findings are very similar to the “allopurinol hypersensitivity syndrome” [5] or phenytoin hypersensitivity [6] except for the absence of skin rash. Although it is possible that any of the drugs administered to the patient may have caused this reaction, the temporal relationship between clarithromycin administration and subsequent problems suggests that clarithromycin is the most likely culprit. The patient had been receiving treatment with furosemide since 1993 and captopril since September 1996.

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Valvular and Myocardial Abscesses
Due to Erysipelothrix rhusiopathiae

In humans, Erysipelothrix rhusiopathiae infection manifests primarily as a skin disease. Systemic infection with E. rhusiopathiae is uncommon, and <1% of all cases of E. rhusiopathiae infection results in bacteremia and endocarditis [1, 2]. We describe a case of E. rhusiopathiae bacteremia and subsequent development of valvular and myocardial abscesses in a patient with a history of consumption of undercooked pork.

A 78-year-old man with a history of chronic alcohol abuse was admitted to the hospital with chills, weakness, fatigue, and poor appetite 3 weeks after noticing streaks of blood in his stools. He had consumed a batch of partially cooked pork over a 1-week period before the episode of blood in his stools. Blood cultures yielded non–spore-forming gram-positive bacilli consistent with Lactobacillus species. Therapy with intravenous penicillin G was initiated, but the patient left the hospital the next day and stopped receiving penicillin G therapy. One week later, he was readmitted with shortness of breath on exertion, and a transesophageal echocardiogram revealed vegetations on the mitral valve with mild mitral regurgitation. Intravenous penicillin G therapy was restarted, but over the next few days, he developed acute congestive heart failure and was transferred to our institution.

Physical examination was remarkable for heart failure, and cardiac examination revealed a grade 5/6 pansystolic murmur in the mitral area and a grade 4/6 early diastolic murmur in the aortic area. A transthoracic echocardiogram revealed severe aortic and mitral regurgitation, as well as vegetations on the aortic and mitral valves. On the same day, organisms recovered in previous blood cultures were reidentified as E. rhusiopathiae by the state public health laboratory. The dosage of intravenous penicillin G was increased to 4 million U every 4 hr, and the patient underwent replacement of the mitral and aortic valves on the following day. During surgery, he was found to have a large abscess on the aortic valve with disruption of the entire valve. The abscess extended to the anterior leaflet of the mitral valve and the septum. A second abscess was identified; this abscess involved the posterior leaflet of the mitral valve and extended to the posterior wall of left ventricle.

Histopathologic examination of the heart valves showed findings consistent with infective endocarditis. Subsequent blood cultures were all negative. The patient did well postoperatively and was discharged to home; medication at the time of discharge was intravenous penicillin G to be continued for a total of 6 weeks.

Domestic swine is the major reservoir of E. rhusiopathiae [3].

Table 1. Laboratory findings for a patient receiving clarithromycin treatment that resulted in acute interstitial nephritis and thrombocytopenia.

<table>
<thead>
<tr>
<th>Finding</th>
<th>11/22/96</th>
<th>1/12/97</th>
<th>1/13/97</th>
<th>1/14/97</th>
<th>1/15/97</th>
<th>1/16/97</th>
<th>1/17/97</th>
<th>1/18/97</th>
<th>1/19/97</th>
<th>1/23/97</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total WBCs/mm³</td>
<td>5.6</td>
<td>11.2</td>
<td>19.6</td>
<td>17.1</td>
<td>18.6</td>
<td>17.9</td>
<td>20.1</td>
<td>23.2</td>
<td>16.8</td>
<td>19.5</td>
</tr>
<tr>
<td>Eosinophils (%)</td>
<td>9.2</td>
<td>10.0</td>
<td>10.0</td>
<td>28.0</td>
<td>42.0</td>
<td>48.0</td>
<td>16.0</td>
<td>12.0</td>
<td>28.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Creatinine level (mg/dL)</td>
<td>3.4</td>
<td>4.9</td>
<td>6.5</td>
<td>7.2</td>
<td>6.9</td>
<td>5.5</td>
<td>4.1</td>
<td>2.6</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td>BUN level (mg/dL)</td>
<td>13.0</td>
<td>30.0</td>
<td>42.0</td>
<td>54.0</td>
<td>63.0</td>
<td>69.0</td>
<td>67.0</td>
<td>62.0</td>
<td>57.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Eosinophils in urine (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Platelets/mm³</td>
<td>214</td>
<td>206</td>
<td>154</td>
<td>83</td>
<td>71</td>
<td>45</td>
<td>67</td>
<td>62</td>
<td>57</td>
<td>27</td>
</tr>
</tbody>
</table>

NOTE: BUN, blood urea nitrogen.
Most cases of endocarditis caused by *E. rhusiopathiae* occur after occupational exposure to animals, most commonly domestic swine [2]. Animal to human transmission is by direct cutaneous contact, although 2 reported cases of bacteremia (one with endocarditis) were reported to occur after ingestion of undercooked pork [4]. A carrier state in swine has been described and is thought to be important in transmission of the organism [2]. We postulate that the patient described here acquired *E. rhusiopathiae* infection by ingestion of undercooked pork and became bacteremic during an episode of gastrointestinal bleeding, since the organisms are known to persist in the gastrointestinal tract following ingestion of pork or fish. Our patient’s only known risk factor was chronic alcohol abuse [2], and there was no occupational exposure.

Acute or subacute *E. rhusiopathiae* endocarditis develops in >75% of septicemic cases; it involves previously normal heart valves in ~60% of cases, with a high propensity for the aortic valve. The mortality rate associated with endocarditis due to *E. rhusiopathiae* is 38% compared with 20% associated with endocarditis due to other organisms [2]. Despite appropriate antibiotic therapy, about one-third of patients require valve replacement [2], thus indicating the destructive nature of endocarditis caused by *E. rhusiopathiae*. Predisposing factors include alcohol abuse (33% of cases), immunosuppression due to any cause (17%) [2], chronic debilitating diseases, and intravenous drug abuse [5]. Intravenous penicillin G at high dosages (12–20 million U/day) for 4–6 weeks is the recommended primary antibiotic regimen. To our knowledge, this is the first reported case of valvular and myocardial abscesses due to *E. rhusiopathiae* after an episode of gastrointestinal bleeding in a patient with a history of consumption of undercooked pork.

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**References**


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**Subacute Thyroiditis Presenting as Pyrexia of Unknown Origin in a Patient with Human Immunodeficiency Virus Infection**

Subacute thyroiditis, also known as de Quervain’s thyroiditis, is a self-limited inflammation of the thyroid gland that may cause pyrexia of unknown origin [1]. It is the most common cause of a painful thyroid gland and is usually caused by a viral infection, often following an upper respiratory tract infection [1]. Several opportunistic infections related to infection with human immunodeficiency virus (HIV), including *Pneumocystis carinii* infection, can involve the thyroid gland and result in thyroiditis [1–3]. Only one case of presumed viral thyroiditis in AIDS has been reported previously [4]. We describe a case of subacute thyroiditis presenting as pyrexia of unknown origin in an HIV-infected man.

A 53-year-old man was admitted to the hospital with a 1-month history of lethargy and a 5-kg weight loss. He also described 5–10 days of exertional dyspnea, dry cough, fleeting arthralgias and myalgias, occipital headaches, and night sweats. He also had a 1-year history of diarrhea, which had recently worsened. HIV infection was diagnosed in 1986; at that time, the patient did not have a history of opportunistic infections. At admission, his CD4 cell count was 157/mL, the viral load was undetectable, and his medications were stavudine, didanosine, nelfinavir, co-trimoxazole, and acyclovir.

Physical examination revealed a temperature of 37.4°C and heart rate of 105. There were no other abnormal findings. Laboratory studies disclosed the following values: hemoglobin, 147 g/L; white blood cells, 12.7 × 10⁹/L (72% neutrophils); and platelets, 343 × 10⁹/L. Results of liver and renal function tests were normal, and testing for serum cryptococcal antigen was negative. A chest roentgenogram was clear, and cultures of stool and urine resulted in no growth. Three sets of blood specimens for culture were obtained, and the patient was prescribed roxithromycin for treatment of presumed bronchitis and loperamide for treatment of diarrhea.

The patient continued to be febrile in the absence of new physical findings. By day 4, all blood cultures and examination of an induced sputum specimen were negative, and there were no abnormal findings on thoracic and abdominal computed tomography (CT) (with contrast medium) scans. On day 6, the patient complained of superficial anterior neck pain, with associated mild odynophagia. Physical examination showed a tender beefy anterior neck mass, tachycardia, anxiety, and mild proximal lower limb weakness. There was no ophthalmoplegia.