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OSLER'S NODE IN A PATIENT WITH BRUCELLA ENDOCARDITIS

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Osler's Node is one of the classic Peripheral Sign of bacterial endocarditis(1), Which was first described by Osler as painful nodular lesions (2). These lesions size from one millimeter to one centimeter or more, may last from hours to several days and appear most commonly over the pulp of the fingers and toes, thenar and hypothenar eminences (2-7). A recent patient with brucellosis infectious endocarditis and cutaneous lesion at an unusual site (radial area of the wrist) with signs and symptoms of Osler's nodes made us to report this case to re-emphasize this valuable sign in a rare (8-9) type of endocarditis.

Case History:

A 20 year old peasant boy with a history of reumatic Carditis since childhood was admitted to Dr. Shariati Hospital, cardiovascular unit because of fever, night sweats, myalgia, backpain, dyspnea and palpitation. He was well until three months earlier when symptoms of congestive heart failure and infectious disease began to occur insidiously. Patient had the history of drinking "home milk" (unpasteurized) for years.

On admissin the patient was looking ill with an oral temperature of 38.9^{oC}, pulse rate of 120 beats per minute, respiratory rate of 28 per minute and a blood pressure of 135/35 mm Hg. Physical examination showed distended neck veins and pulsatile carotid artries with rapidly rising "water-hammer" pulse, long duration diastolic blowing murmur over left sternal border, grade III/VI, systolic ejection murmur at the base of the heart transmitted to jugular notch, grade III/VI apical pansytolic murmur with radiation into the axilla and a third heart sound. Lungs were clear. In the abdomen; an enlarged spleen that extended 3 centimeters below the left costal margin and enlarged liver with a span of 15 centimeters were palpable. Splinter hemorrhage under fingernails and marked scattered petechiae over both legs were noted. Funduscopic examination was normal. Laboratory results included Hemoglobin 7.8 g/dl white blood cell count of 4500, platelet count of 180000, reticulocyte count. %1 and sedimentation rate after one hour 60mm (Westergren). values for prothrombin time, FBS,BUN, Creatinin, liver function tests and urine analysis were normal. Blood, bone marrow aspiration and urine cultures were all nega-

tive. Brucella agglutination Test 1/6400, VDRL 1/8 and Reumatoid factor (anti IgG) by latex floculation 4 plus were positive. Widal agglutinatin and fluorescent treponemal antibody absorption tests were negative. Chest X-ray showed enlarged left Ventricle with pulmonary venous congestion. ECG was normal sinus rhythm with left ventricular hypertrophy. Echocardiography showed vegetations over anterior mitral valve leaflet. Technetium 99m liver and spleen scan revealed enlarged liver and spleen with nonhomogeneous absorption of radionuclide material in the liver. Per cutaneous liver biopsy confirmed granulomatous hepatitis Fig.1. Once the diagnosis of brucellosis was established, the patient was treated with combination of tetracyclin, streptomycin and rifampin. After complete remission Aortic and mitral valve replacement was done successfully.

Hospital Course

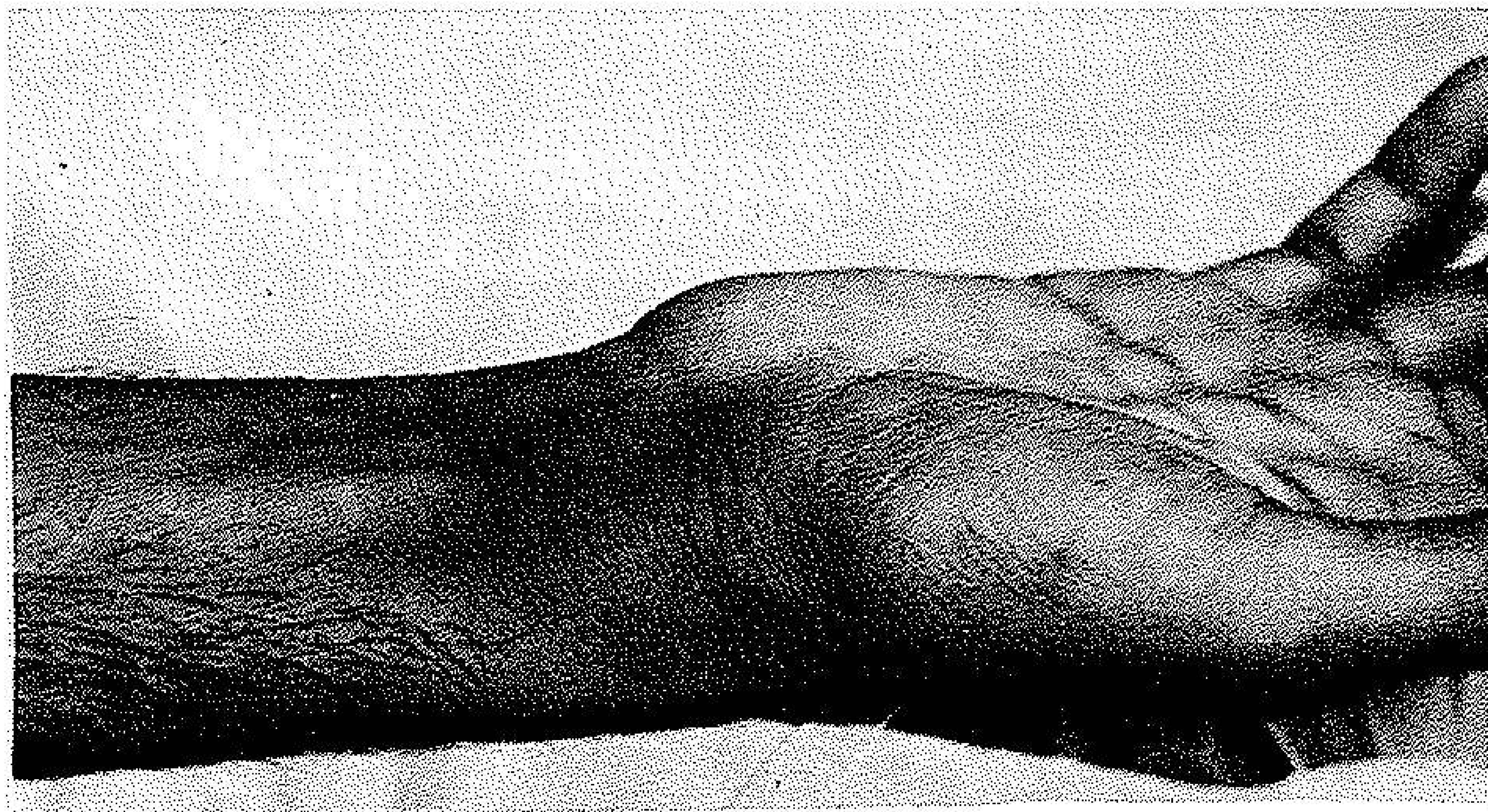

Figure 1: Microscopic view of liver shows infiltration of mononuclear cells in portal area, at the middle left border of the picture this infiltration has formed granuloma with irregular border (Hematoxylin Eosin 200X).

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