## References

1. Jacobson MA, O'Donnell JJ, Porteous D, Brodie HR, Feigal D, Mills J. Retinal and gastrointestinal disease due to cytomegalovirus in patients with the acquired immune deficiency syndrome: prevalence, natural history, and response to ganciclovir therapy. *Q J Med* 1988; **67**: 473–486.
2. Wilcox CM, Diehl DL, Cello JP, Margaretten W, Jacobson MA. Cytomegalovirus esophagitis in patients with AIDS. *Ann Intern Med* 1990; **113**: 589–593
3. Connolly GM, Hawkins, D, Harcourt-Webster JN, Parsons PA, Husain OAN, Gazzard BG. Oesophageal symptoms, their causes, treatment, and prognosis in patients with the acquired immunodeficiency syndrome. *Gut* 1989; **30**: 1033–1039.


## Kikuchi's disease associated with Epstein–Barr virus infection

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Sir,

Kikuchi's disease (KD) is a cause of benign lymphadenitis known to have a worldwide distribution, reports of nearly 450 cases having been published.[1] We did not know, however, of any case in Portugal until a 15-year-old caucasian boy presented to us with pyrexia of unknown origin (PUO) and liver dysfunction.

The patient gave a 4 weeks' history of daily fever (39–40 °C), enlarged cervical lymph nodes, night sweats, chills, malaise, anorexia and a 4 kg loss of weight. He had complained of a sore throat during the first week and had developed a skin rash after a 1-day course of amoxicillin. He denied any other symptoms. His epidemiological history was unremarkable. On examination he had an axillary temperature of 39 °C and a single 3 cm × 4 cm, non-tender cervical lymph node and a few small supraclavicular nodes on the left side. His physical examination was otherwise unremarkable.

Laboratory investigation showed leucopenia ($3{\cdot}45 \times 10^9$/l) with relative lymphocytosis ($1{\cdot}7 \times 10^9$/l), ESR of 86 mm/h (Westergren), serum lactate dehydrogenase (LDH) 1287 IU/l ($n$ = 160–330 IU/l), serum alanine aminotransferase of 178 IU/l ($n$ = 0–29 IU/l) and aspartate aminotransferase of 121 IU/l ($n$ = 0–25 IU/l). All blood, urine stool and bone marrow bacterial cultures were negative. Acid-fast bacilli were not found in sputum, bone marrow, urine and gastric washings. His Mantoux test was negative. Bone marrow aspirate and biopsy, autoimmune studies, chest roentgenography and abdominal ultrasonography were unremarkable. Rose Bengal and Paul–Bunnell tests were negative. No yersinia antibodies were detected and toxoplasma and cytomegalovirus IgM and IgG titres were not raised. However, IgM VCA antibody to Epstein–Barr virus (EBV) was detected. During the first week in the ward the patient maintained a fever (39–40 °C), with progressive weight loss (5 kg), increased serum aminotransferases and LDH, sustained leucopenia and relative lymphocytosis. In the second week, a biopsy of a supraclavicular lymph node showed extensive necrosis within the cortical and paracortical areas, with karyorrhectic debris and no neutrophil polymorphonuclear leucocytes. No tubercle bacilli were seen. The specimen was reported to show benign necrotising lymphadenitis, consistent with Kikuchi's disease. Treatment with naproxen (250 mg b.d.), resulted in prompt lysis of the fever. Four weeks later, when he was discharged, he was apyrexial, regaining weight and had resolving cervical adenopathy. His serum aminotransferase values were improving. At a 6 month follow-up he was well, had no adenopathy and his aminotransferases were normal.

Kikuchi's disease is probably misdiagnosed in our country, and therefore, the clinical manifestations of this benign lymphadenitis should be more widely known and lymph node biopsy more readily performed. Kikuchi's disease with abnormal liver

function tests[1–4] and PUO[3–5] has been described recently. We suggest, as Bailey *et al.*,[3] and Pearl and Strauchen[5] have done, that KD must be considered a potential cause of PUO. Our patient's illness resolved following treatment with naproxen which is as Kapadia *et al.*[4] described, but why this drug is effective is not understood. The aetiology of the disease remains uncertain but an association with yersinia,[4,6] toxoplasma,[7] herpes virus 6,[6] EBV,[8] and more recently human immunodeficiency virus[9] and parvovirus B 19[1] infections has been suggested. Like Rivano *et al.*,[8] we found an association with the Epstein–Barr virus.

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## References

1. Meyer O, Ribard P, Belmatoug N *et al.* Trois cas de lymphadénite de Kikuchi au cours du lupus erythémateux systémique. Rôle du parvovirus B19. *Ann Méd Intern* 1991; **142**(4): 259–264.
2. Ohta A, Matsumoto Y, Ohta, T *et al.* Still's disease associated with necrotizing lymphadenitis (Kikuchi's disease): report of 3 cases. *J Rheumatol* 1988; **15**: 981–983.
3. Bailey EM, Klein NC, Cunha AB. Kikuchi's disease with liver dysfunction presenting as fever of unknown origin (letter). *Lancet* 1989; **ii**: 986.
4. Kapadia V, Robinson BA, Helen HB. Kikuchi's disease presenting as fever of unknown origin (letter). *Lancet* 1989; **ii**: 1519–1520.
5. Pearl D, Strauchen JA. Kikuchi's disease as a cause of fever of unknown origin (letter). *N Engl J Med* 1989; **320**(17): 1147–1148.
6. Feller AC, Lennert K, Stein H *et al.* Immunohistology and etiology of histiocytic necrotizing lymphadenitis: report of three instructive cases. *Histopathology* 1983; **7**: 825–839.
7. Kikuchi M, Yoshizumi T, Nakamura H. Necrotizing lymphadenitis: possible acute toxoplasmic infection. *Virchows Arch (A)* 1977; **376**: 247–253.
8. Rivano MT, Falini B, Stein H *et al.* Histiocytic necrotizing lymphadenitis without granulocytic infiltration (Kikuchi's lymphadenitis). Morphological and immunohistochemical study of eight cases. *Histopathology* 1987; **11**: 1013–1027.
9. Pileri SA, Sabattini E, Costigliola P *et al.* Kikuchi's lymphadenitis and HIV infection. *AIDS* 1991; **5**(4): 459–461.

## *Gemella morbillorum* endocarditis in an intravenous drug abuser

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Sir,

*Gemella* species rarely cause infective endocarditis. We wish to report a case of endocarditis caused by *Gemella morbillorum*. There appear to be only two previous reports of endocarditis caused by *G. morbillorum*, formerly *Streptococcus morbillorum* in the U.K.[1] *Streptococcus morbillorum* was recently transferred to the genus *Gemella* as a result of DNA homology studies.[2]

A 19-year-old male intravenous drug abuser presented in October 1990 with a 2 weeks' history of malaise, night sweats and intermittent fever. He had started injecting heroin at the age of 14 years. Since then, he had been on various drug rehabilitation schemes, all unsuccessful. In the months before his admission to hospital, he had been