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A CASE OF RELAPSE OF TULAREMIA

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The problem of the possible existence of chronic tularemia and relapses of this infection has as yet been insufficiently investigated. For this reason, we decided to publish a case we observed.

Patient P was 45 years old. A week before his illness, he handled food products which had been spoiled by rodents. He finally became sick on 5 May 1946. On the sixth day of his illness he reported to a doctor complaining of a chill, a severe headache, a tendency to perspire, general asthenia, muscular pains throughout his body, and pain in the throat when swallowing. On examination he had a temperature of 38 degrees. The submaxillary gland on the left side was enlarged to the size of a hen's egg, and was movable and painful, while the skin over the gland was not changed. The tonsils were enlarged and there was acute hyperemia and swelling in the throat. Intracutaneous test with tularin gave positive results (4 x 5 centimeters). Diagnosis was anginousbubonic form of tularemia.

The patient was treated with quartz under ambulatory conditions. After 1½ months the clinical symptoms of tularemia disappeared.

On 13 February 1947 the patient reported again with the same complaint. On examination a bubo somewhat smaller than a hen's egg was found in the submaxillary region on the left side. Acute hyperemia of the mucus tissue of the throat and swollen tonsils with the appearance of necrosis were also observed. An exudate from the bubo was injected subcutaneously into a white mouse. On the sixth day the mouse died. The emulsion from its organs was injected into another mouse which died on the third day. A culture of tularemia microbes was taken from the second mouse. Two reactions of agglutination, on admission and after a week, were positive in dilutions of 1:100 and 1:800.

The patient was treated with tularemia vaccine. After 22 days the patient was discharged to ambulatory treatment. His temperature had become normal and the bubo in the left submaxillary region had decreased to the size of a walnut.

- 1 -

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50X1-HUM

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On 3 May 1947 he was readmitted to the hospital with a decided anginous-bubonic form of tularemia. The submaxillary bubo of the left side was somewhat larger than a walnut, slightly painful when palpated, of elastic consistency, and movable. The submaxillary gland on the right side, those under the arms, and the inguinal and hip glands were the size of beans, of quite elastic consistency, painless and movable. Also observed were hyperemia and hyperplasia of the tonsils and exudative-erythematose inflammation in the region of both forearms and on the spine. In regard to the heart there was the appearance of myocarditis. The patient was discharged after 63 days with a normal temperature and the submaxillary gland reduced to the size of a woodnut. The patient did not report to us any further.

Similar cases were reported by Berinskaya, Bilinbin, Gurfinkel, and Khatenever. In cases of tularemia relapses observed by us, the clinical picture was the same as at the onset of the disease. Berinskaya observed these relapses 11 to 33 months after the onset of the disease. Some authors detected the causative agents of tularemia 3-5 months after the onset of the illness. Cultures were made from abscesses of the underarm lymph nodes from biopsied sections of the skin, and from pus. Khatenever obtained cultures of tularemia microbes from patients who had relapses of tularemia 14 months after the onset of the disease. These cases confirm that the causative agents of tularemia can for a long time be found in the body of patients who had tularemia without developing clinical manifestations of the disease and that this presence of the causative agent is the reason for the relapses.

Tularemia is regarded as an infection characterized by the presence of a residual immunity after the disease. On this subject there are a number of individual works and series of investigations. Khatenever (1929 and 1930) mentioned the presence of a residual immunity to tularemia. Spirov (1940) investigated repeated outbreaking of tularemia in one of the tularemia loci, and noted that there were no reinfections of tularemia in these cases. Some authors remarked on the presence of agglutinin in patients who had had tularemia after a period of 18 to 20 years.

The existence of such a degree of residual immunity to tularemia decreases the possibility of reinfection in the case studied. This is also supported by epidemiological data. Tularemia was epizootic among gray rats and house mice in the populated section where the patient lived 10 days before the onset of the disease. The number of gray rats in this section was very large. At the time of the second admission of the patient, tularemia was not epizootic either for rats or other rodents, consequently the possibility of a second infection was very unlikely.

Thus, it can be concluded that our patient had chronic tularemia with repeated relapses.

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- 2 -

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