Lemierre’s syndrome: A forgotten entity with a very rare presentation

Sailesh Kumar Bansiwal, Prabal Rajvanshi, Harshita Sharma, Rajesh Manocha

ABSTRACT

Lemierre’s syndrome is a potentially lethal condition, which originates as a complication of an oropharyngeal infection which causes suppuration of lateral pharyngeal space, bacteremia, and thrombophlebitis of internal jugular vein (IJV) leading to distant septic emboli. This is a forgotten disease in modern era of antibiotic therapy though it has been reported with increasing frequency in 21st century. We present a case of 34-year-old female who presented with fever, headache, neck pain, odynophagia, and hemoptysis, found to have thrombosis of IJV and Internal Carotid Artery (ICA) on imaging which responded to antibiotics and anticoagulant therapy. A high index of suspicion is necessary for diagnosis and early treatment is life saving.

Keywords: Lemierre’s syndrome, Forgotten disease, Septic thrombophlebitis of internal jugular vein, ICA thrombosis

INTRODUCTION

Lemierre’s syndrome, also known as postanginal septicemia or necrobacillosis was first reported in 1890. It was named after André Lemierre who explained the disease in 1936[1]. It is usually caused by gram negative anaerobic bacillus Fusobacterium necrophorum [2]; however Peptostreptococcus, Staphylococcus, Streptococcus and Proteus have also been isolated. The disease progresses in several steps following a primary infection, which is usually pharyngitis (87.1%). Further invasion of deep neck spaces occurs, leading to
internal jugular vein (IJV) thrombophlebitis (71.5%), and infective metastasis to distant sites most commonly to lungs (79.8%) [3]. Imaging and other investigations help in the diagnosis. Surgery is seldom required as prolonged IV antibiotics have been documented as the mainstay of treatment.

CASE REPORT

A 34 year old housewife presented to us with a short history of fever, headache for 20 days; odynophagia, neck pain, right sided facial swelling for 10 days; and hemoptysis for 5 days. Patient denied any history of seizures, altered sensorium, photophobia, arthralgias. The past history was unremarkable.

On examination, the patient was ill looking, tachypneic, and febrile to touch. However, her vitals were normal with pulse rate of 104/min, and blood pressure of 130/80. General examination showed right sided facial swelling and tenderness along the right sided sternocleidomastoid. Oral examination revealed inflammation of right tonsillar fossa. In the systemic examination, there were fine infraaxillary crepitations in bilateral lungs; and neurological examination showed terminal neck rigidity; while the examination of other systems was unrewarding. (Figure 1A, 1B, 1C).

Laboratory data showed total leukocyte count of 18,650 (4,500–11,000 per μl) with 86% neutrophils. C-reactive protein (CRP) with value 31mg/L (0-10mg/L) and erythrocyte sedimentation rate (ESR) with value 62 mm/hr (0-20mm/hr) were significantly raised; anti-nuclear antibody (ANA), anti-phospholipid antibody (APLA), protein C, protein S, Factor 5 Leiden, antithrombin, homocysteine were normal. HIV was non-reactive. Cerebrospinal fluid analysis revealed 40 cells with 98% lymphocytes while adenosine deaminase (ADA), proteins and sugar were insignificant.

Ultrasoundography of abdomen and echocardiography were normal; however, ECG showed sinus tachycardia. The chest radiograph showed bilateral patchy shadows with mild bilateral pleural effusion. (Figure 2A, 2B)

MRI head and neck showed right peritonsillar abscess, thrombosis of bilateral proximal IJV along with the thrombosis of right sigmoid sinus and left retromandibular vein; it also suggested bilateral ethmoid and sphenoid sinusitis / abscess, with extension of abscess to bilateral masticator space caudally and cranially to dura leading to subdural abscess and leptomeningitis.

A CT angiography chest (figure 3a) and neck (figure 4a,b,c,d) was done which revealed thrombosed left ICA, partially thrombosed left IJV, sphenoid sinusitis and cavitation in bilateral lung fields suggestive of septic emboli. Colour doppler bilateral neck was done to assess the extension of thrombus in the vessels, surprisingly it
showed involvement of both IJV (partially occluded) and ICA (80% occluded) of left side.

Blood (anaerobic and aerobic), urine, sputum, and throat cultures were negative as the patient had received antibiotics prior to admission in our hospital.

The patient was given IV ceftriaxone (1 g q12 h), vancomycin (1 g q12 h), and clindamycin (600 mg q8 h) for 4 weeks; she also received anticoagulation with LMW heparin (6 mg SC q12 h) and acenocoumarol (2 mg q24h) and INR was monitored subsequently. Patient responded to the therapy as evident on radiographic resolution of the thrombosis both in IJV and ICA.

DISCUSSION

Lemierre’s syndrome, being a rare entity (incidence 1 in a million) [4] has been drawing our attention because of its increasing incidence and dreaded complications; reemergence of this disease is most likely due to the antibiotic resistance and discouragement of the use of antibiotics for sore throat.

This patient had been worked up to rule out the closely mimicking differentials which were disseminated tuberculosis, cavernous sinus thrombosis, autoimmune vasculitis and thrombophilias.

Lemierre’s syndrome can have a spectrum of presentation ranging from mild pharyngitis to peritonsillar abscess. However, sinusitis, otitis media, mastoiditis, and odontogenic infections have also been described rarely. Sinusitis / sinus abscess (sphenoid and ethmoid) was probably the primary source of infection in our case (as per the history given by the patient), which involved the pharynx (peritonsillar abscess), lateral pharyngeal space, masticator space and the meninges. Meningitis in this case could be either due to direct spread from the sinus (sphenoid and ethmoid), or indirect spread through septic emboli (via ICA & IJV), or retrograde involvement of the sigmoid sinus (via IJV). There was involvement of the carotid sheath which was evident on CT angiography and color Doppler neck, leading to thrombosis of ICA and IJV. In our case, ICA thrombosis could be either due to its proximity to IJV or due to septic emboli. Though involvement of ICA is rarely reported in the literature but in our case, this finding was very much evident on the imaging. Considering the endovascular nature of the disease, metastatic spread most commonly involves the lungs (79-100%)[3]; however, joints, bones, skin, liver, kidney may also be involved.

A prolonged antibiotic course (2-6 weeks) is needed in order to eradicate the microorganisms within the thrombus. The role of anticoagulation is controversial, however, some authors consider it if there is extension of thrombosis. Surgical intervention is seldom required in the present era.

Untreated cases may have mortality of upto 90%[5]. The prognosis of Lemierre’s syndrome is favorable if there is early diagnosis and treatment. Rare presentation of Lemierre’s syndrome, ICA thrombosis along with IJV thrombosis, meningitis and sinusitis are being highlighted in our case report.
CONCLUSION

Lemierre’s syndrome occurs primarily in young, otherwise healthy individuals and is characterized by a history of recent oropharyngeal infection, clinical or radiological evidence of IJ venous thrombosis and anaerobic bacteremia caused primarily by F. necrophorum. This is a rare illness in the modern era of antibiotic therapy, though it has been reported with increasing frequency in the twenty-first century. Lemierre’s syndrome should be suspected in young, healthy patients with prolonged symptoms of pharyngitis followed by symptoms of septicemia or pneumonia, or an atypical lateral neck pain. Diagnosis is often confirmed by the identification of IJ vein thrombophlebitis by an imaging study and growth of anaerobic bacteria on blood culture. Prolonged antibiotic therapy is the cornerstone of treatment, occasionally combined with anticoagulation.

Conflict of Interest
Authors declare no conflict of interest.

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