Lemierre’s Syndrome

Jennifer Nguyen
*Providence St. Vincent, Internal Medicine Residency, Portland, Oregon*

Tom Chau
*Providence St. Vincent, Internal Medicine, Portland, Oregon, TOM.CHAU@providence.org*

Follow this and additional works at: https://digitalcommons.psjhealth.org/psv_internal

Part of the Internal Medicine Commons

**Recommended Citation**
https://digitalcommons.psjhealth.org/psv_internal/8

This Poster is brought to you for free and open access by the Oregon Academic Achievement at Providence St. Joseph Health Digital Commons. It has been accepted for inclusion in Providence St. Vincent Internal Medicine by an authorized administrator of Providence St. Joseph Health Digital Commons. For more information, please contact digitalcommons@providence.org.
Lemierre’s Syndrome
Jennifer Nguyen, MD and Tom Chau, MD
Providence St. Vincent, Internal Medicine Residency, Portland, Oregon

INTRODUCTION
Lemierre’s syndrome is a rare and potentially fatal complication of acute pharyngitis most commonly seen in healthy, young adults who present with neck pain and persistent, high-grade fever.

It is caused by anaerobic gram-negative organisms, most often Fusobacterium necrophorum, spreading into the deep spaces of the neck. This leads to septic thrombophlebitis of the internal jugular vein (IJ) with septic emboli, most frequently to the lungs.

CASE REPORT
A healthy 18-year-old woman presented to the hospital with five days of fever, rigors, sore throat, and left neck pain.

She appeared relatively non-toxic but was febrile to 105.6°F and in septic shock.

Her source of infection was initially unclear.

Her work up included:
• Normal CT neck with contrast and urinalysis.
• CT abdomen and pelvis coincidentally showed multiple septic emboli within the lungs.
• Blood cultures grew F. necrophorum.

Re-evaluation of her admission neck CT revealed a modest filling defect in her left IJ.

With her constellation of sore throat, left IJ thrombophlebitis, septic pulmonary emboli, and F. necrophorum bacteremia, her presentation was felt to represent Lemierre’s syndrome.

She was initially treated with piperacillin/tazobactam and then transitioned to IV penicillin G with rapid clinical improvement.

She was discharged home to continue two more weeks of IV penicillin G followed by two weeks of oral amoxicillin/clavulanate.

REFERENCES