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.

Robert Freercks and Mark Sonderup are affiliated to the Department of Medicine, University of Cape Town, and Groote Schuur Hospital.
**Discussion**

Two case series\(^1\)=^4\ 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.\(^1\)=^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.\(^3\) 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.’\(^3\) 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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**Maurice Silbert is a family practitioner in Sea Point, where he commenced practice in 1957. He was actively involved in the promotion of General Practice as a discipline to be included in the undergraduate curriculum and, in 1968, was awarded the Louis Leipoldt Medal by the South African Medical Journal for his work in a research project entitled The Cape Morbidity Survey and its Significance in Training for General Practice. He has published extensively on the doctor-patient relationship, geriatric medicine and the GP’s role in caring for the terminally ill. In 1983, he was awarded the Hans Snyckers Memorial Medal for Dedicated and Distinguished Service in Medicine in South Africa and, in 1998, the Distinguished Family Practitioner Medal of the University of Cape Town.**

**Corresponding author:** M Silbert (msilbert@mweb.co.za)