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PHOTO QUIZ

Keratoconjunctivitis, pharyngeal ulcera, hypoxaemia and fever

A.J. Kales, N. Smit, P. Gruteke, J. Branger*

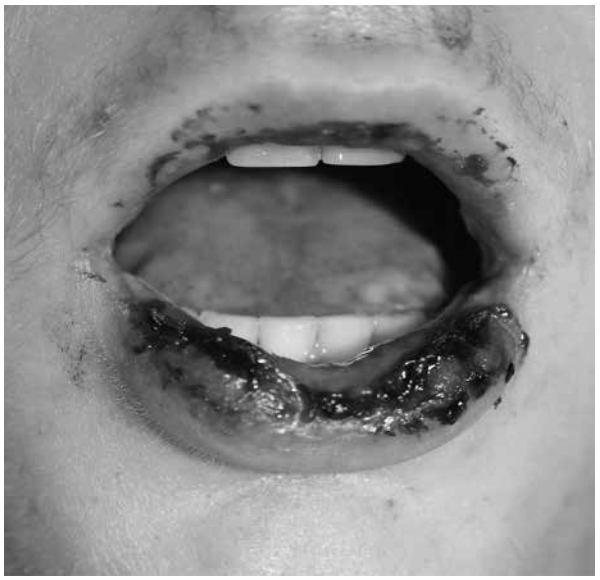
Department of Internal Medicine, Flevoziekenhuis, Almere, the Netherlands, *corresponding author: tel.: +31 (0)36 8688717, fax: +31(0) 368 688898, e-mail: jbranger@flevoziekenhuis.nl

CASE REPORT

A 20-year-old Caucasian male presented at our clinic with fever, a sore throat, coughing, red swollen eyes, photophobia, blurred vision and crusted lips for ten days. He had no relevant medical history and was not taking any medication. On physical examination the patient was febrile (39.4°C) without dyspnoea. The ophthalmologist diagnosed a bilateral keratoconjunctivitis (*figure 1*). Furthermore, he had a severe stomatitis with crusted swollen lips (*figure 2*) and pharyngitis. No lymphadenopathy or genital ulcers were present. Blood analysis showed a mild leucocytosis (10.5 x 10^9/l, 73.7% neutrophils) and elevated C-reactive protein (127 mg/l).

Figure 1. *Red swollen eyes*

Figure 2. *Crusted lips with ulcera on the lips and tongue*



Arterial blood gas analysis showed hypoxaemia (PO_2 57 mmHg). The chest X-ray revealed an increased density in the right lower lobe, suggestive of a small infiltrate.

WHAT IS YOUR DIAGNOSIS?

See page 468 for the answer to this photo quiz.

ANSWER TO PHOTO QUIZ (PAGE 463)

KERATOCONJUNCTIVITIS, PHARYNGEAL ULCERA, HYPOXAEMIA AND FEVER

DIAGNOSIS

Our patient presented with fever, keratoconjunctivitis, stomatitis, pharyngitis and a respiratory tract infection. A chest computed tomography confirmed the diagnosis of pneumonia.

The differential diagnosis included a primary herpes simplex infection, other viral infections or a bacterial infection. Our patient was empirically treated with acyclovir and amoxicillin-clavulanic acid intravenously. Extensive testing (cultures, serology, polymerase chain reaction (PCR) revealed a positive *Mycoplasma* complement binding reaction of >1:128 and a positive *Mycoplasma* pneumonia PCR on a throat swab. Therapy was subsequently switched to azithromycin for five days after which the symptoms resolved completely.

Mycoplasma pneumoniae is a small organism frequently causing upper respiratory tract infections, but also pneumonia. Infection rates are highest among adolescents.[1] Although *M. pneumoniae* usually causes a mild self-limiting disease, there are case reports describing fulminant *M. pneumoniae* pneumonia.[1,2] Extrapulmonary manifestations, as seen in our case, are also reported in the literature. These include pharyngitis, otitis and sinusitis. Rare manifestations are dermatological disorders, conjunctivitis, stomatitis, arthralgia and haemolysis.[1,3] Latsch *et al.* reported on two adolescents with conjunctivitis, genital erosions, exudative and ulcerative stomatitis (without skin lesions) due to an acute *M. pneumoniae* infection.[4] Clinicians should include diagnostic tests for *M. pneumoniae* infection in patients presenting with fever, pneumonia, conjunctivitis, or mucocutaneous lesions.

REFERENCES

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