

A 32-year-old woman with fever, sore throat, jaundice and pulmonary infiltrates

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A previously healthy 32-year-old woman was referred from a secondary care hospital with fever, dyspnea and icterus. She had acute tonsillitis 17 days earlier (treated with a first-generation cephalosporin). Six days before admission, fever relapsed and the patient presented with dysphagia, tenderness and swelling along the right sternocleidomastoid muscle, dry cough and dyspnea. She was treated with clarithromycin for 5 days, but the dyspnea worsened and she developed chest pain and icterus. However, her neck swelling improved. Laboratory tests performed in the secondary care hospital showed anemia (Ht 33%), leukocytosis (white blood cells 23 000/ μ L), mild thrombocytopenia (98 400/ μ L), and elevation of creatinine, bilirubin and aminotransferase values. Prothrombin time was increased (15.9''/11.5'').

Upon admission, she looked severely ill. On physical examination, her temperature was 37.5 °C, her blood pressure was 110/70, her pulse was 110/min and there were diffuse respiratory crackles. Laboratory tests showed anemia (Ht 28.4%), leukocytosis (WBC 23 450/ μ L, neutrophils 90.9%, lymphocytes 5.8% with few activated lymphocytes, monocytes 2.3%, eosinophils 0.1%), platelets 122 000/ μ L, erythrocyte sedimentation rate 120 mm/h, urea 136 mg (%), creatinine 1.8 mg (%), total bilirubin 4.5 mg (%), aspartate aminotransferase (AST) 144u/L, alanine aminotransferase (ALT) 180 u/L, prothrombin time 16''/12.3'', direct Coombs (+), Fe 33 μ g/dL, ferritin 507 ng/mL. Urinary microscopy: microscopic hematuria, culture negative. Pharyngeal culture: normal flora. A chest X-ray showed a nodular lesion and unilateral pleural effusion. Pleural aspiration revealed a sterile exudate. Transthoracic echocardiography study showed a pericardial effusion. Blood cultures were taken. Widal, Wright, FTA, serologic tests for Epstein–Barr and Coxsackie viruses, HBV, HCV, HIV, CMV, HSV, *Legionella* spp., *Rickettsia* spp. and *Leptospira* spp. showed no evidence of current infection. Chest contrast-enhanced high-resolution computed tomography (HRCT) revealed multiple cavitated nodular lesions, infiltrates and pleural effusion; this is shown in Figure 1.

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QUESTIONS

1. What is the diagnosis and how was it confirmed?
2. What are the main clinical, laboratory and imaging characteristics of the syndrome?
3. What treatment would you recommend?

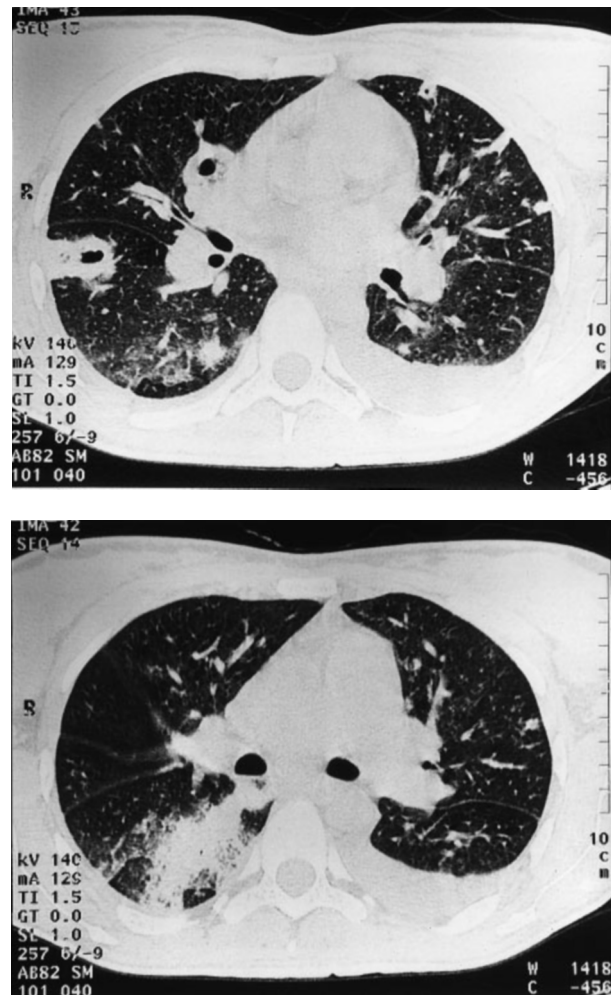


Figure 1

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