

FEVER & RASH | The perplexing presentation of a common disease

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INTRODUCTION

Epstein-Barr virus (EBV) is a widely disseminated herpesvirus that is spread by intimate contact between susceptible persons and asymptomatic EBV shedders. Though the majority of EBV infections worldwide are sub-clinical, EBV can cause a number of primary infections, complications and malignancies and should be considered in the differential for any patient presenting with fever, rash and cytopenias (particularly lymphocytopenia).

CASE DESCRIPTION

35 year old G5P4 was admitted to the hospital 17 days post partum with acute onset fever, arthralgia and rash.

- Symptoms started approximately 2 weeks post partum
- Daily fever (102-103 F)
- Extensive pruritic rash (face, torso, upper and lower extremities)
- Diffuse painful swelling of bilateral hands and feet



ROS

- Recent productive cough
- No coryza, rhinorrhea, chest pain, dyspnea, abdominal pain, dysuria, diarrhea, initiation of new medication (except Labetalol) or sick contacts
- No prior history of arthralgia, IBD, rash, or uveitis



Family Hx

- Younger sister died from complications of leukemia
- Maternal grandmother with hx of thyroid malignancy



PMHx

- Gestational Diabetes and Preeclampsia
- Iron Deficiency Anemia



Medications

- Labetalol 300 mg BID (discontinued 12 days post partum)
- ASA 81 mg daily
- Ferrous Sulfate 325 mg daily

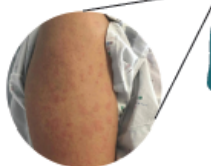
PHYSICAL EXAM

Vitals: T max: 103.3 F, HR: 94, BP: 120/80, RR: 16, SpO2: 97% on RA

General: Young female, NAD

HEENT: No scleral injection or discharge, no oral lesions

Skin: Diffuse urticarial rash



Cardiovascular: RRR, no murmurs/rubs or gallops

Respiratory: No respiratory distress, clear to auscultation bilaterally

Gastrointestinal: NABS, soft, NTTP, no hepatosplenomegaly

MSE: non-pitting edema of bilateral hands with associated tenderness to palpation of left 2nd and 4th DIP and 2nd and 3rd MCP

LABORATORY STUDIES

CBC

1.97 $\frac{10}{30}$ 123

Differential

- 74% neutrophils
- 11% lymphocytes (low)
- 1.8% monocytes
- 13.3% eosinophils (high, though absolute eosinophil count normal)

BMP

137/4.0/107/22/8.0/0.42/93

LEIs

AST: 59 (last 20)
ALT: 96
Alk Phos: 186
T.Bili: 0.5
Total Protein: 7.5
Albumin: 3.1

ANA: negative
C3: 148 (nl)
C4: 15 (low, nl range 16-47)

HIV 1-2: negative
HCV Ab: not detected
HBV not detected
Group A Strep: negative
CMV: negative
EBV: Positive, EBV Ab to viral capsid antigen IgG >600, IgM not detected,
Ab to nuclear Ag >600, EBV Ab to early D antigen IgG positive

DISCUSSION

Rheumatology was consulted due to concern for possible autoimmune etiology, particularly SLE, who felt history and exam were not typical for SLE, though advised checking ANA and complements, which were negative and normal respectively.

Dermatology was consulted and their differential for her urticaria was broad, including infection and malignancy given her leukopenia.

Hematology was consulted who felt her cytopenias were likely secondary to marrow suppression from viral infection versus medication toxicity and recommended checking for infectious etiologies. Evaluation notable for negative HIV 1-2, negative hepatitis C Ab, non-detectable hepatitis B surface Ag, surface Ab and core Ab, negative group A streptococcus, negative CMV and positive EBV studies (EBV Ab to viral capsid antigen IgG > 600, Ab to nuclear Ag >600 and detectable EBV Ab to early D antigen). Based on this constellation of findings and EBV results, diagnosis of EBV viremia was made. Patient clinically and objectively improved and was able to be discharged home with continued supportive care.

Most people will be infected with Epstein-Barr virus during their lifetime and remain asymptomatic. Associated signs/symptoms include fatigue, fever, sore throat, lymphadenopathy, hepatosplenomegaly, rash, neurologic disorders and hematologic disorders including cytopenias which can mimic other rheumatologic, malignant or viral diseases. Checking antibodies against EBV capsid antigen, which typically appear at the onset of acute infection and remain positive for life, EBV nuclear antigen-2 and EBV early Ag can be helpful in diagnosis.

TAKE HOME POINTS

- 1) Consider EBV infection in patients with fever, rash and cytopenias.
- 2) Confirm EBV diagnosis by checking EBV viral capsid Ag (IgM and IgG), Early Ag, and EBV Nuclear Ag.
- 3) Supportive care is the cornerstone of treatment for acute EBV infection/viremia. There is limited data to support the use of corticosteroids or antiviral agents.

REFERENCES

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Pancytopenia Framework



Blood Smear

