Infectious Mononucleosis

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An 18-year-old man presented with a 3-day history of fever, sore throat, and neck swelling. He had previously been healthy, and his immunizations were up-to-date. There was no history of travel outside the country or of an animal bite or scratch. The patient's temperature was 39.5°C (103.1°F); heart rate, 98 beats per minute; blood pressure, 120/80 mm Hg; and respiration rate, 20 breaths per minute. The pharynx and tonsils were erythematous. Whitish exudates were seen in the tonsillar areas. The lymph node in the right posterior aspect of the neck was enlarged and tender. In addition, there were shotty lymph nodes in both cervical areas. There was no lymphadenopathy elsewhere. The spleen and liver were not palpable. Results of a throat swab proved negative for group A β-hemolytic streptococci. The patient was treated with benzydamine hydrochloride oral rinse and acetaminophen. The patient returned 24 hours later with a maculopapular rash covering the whole body. The hemoglobin level was 12 g/dL; the white blood cell count was 1350/μL, with 78% lymphocytes, 15% neutrophils, and 7% monocytes; and the platelet count was 150,000/μL. Results of a monospot test were positive. A diagnosis of infectious mononucleosis was made. At follow-up 3 days later, the patient’s rash had started to fade and the spleen was palpable 2 cm below the costal margin. Infectious mononucleosis is caused by the Epstein-Barr virus. It is transmitted primarily in saliva (hence, its colloquial appellation, “the kissing disease”) and, less commonly, by blood transfusion. The disease most commonly affects those aged 15 to 35 years, with a peak at 15 to 19 years. The incubation period from the time of viral exposure to development of infectious mononucleosis is approximately 4 to 7 weeks. The classic symptoms are fever, sore throat, and lymphadenopathy. The patient’s temperature may reach 38.8°C to 40°C (102°F to 104°F), and the fever may last for 1 to 2 weeks. The pharynx is usually diffusely inflamed. There is often marked tonsillar enlargement with thick tonsillar exudates. Palatal petechiae may be present. Lymphadenopathy occurs most commonly in the anterior and posterior cervical lymph nodes, but generalized lymphadenopathy may be observed. Splenomegaly is usual, and hepatomegaly may be present. The rash is usually maculopapular and occurs in approximately 10% to 15% of cases. Between 80% and 90% of patients who are treated with antibiotics containing ampicillin or amoxicillin experience a pruritic maculopapular rash. Treatment is mainly supportive. Reduction of activity and bed rest as tolerated are recommended. Advise patients to avoid contact sports or strenuous exercise for 2 to 3 weeks or while splenomegaly is still present. Most patients have an uneventful recovery.

(Case and photograph courtesy of Alexander K. C. Leung, MD, and Alfredo Pinto-Rojas, MD.)

REFERENCE:

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