A 45-Year-Old Male with Rash, Fever, and Diarrhea

A 45-year-old male was admitted with profuse watery diarrhea, rash, and a fever. His present illness began approximately 1 week prior to admission, when he noticed a fever, chills, headache, cough, nausea, vomiting, and profuse watery diarrhea. He also developed a rash that began on his face and spread quickly over his body in less than 24 h, sparing his palms and soles. His admission temperature was 99.7°F, and his pulse was 76 beats/min. The results of the relevant physical examination were unremarkable except for conjunctival suffusion and rash. His white blood cell (WBC) count was $8 \times 10^3/\mu l$ (normal range [n] $= 3.9 \times 10^3$ to $11 \times 10^3/mm^3$) (neutrophils, 61%; lymphocytes, 9%; monocytes, 5%; eosinophils, 2%; and atypical lymphocytes, 7%), with a platelet count of $116 \times 10^3/mm^3$ (n = $160 \times 10^3$ to $392 \times 10^3/mm^3$). His alanine aminotransferase (ALT) level was 36 IU/liter (n = 4 to 36 IU/liter), his aspartate transaminase (AST) level was 43 IU/liter (n = 13 to 39 IU/liter), and his alkaline phosphatase level was 116 IU/liter (n = 25 to 100 IU/liter). His chest X-ray was unremarkable. He had been given pre- and intraoperative prophylactic antibiotics for a spinal surgery procedure 3 weeks earlier. He had received all of his scheduled childhood immunizations. His diarrhea was profuse and prolonged and was the main reason for his hospital admission, and Clostridiun difficile diarrhea was the working diagnosis. Stool specimens for C. difficile toxins were ordered. It was also thought the patient’s rash was due to antibiotics, as the distribution of the rash was consistent with a drug rash in that it was maculopapular and spared the palms and soles. Because this occurred in the summer months, enteroviral enteritis with rash and diarrhea was an alternate consideration, but cough is not a typical feature of enteroviral infections. Importantly, no Koplik’s spots were seen opposite the first molars on the buccal mucosa.

The diagnosis was established from a cytologic exam of a nasal specimen (Fig. 1).

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