CASE REPORTS

Erythema nodosum – diagnostic difficulties in the accident and emergency department

Patrick Hyland-McGuire, Henry Guly

Abstract
Five patients presenting with erythema nodosum to an accident and emergency department are described. Initially they were misdiagnosed as cellulitis, infected insect bites, and minor trauma. Suspicious skin lesions or joint manifestations occurring either alone or especially if in combination should alert the wary clinician to the possibility of erythema nodosum and follow up in a few days may help to confirm the diagnosis. (J Accid Emerg Med 1996;13:211–212)

Key terms: erythema nodosum; diagnosis; misdiagnosis

Erythema nodosum is an uncommon skin eruption1 which may be a marker of underlying systemic disease. Clinical recognition should prompt investigation into possible causes, some of which are serious and amenable to treatment. In its early stages, the condition may mimic soft tissue infections2 or subacute musculoskeletal conditions,3 which are commonly seen in accident and emergency (A&E) departments. We report on five patients with erythema nodosum who were initially misdiagnosed in the A&E department

Case reports
CASE 1
A 36 year old woman with a previous right below knee amputation following trauma presented to the A&E department with a one week history of pain in her left leg with redness extending from the ankle to the knee which had failed to respond to flucloxacillin prescribed by her family doctor. This was initially diagnosed as cellulitis. She was admitted under the A&E service for rest, elevation, and intravenous flucloxacillin and benzylpenicillin.

The next day a “bruise” was noted on the right amputation stump. The original inflammation initially improved but over the next 7 d red patches appeared over both thighs, left elbow, left hand, and neck. A diagnosis of erythema nodosum was made and this was confirmed by a dermatologist. A chest x ray showed hilar lymphadenopathy. Antistreptolysin-O titre was normal. A clinical diagnosis of sarcoidosis was made. Follow up one month later revealed residual bruising over the area of the lesions.

CASES 2-5
Four further cases are summarised in the table.

Discussion
Erythema nodosum classically presents as bilateral, painful, red, tender nodules of varying size and number on the anterior shins.4 Much less commonly, lesions occur on the backs of the legs, thighs, soles of the feet, arms, and neck. Nodules may not necessarily be symmetrical and may appear at different times.5 Areas may become confluent and appear as a single lesion. Erythema nodosum is commonest in the third to fifth decade, with a female to male predominance of 3:1.

Erythema nodosum is associated with a wide spectrum of diseases and thorough investigation has been reported to yield an underlying cause in 67.5% to 95% of cases.6 Associated conditions include sarcoidosis, streptococcal infection, tuberculosis, histoplasmosis, other infections such as yersinia, mycoses, chlamydia and lymphogranuloma venereum, drugs (for example, oral contraceptives and sulphonamides), ulcerative colitis and Crohn’s disease, and neoplasms such as Hodgkin lymphoma and leukaemia. The

Clinical details of four further cases of erythema nodosum

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Presenting symptoms</th>
<th>Initial diagnosis</th>
<th>Initial treatment</th>
<th>Subsequent history</th>
<th>Underlying cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>F</td>
<td>31</td>
<td>Pain right hip and knee</td>
<td>Minor trauma</td>
<td>Nil</td>
<td>2 d: 5 nodules right lower limb</td>
<td>Sarcoidosis</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>36</td>
<td>Redness and swelling left shin (also bilateral Achilles tendinitis)</td>
<td>Cellulitis</td>
<td>Admitted for IV antibiotics</td>
<td>2 d: Pain and inflammation both shins</td>
<td>Sarcoidosis</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>9</td>
<td>“Insect bites” both shins Left worse than right</td>
<td>Insect bites both shins Left side infected Non-specific inflammation</td>
<td>Flucloxacillin</td>
<td>2 d: Pain left ankle ES: 68 mm/hour</td>
<td>None found</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>43</td>
<td>Pyrexia 39°C Pain left wrist with a red area over joint</td>
<td>Non-specific inflammation</td>
<td>Ibuprofen/splint</td>
<td>2 d: 8 nodules left shin diagnosed as insect bites</td>
<td>None found</td>
</tr>
</tbody>
</table>

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IV, intravenous
A confused drug addict: the importance of considering sepsis

P Cornelius, E Pourgourides, S Meek

Abstract
The case is reported of a 35 year old heroin addict presenting with acute confusion which was later found to be due to meningococcal meningitis. Other than his altered mental state, the only abnormal finding on examination was a mild pyrexia.


Key terms: sepsis; heroin addiction; acute confusion

Case report
A 35 year old male who is a registered heroin addict was brought by ambulance to the accident and emergency (A&E) department at 11 pm, accompanied by his girlfriend, who had found him in an aggressive and confused state. He was on a methadone replacement programme and had taken his normal dose of methadone in the morning, together with a small dose of intravenous heroin. He subsequently went to college and returned at midday complaining of a mild headache. His girlfriend then left him alone and returned in the evening to find that the room had been smashed up and the patient was acutely disturbed, violent, and aggressive.

On examination in the A&E department, he was alert but disorientated in both time and space and was aggressive and uncooperative. General physical examination was unremarkable apart from the presence of a mild pyrexia of 37.5°C; there was no focal neurological deficit, no neck stiffness, and no rash. Venepuncture was difficult because of his intravenous drug abuse and aggressive state. Eventually a small sample was obtained which was sent for a full blood count. This showed a haemoglobin concentration of 16.4 g/litre and a white count of 28.8 × 10⁹/litre, with 89% neutrophils. A diagnosis of toxic confusional state secondary to infection was made and he was admitted for further investigation, including computerised tomography brain scan and lumbar puncture. Because of continued agitation he required sedation and ventilation. Neisseria meningitidis was subsequently grown from his blood cultures and CSF samples. Tests for HIV were negative. His inpatient stay was protracted and complicated by broncho-