PHOTO QUIZ

An unexpected infectious disease in wintertime

V.J. Ruijters¹, H. Visser², B.P.X. Grady¹,³

¹Department of Intensive Care Medicine, University Medical Center Utrecht, Utrecht, the Netherlands; ²Department of Internal Medicine, Beatrix Hospital, Gorinchem, the Netherlands; ³Department of Intensive Care Medicine, Ziekenhuisgroep Twente, Almelo, the Netherlands.

*Corresponding author: v.j.ruijters@students.uu.nl

CASE REPORT

A 31-year-old patient, with known alcohol and drug abuse, was admitted on January 2nd, 2020 to our emergency room presenting with fever, stomach ache, vomiting, diarrhoea, myalgia, coughing, and headache for one week. The patient reported that he had cycled into a ditch after drinking too much alcohol, a week prior to admission. Initial laboratory examinations showed the following: C-reactive protein 464 mg/l, leucocytes 14.9 x 10⁹/l, thrombocytes 32 x 10⁹/l, creatinine 416 µmol/l, alanine aminotransferase 164 u/l, aspartate aminotransferase 281 u/l, gamma-glutamyltransferase 121 u/l, alkaline phosphatase 159 u/l, and bilirubin 123 µmol/l. A few hours after admission, the patient became respiratory insufficient, was admitted to the intensive care unit (ICU), and underwent endotracheal intubation. The chest X-rays and CT scan of the thorax predominantly showed diffuse infiltrative lung disease (figure 1). An ultrasound of the liver demonstrated no liver or bile duct pathology. In the following days, the patient’s vital parameters deteriorated and he developed an acute kidney injury, for which he received continuous renal replacement therapy. He was transferred to the ICU of the nearest academic hospital on day three. The patient’s transaminases were only modestly increased, in contrast to total bilirubin, which peaked at 413 µmol/l (direct 309 µmol/l) at day seven.

WHAT IS YOUR DIAGNOSIS?

See page 306 for the answer to this photo quiz.