: : CASE REPORT : :

The Case Report to be presented was, for a long period of time a Pyrexia of Unknown origin. D. F. was a 33 year old, white fisherman, admitted early in May, to the Medical Ward of Camp Hill Hospital. He was a resident of Nova Scotia, and travelled very little. His family doctor admitted him with the diagnosis of Infectious Mononucleosis, having seen Downey cells on a blood smear. D. F's. complaints were fever (between 100-104 degrees) of two months' duration and dizziness for the same interval. The history and physical were otherwise non-contributory.

The results of laboratory tests for the first six weeks of admission are given next. AC blood sugar and NPN normal. Hemogram revealed a normochromic, normocytic anemia of 75.5% (10.95 gm.). Heterophile antibody test negative. Lymphocytes and monocytes were present in normal numbers. Repeated blood cultures were negative. Sample of blood for virus and rickettsial studies was negative. Blood for L.E. phenomeon also negative. Sternal marrow puncture was normal. Repeated urinalysis with exception of one, were negative for culture and routine exam. Stool cultures were negative for pathogenic enteric organisms. Widal Test was negative. No ova, cysts, nor parasites were found in the stools. Serology negative. Chest plate and ECG were normal on admission. Two lumbar punctures were done, CSF being normal, no organisms grown on culture. Meanwhile, the fever continued unabated, rising to peaks of 105 degrees. Near the end of May his hemoglobin was 64.5% and blood was given. He was then slightly jaundiced. Liver function tests other, than slight increase in serum bilirubin (direct) were negative. Despite negative intradermal P.P.D's. and repeated clear chest plates, D.F. was placed on tuberculostatic therapy, the feeling being that he could have miliary tuberculosis. There was a remission of fever only for a few days.

His condition was now poor. In the middle of June, a lymph node biopsy from the right axilla was done, the gland being just palpable. On June 24, the following lymph node microscopic report read, "the presence of necrosis, abnormal mitoses, and the replacement of the normal architecture of the lymph node by histiocytic cells is indicative of a serious lymphodenopathy, and the appearance is strongly suggestive of a form of Hodgkin's Disease." Immediately he was placed on Cortisone, 300 mg. daily, then Meticorten, 75 mg. daily, with almost complete remission of symptoms including the pyrexia for three weeks. Following this, he became quite jaundiced, pyrexic, anorexic, and anemic. Nitrogen mustard therapy was instituted with some improvement for a short period of time. Another course of nitrogen mustard therapy was moderately effective. During September he was given two courses of nitrogen mustard therapy, Meticorten, and repeated transfusions. Despite this therapy, he pursued a downward course with pyrexia up to 105 degrees, profound anemia, and, near the end, marked jaundice, the serum bilirubin being mainly direct. He had a prothrombin time of 41% which failed to rise despite adequate Vitamin K therapy indicating a parenchymal type of hepatitis. He developed a Staphylococcal bronchopneumonia treated with Chloromycetin. On October 4, D. F. died in oliguria with intense jaundice.

Briefly, the autopsy findings are presented. On gross examination, the lungs revealed a pyogenic bronchopneumonia. There was hepato-splenomegaly, both organs enlarged to twice their normal size, the spleen showing suet-like deposits typical of Hodgkin's. The kidneys were moderately enlarged. Only a few retroperitoneal lymph nodes were enlarged. On microscopic section, the lungs showed a Staph. bronchopneumonia modified by antibiotics. The marrow was revealed as ery-

trophagocytic. The lymph nodes, spleen, and liver revealed a reticuloses, a variety of Hodgkin's. There was a hepatitis. The kidneys were the site of mild glomerulonephritis (an endothelial proliferation) and there was a lower nephron nephrosis with deposition of haematin in the renal tubules.

This case is presented as an atypical form of Hodgkin's. There was except for remissions due to therapy, a continuous high pyrexia. There was no lymphadenopathy. The serum proteins were greatly reduced. The anemia was not completely of the hemolytic type. The highly fulminant course of seven months, with jaundice, anemia, and high pyrexia as principal features was similar to the course taken in a histiocytic medullary reticulosis.

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