An 11-year-old girl was admitted with fever, left preauricular pain and swelling and left eye pain. She had fever for 3 days before admission, and developed a diffuse maxillary preauricular rash after discharge from the hospital. She was diagnosed with oculoglandular infection due to endemic typhus based on serology.

Introduction

Parinaud’s oculoglandular syndrome is characterized by unilateral granulomatous conjunctivitis and ipsilateral preauricular and/or cervical lymphadenopathy [1].

It was first described by Henri Parinaud in association Bartonella henselae infection. It has since then been associated with other bacterial, viral and fungal infections.

Case Report

A previously healthy 11-year-old girl developed left preauricular pain, followed by swelling and fever for over four days. The family had a cat and recently adopted a kitten. She had 2 cm firm and tender left preauricular mass without overlying skin erythema. Initially treated with oral clindamycin for possible abscess/parotitis as outpatient.

On the same day, she developed swelling and erythema of left upper eyelid. Seen in our ER, and admitted for treatment of cellulitis with intravenous vancomycin and ceftriaxone.

On admission her white blood cell count was 5,500 cells/mL, with 54% segmented cells, 12% monocytes, 5% lymphocytes and 4% atypical lymphocytes. Hemoglobin of 13.5 g/dL, and platelet count 201,000/mL. Blood culture final report no growth.

CT scan of the face and parotid glands was normal. She was afebrile on day 14 of her illness.

On day 11 of her illness: fever continued, complained of headaches and developed a diffuse macular rash. The patient became afebrile on day 14 of her illness.

Patient was discharged. Outpatient oral clindamycin for possible abscess/parotitis.

Fever continued up to 40.3°C for 9 days. Treated with azithromycin for suspected Bartonella henselae infection and discharged. Outpatient abdominal ultrasound was reported as normal. The Bartonella henselae panel drawn on admission was reported as negative IgG and IgM.

On day 14 of her illness: fever continued, complained of headache and developed a diffuse macular blanching rash. Her WBC 5100 cells/mL, 49% segmented cells, 7% lymphocytes, 14% monocytes, 2% bands, 24% lymphocytes and 6% atypical lymphocytes. ESR was 39 mm/hr, CRP 1.6 mg/dl.

Biopsy of the left parotid gland showed parotitis, without abscess formation. Treatment: Doxycycline is the drug of choice. Duration of treatment is at least 3 days after defervescence is documented.

This is, to our knowledge, the first reported case of endemic typhus causing Parinaud’s oculoglandular syndrome. In endemic typhus, the rash is usually maculopapular and is characteristic of the rash is faint and usually appears on days 4-7 of illness and lasts 4 to 8 days. Additional symptoms include abdominal pain, myalgia and cough.

Treatment: Doxycycline is the drug of choice. Duration of treatment is at least 3 days after defervescence and for 5-10 days after clinical improvement is documented. [10]

References