for the preservation of life, even till the last breath, must never be abandoned – a concept that is ingrained in Judaism.

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