Acute Infectious Mononucleosis in a 64 Year Old Woman

By THOMAS FITZ-HUGH, JR.

IT HAS been stated recently that acute infectious mononucleosis is acquired by intimate oral exchange of saliva.[1] According to this hypothesis, the disease is said to be most common in the teens and twenties when semi-promiscuous and prolonged kissing is presumably more often practiced than during earlier and later years. Authentic instances of the disease after 35 are rare.[2]

The following case report documents an attack of acute infectious mononucleosis, which simulated lymphatic leukemia, in an elderly spinster who seemed a most unlikely candidate for this communicable disease.

Miss C., aged 64, operator and owner of a seashore restaurant-inn, was referred on 4/9/56 (University Hospital Record No. 08 46 42 ME) with a presumptive diagnosis of lymphatic leukemia. Her illness began as a supposed virus infection on February 8, 1956, with cough, mucous expectoration, sore neck, hoarseness and fever. Malaise persisted, and about March 20 an exacerbation occurred. She became nauseated, her neck glands became tender, and she noted blurring of vision, severe headache, ataxia, somnolence and great weakness. On about April 1, examination of her blood is said to have disclosed "a lymphatic blood picture."

Admissing findings:—Obesity, hypertension, fever, slight icterus, enlarged lymph nodes in neck and axillae, palpable liver and questionably palpable spleen. Blood count (4/10/56):—Hemoglobin 13 Gm., leukocytes 13,300, neutrophils 15%, lymphocytes 78% (mostly adult forms), monocytes 5% and plasma cells 2%. Reticulocytes 2.4%. Platelets 200,000. Sternal marrow obtained by aspiration showed "hypercellularity, well marked lymphocytic infiltration, adequate erythropoiesis, granulopoiesis and megakaryocyte formation. The lymphocytes were generally mature. A scattering of plasma cells were noted. Marrow diagnosis:—Chronic lymphatic leukemia."

Despite this "substantiation" of a nearly obvious-seeming diagnosis, several inconsistencies made it interesting to consider other remote possibilities. The onset of illness suggested an acute process, yet the normal red-cell and platelet levels and the predominantly adult type of lymphocytosis and the absence of ulceration and hemorrhage pointed away from acute leukemia. Serologic tests for brucellosis, heterophil antibody and syphilis were performed. To our amazement, the heterophil antibody test was reported on 4/11/56 "positive in dilution of 1:2048." This was repeated on 4/15/56 and the titer was still high (positive 1:1068) with complete absorption of the antibodies by ox blood and slight absorption by guinea pig kidney (positive 1:860).

On 4/17/56 the blood counts were: Hemoglobin 13.5 Gm., leukocytes 9,700, neutrophils 13%, lymphocytes 83% (8% young forms), monocytes 3%, basophils 1%.

Other studies revealed some evidence of liver damage (plasma albumin 2.6 Gm., globulin 4.6 Gm., bromsulphalein retention of 21% in 45 minutes and serum bilirubin 1.0 mg/100 ml), a solitary renal cyst (urographic demonstration), "enlargement of liver and spleen" and an electrocardiographic pattern of "myocardial damage with left ventricular hypertrophy."

Before the heterophil antibody test was reported, x-ray therapy (50r to the post-cervical area) was started on the supposition that the patient was suffering from lymphatic leukemia. Further irradiation was stopped. There was prompt subsidence of lymphadenopathy and fever, and improvement in strength, appetite and morale. She was discharged on 4/20/56, to continue convalescence at home.

The patient was re-examined on 5/28/56. She felt well, and offered no complaints except persisting but lessening fatigue. Physical findings were all normal except for obesity and hypertension. Blood count:—Red cells 4.5 million, hemoglobin 12 Gm., leukocytes 8,700,

From the Medical Clinic-Hospital of the University of Pennsylvania.
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neutrophils 45%, lymphocytes 42% (5 young forms), monocytes 6%, eosinophils 5%, basophils 2%. Heterophil antibody titer positive 1:56. Cephalin flocculation plus 1. Final examination was made on 9/12/56. She was hematologically perfectly normal and was discharged to the care of her local physician.

After the diagnosis was established in the hospital the patient was questioned carefully, and was informed of the kissing theory. She was unable to account for her condition on this basis and wondered about the possibility of drinking from contaminated glassware.

Conclusion

This case emphasizes the fact that acute infectious mononucleosis must be considered in the differential diagnosis of chronic lymphatic leukemia, even in the older age group.

Summario in Interlingua

Es presentate un caso de acute mononucleose infectiose que illustra le facto que iste morbo debe esser prendite in consideration in le diagnose differential de chronic leucemia lymphatic' mesmo in patientes de etates plus avantiate.

REFERENCES

[1] Hoagland, R. J. Transmission of infectious mononucleosis. Am. J. M. Sc. *229:* 262–272 (Mar.) 1955.

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