

CLINICAL IMAGE

A classical image of a rare entity

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Keywords - Lemierre syndrome, septic emboli, fusobacterium necrophorum

Abstract

A 21-year-old male without a medical history presented to the emergency department after five days of non-resolving pain in his throat. What started as a mild discomfort in the throat progressed into a severely painful throat while swallowing. The patient had a high fever and developed a progressive headache, nausea and diarrhoea.

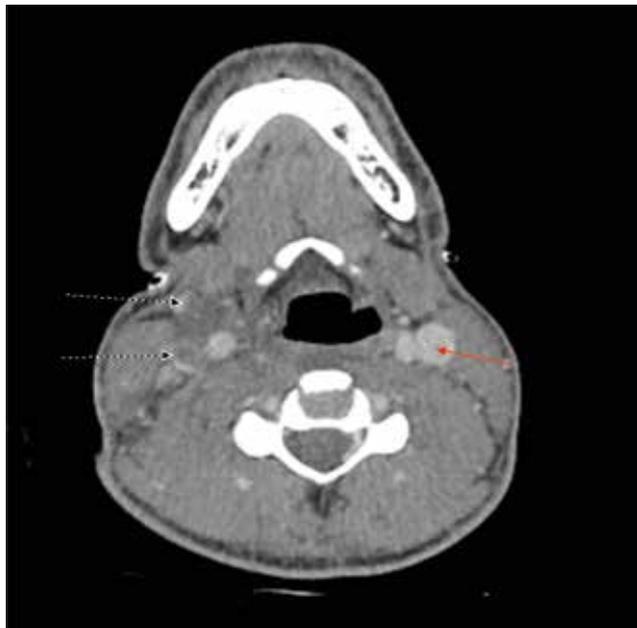


Figure 1. CT of the neck with a peri-tonsillar mass, and absence of contrast suggesting thrombus in the right internal jugular vein (black arrow) as compared with the normal internal jugular vein on the left (red arrow).

On presentation to the emergency department the patient appeared critically ill. He had a high fever, a sinus tachycardia, and a low blood pressure. There was no stridor. The lactate level was elevated. There were no respiratory symptoms, the chest

examination was normal and the chest X-ray was unremarkable. Inspection of the throat with a fiberscope by the ear-nose-throat physician did not show a threatened airway and there were no abnormalities seen in the oropharyngeal cavity.

Because of his septic profile he was admitted to the intensive care department. The patient was treated with cefuroxime, metronidazole and a single dose of tobramycin. His haemodynamic condition improved promptly after fluid replacement and vasoactive therapy.

About six hours after admission to the intensive care department the patient developed respiratory failure and needed to be intubated.

The computer tomogram (CT) of the neck revealed a thrombotic mass in the right internal jugular vein (*figure 1*). A CT of the thorax showed bilateral round consolidations suspected for septic emboli (*figure 2*). Blood cultures became positive for *Fusobacterium necrophorum*, and *Prevotella melaninogenica*. Both were sensitive to metronidazole.

The clinical presentation in combination with the findings on the CT of the neck and the positive blood cultures are typical for the diagnosis of Lemierre's disease. The patient recovered without sequelae.



Figure 2. CT thorax; a slice just below the main carina. Multiple consolidations in both lungs suspected for septic emboli (arrows).