ANSWER TO PHOTO QUIZ (PAGE 127)

RED EYES AND MUCOUS ULCERS

DIAGNOSIS

The complex of symptoms of conjunctivitis, stomatitis and urethritis, as can be seen in the clinical images, was mistakenly thought to be an allergic reaction. Taking into consideration the general malaise and the sore throat the patient had had previously, our preliminary diagnosis was *Mycoplasma pneumoniae* infection. The differential diagnosis included viral infection, systemic disease (Behçet's syndrome, Crohn disease or IgG4-related disease) and Stevens-Johnson syndrome.

The patient's serology was positive for *M. pneumoniae* IgG and IgM. Furthermore, laboratory analysis showed no eosinophilia (which could indicate an allergic reaction), autoimmune screening with ANA/ANCA was negative and there were no signs of arthritis. Absence of arthritis and aphthae makes Reiter syndrome and Behçet's syndrome less likely. In the blood cultures, no growth was seen. PCR assay on sputum was positive for both *M. pneumoniae* and herpes simplex virus (HSV) type 1. Primary infection or recurrence of HSV type 1 was less likely the cause of conjunctivitis or stomatitis because the lesions were neither vesicular nor painful and the conjunctivitis was bilateral. It is possible that there was a mild recurrence of HSV type 1 upon presentation.

Our diagnosis was *M. pneumoniae* associated mucositis (MPAM), also called *M. pneumoniae*-induced rash and mucositis (MIRM; and in this case MIRM sine rash). The patient was treated with azithromycin for three days. After one month his symptoms resolved completely. There was a decrease in *M. pneumoniae* serology titres (56.5 and 33.0 at diagnosis and 52.2 and 26.6 after one month for IgG and IgM, respectively).

M. pneumoniae is known for its extrapulmonary manifestations, which can include cardiovascular symptoms, symptoms of the digestive tract, neurological symptoms, symptoms of the haematopoietic system, urogenital symptoms and dermatological manifestations.[1] In fact, approximately 25% of the patients experience extrapulmonary symptoms.[2] *M. pneumoniae* can cause clinical images similar to toxic epidermal necrolysis, Stevens-Johnson syndrome (SJS) and bullous erythema multiforme. In the past years, however, MPAM or MIRM is more and more recognised as a separate entity instead of 'atypical SJS'.[1-3] Respiratory symptoms usually precede mucositis by a week; however, in patients with extrapulmonary manifestations of *M. pneumoniae* infection, overt pneumonia and even respiratory symptoms may be absent.[1,3]

In patients with MPAM/MIRM painful oral lesions are present in 94% of the cases,[3] ocular involvement is seen in 82% of the cases and urogenital lesions are present in at least 63% of the cases. Urogenital lesions are probably underreported. Anal lesions are rarely seen.[4,5] The exact aetiology of these extrapulmonary manifestations is unknown. The involvement of autoimmunity and formation of immune complexes is suspected, which explains the delay between respiratory symptoms and the onset of mucositis.[1] The optimal treatment strategy remains unclear, but supportive care is usually sufficient. There is evidence that suggests that antibiotic treatment and/or steroids reduce antigenic stimuli and bacterial load, which could lead to a decrease in immune responses. Treatment is seldom necessary, but should be considered in severe cases. The majority of patients recover completely.

REFERENCES

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