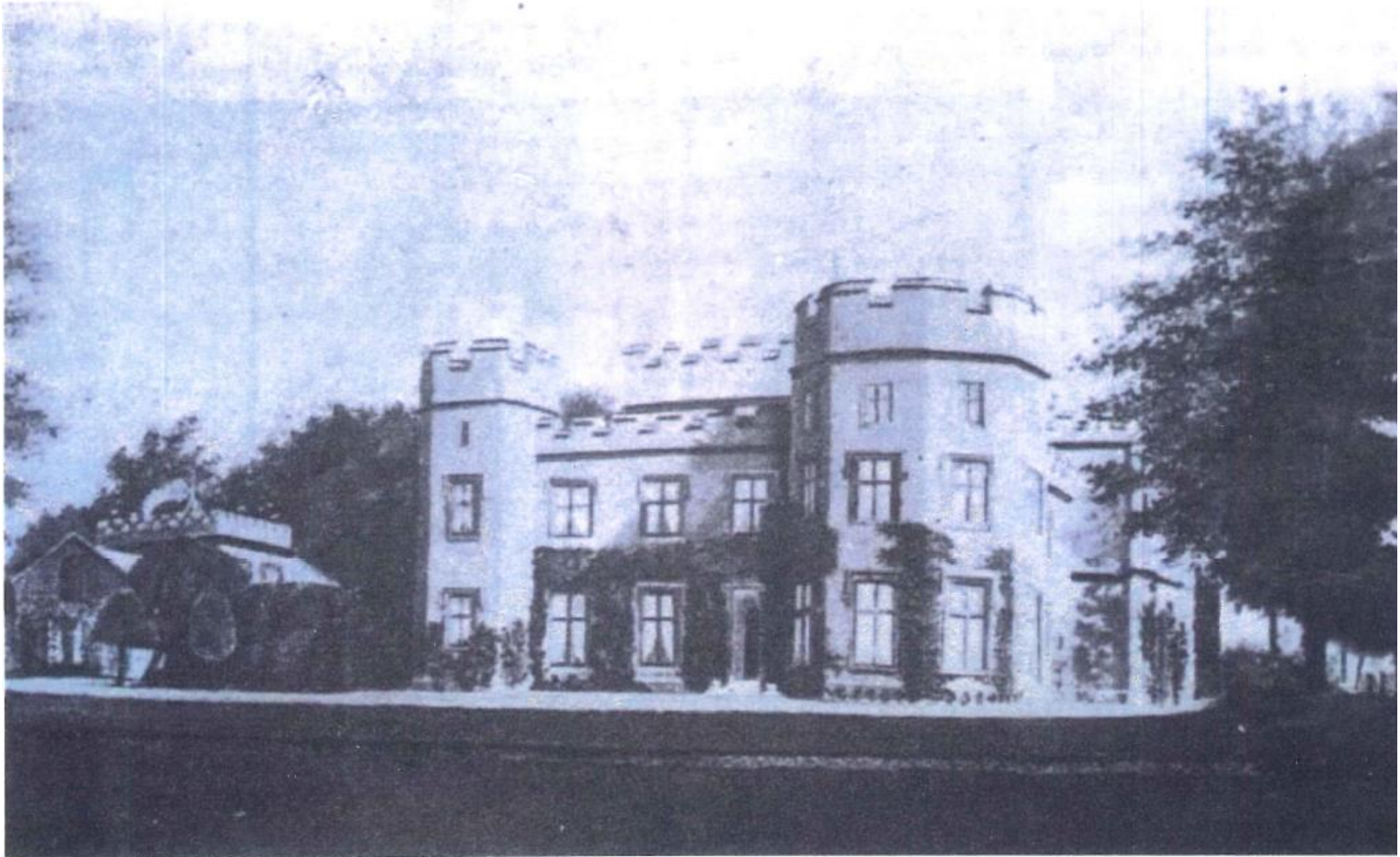


Tuberculosis and Castle Hill Hospital

Rolf Meigh

Cottingham Castle



Entrance 3, 1905

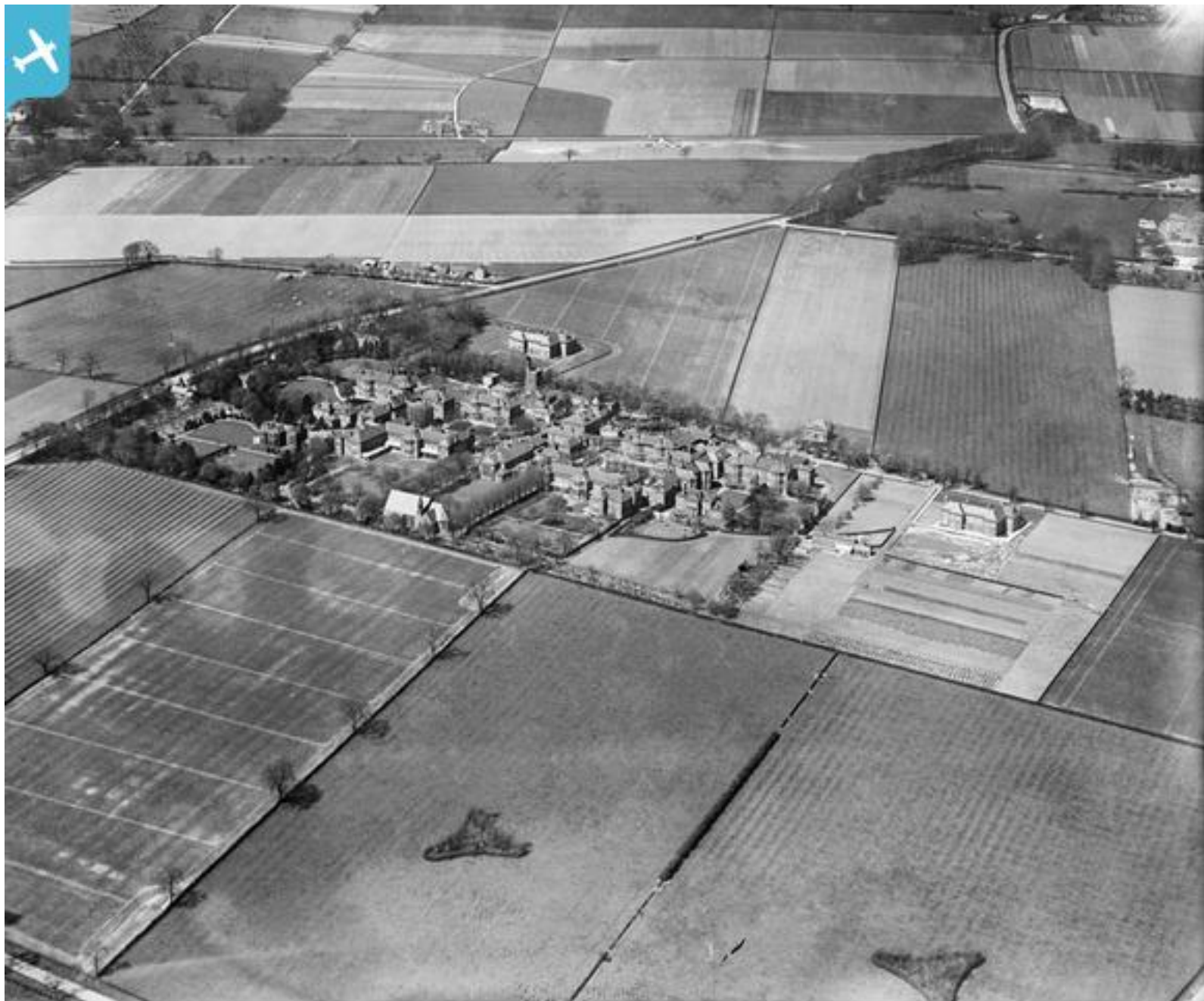




Castle Hill Sanatorium, Corringham, Yorkshire

1562



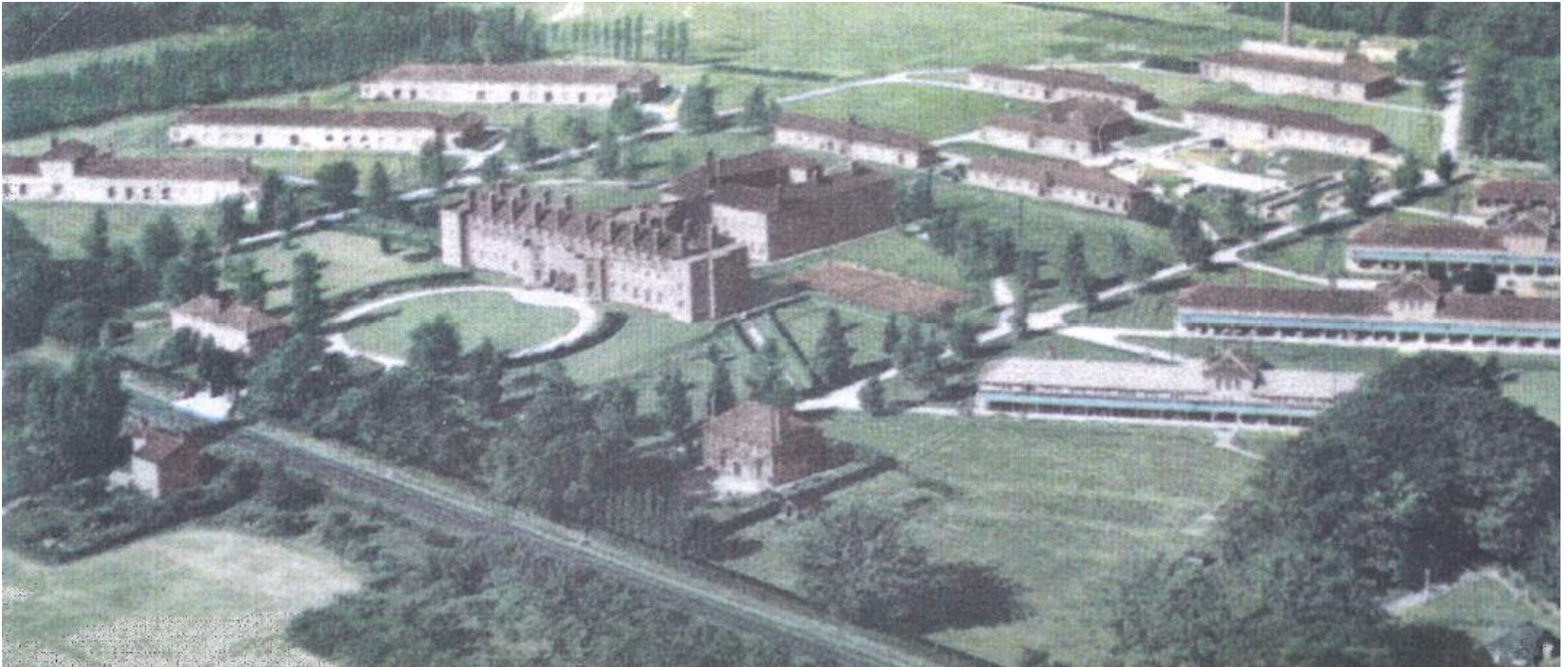




Open-air therapy



1953



Pavilion Ward (3)



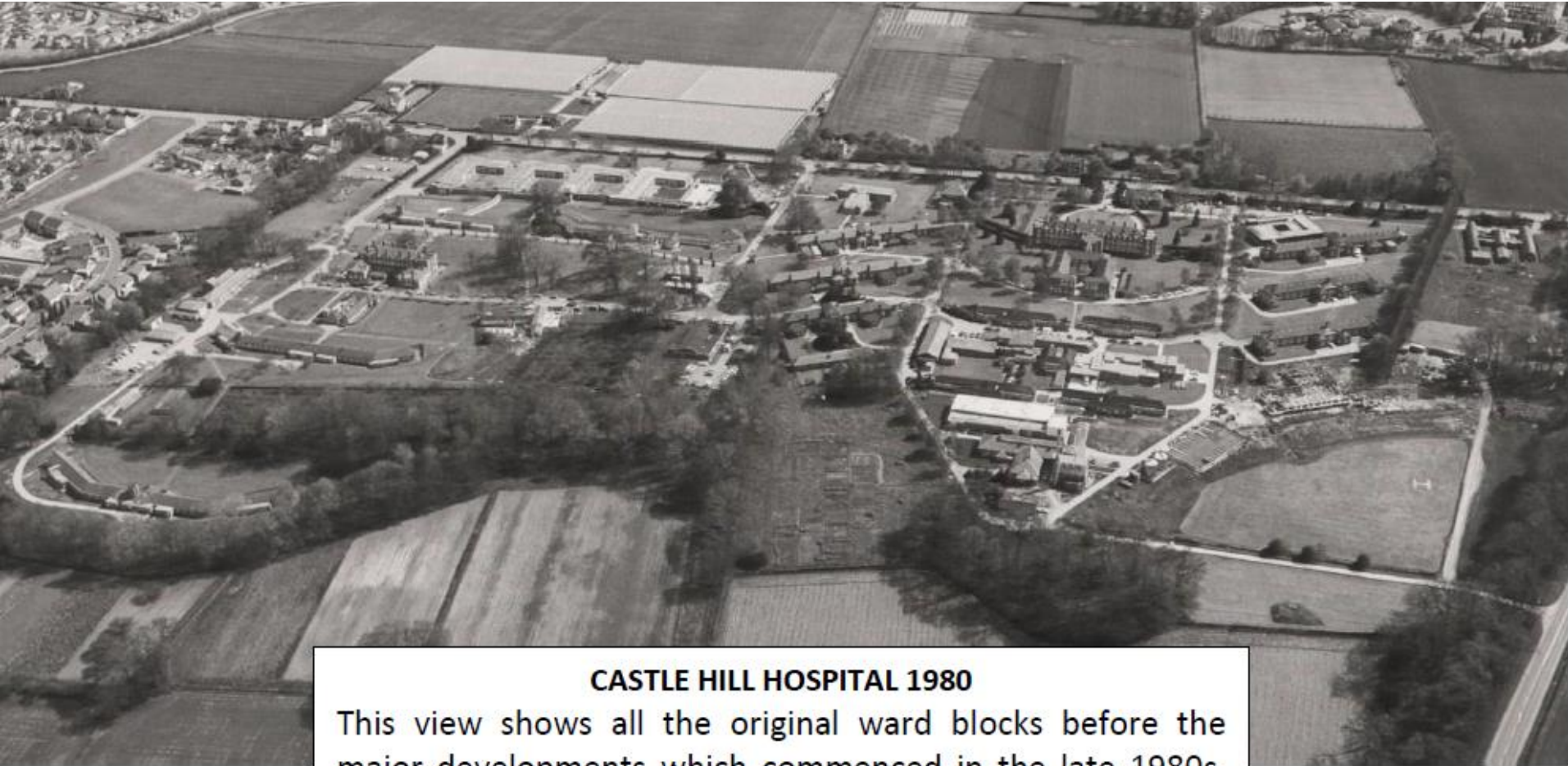
“The Smallpox unit”



Former ward – now Facilities



1980

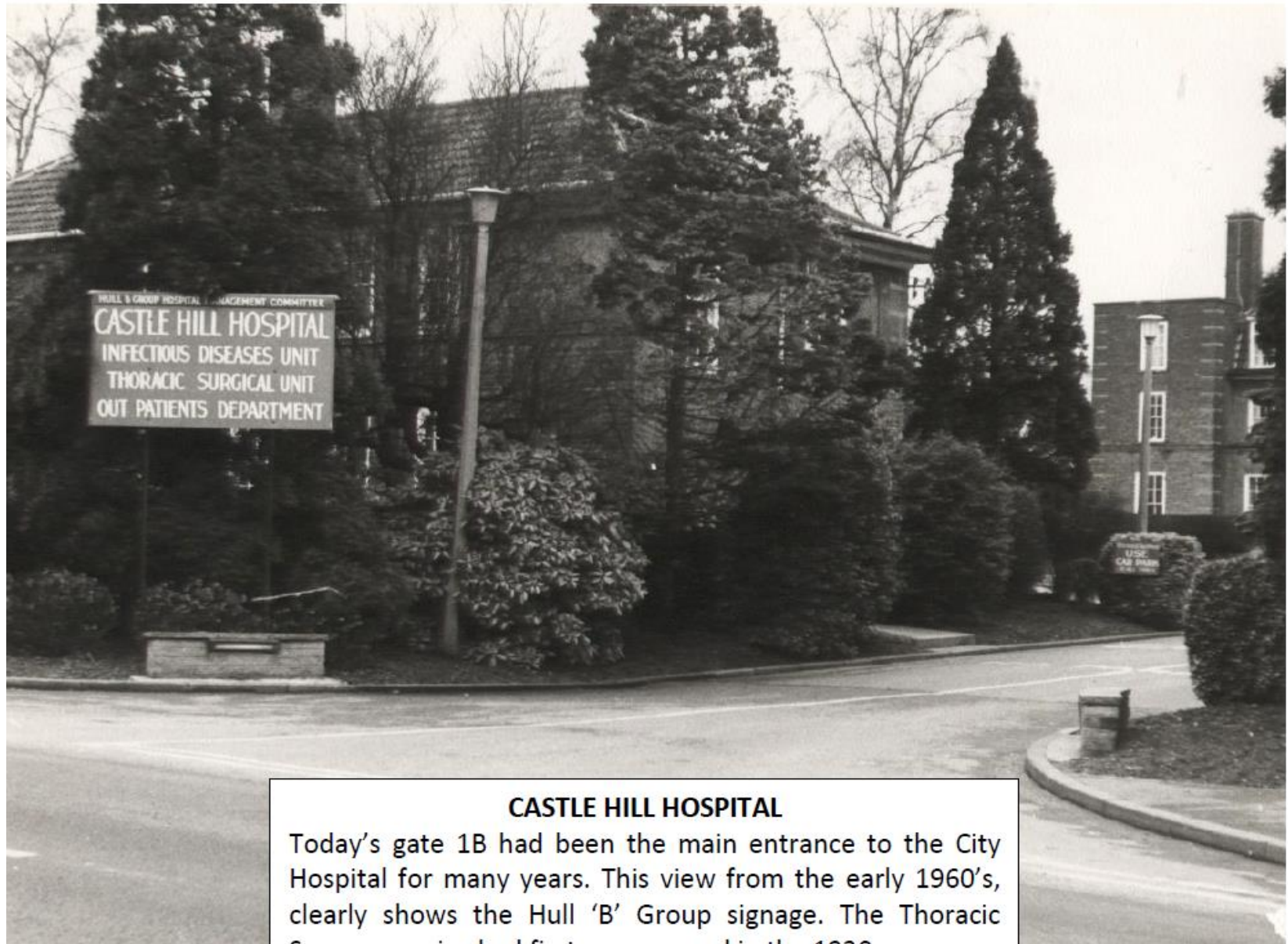


CASTLE HILL HOSPITAL 1980

This view shows all the original ward blocks before the major developments which commenced in the late 1980s. To the top right can also be seen the De La Pole Hospital.

castlehill 1980.jpg

1980's



CASTLE HILL HOSPITAL

Today's gate 1B had been the main entrance to the City Hospital for many years. This view from the early 1960's, clearly shows the Hull 'B' Group signage. The Thoracic Surgery service had first commenced in the 1930s.

1990



2010



CASTLE HILL HOSPITAL -2010

M. Malmöense 1994

844

LETTER TO THE EDITOR

***Mycobacterium malmöense* and carcinoma of lung**

We were interested to read the recent case report of Dr Yoganathan *et al* (February 1994; 49: 179-80) describing a case of *M malmöense* infection in an HIV positive patient. The presentation of their case mimicked a bronchial neoplasm, as can be seen with standard *M tuberculosis* infection.

We have recently seen a 72 year old patient, a heavy smoker, who presented with progressive exertional dyspnoea. A chest radiograph showed a large mass at the left hilum with distal cavitating consolidation. At fiberoptic bronchoscopy narrowing of the left upper lobe bronchus was seen, thought to be due to extrabronchial glandular compression. Bronchial brushings and bronchial washings revealed malignant cells (adenocarcinoma). Staining with auramine-phenol of the second and third sputum samples showed acid fast bacilli, and mycobacterial culture of the sputum resulted in the isolation of *M malmöense*. The poor general condition of the patient precluded surgical resection but she was treated with antituberculosis drugs according to the sensitivity pattern. She tolerated this treatment poorly and, as her condition deteriorated, it was thought inappropriate to continue active treatment. She still survives seven months after initial presentation. There were no HIV risk factors and her HIV status has not been checked.

A search of the literature has revealed two previous similar cases.¹ As with standard (*M tuberculosis*) infection it would appear that, not only may *M malmöense* infection mimic a bronchial neoplasm, but on occasion it can coexist with a bronchial neoplasm.

We thank Dr P A Jenkins, the PHLs Mycobacterium Reference Unit, Cardiff for typing the isolate.

R E MEIGH
A G ARNOLD
Departments of Thoracic Medicine and Public
Health Laboratory,
Cardiff, Wales

London – HIV & MDRTB

An outbreak of multi-drug-resistant tuberculosis in a London teaching hospital

[A.S. Breathnach](#), [A. de Ruiter](#), [G.M.C. Holdsworth](#), [N.T. Bateman](#), [D.G.M. O'Sullivan](#), [P.J. Rees](#), [D. Snashall](#), [H.J. Milburn](#), [B.S. Peters](#), [J. Watson](#), [F.A. Drobniewski](#), [G.L. French](#)



DOI: [https://doi.org/10.1016/S0195-6701\(98\)90324-3](https://doi.org/10.1016/S0195-6701(98)90324-3)



Abstract

References

Abstract

We describe the epidemiology and control of a hospital outbreak of multi-drug-resistant tuberculosis (MDR-TB). A human immunodeficiency virus (HIV)-negative patient with drug-sensitive tuberculosis developed MDR-TB during a period of unsupervised therapy. She was admitted to an isolation room in a ward with HIV-positive patients, but the room, unbeknown to hospital staff, was at positive-pressure relative to the main ward. Seven HIV-positive contacts developed MDR-TB. The diagnosis in the second patient was delayed, partly because acid-fast bacilli in his sputum were assumed to be *Mycobacterium avium-intracellulare*. All the available *Mycobacterium tuberculosis* isolates were indistinguishable by molecular typing. Nearly 1400 staff and patient contacts were offered screening, but the screening programme detected only one of the cases. Despite therapy, the index patient and two of the contacts died. HIV-positive patients are more likely than others to develop tuberculosis after exposure, and the disease may progress more rapidly. In these patients the possibility that acid-fast bacilli may represent *M. tuberculosis* must always be considered. Patients with tuberculosis (suspected or proven) should not be nursed in the same wards as immunosuppressed patients, and should be isolated. MDR-TB cases must be isolated in negative-pressure rooms. Hospital siderooms may be positive-pressure as a fire safety measure; infection control teams must be aware of the airflows in all isolation rooms, and must be consulted during the design of hospital buildings. Good communication between infection control teams and clinicians is important, and all medical and nursing staff must be aware of the principles of management of patients with proven or suspected tuberculosis and MDR-TB.

Keywords:

[Tuberculosis](#), [multidrug resistant tuberculosis](#), [drug resistance](#), [cross-infection](#), [infection control](#), [HIV](#), [airflow](#), [isolation](#), [supervised therapy](#), [contact tracing](#), [typing](#)

MDRTB guidance



THE SCOTTISH OFFICE



The Interdepartmental Working Group on Tuberculosis

The Prevention and Control of Tuberculosis in the United Kingdom:

UK Guidance on the Prevention and Control of Transmission of

1. HIV-related Tuberculosis
2. Drug-resistant, Including
Multiple Drug-resistant,
Tuberculosis