[Streptococcal Infections]

GRAND ROUNDS

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The patient, [redacted]. was a 7 year old white male, admitted to [redacted] on [redacted] 1959, with the history that he had been known to have a heart murmur at the age of 11 months. The mother was aware of no symptoms related to the cardiovascular system. In [redacted] 1959, he had an abrasion on the right leg which was slow to heal and as a result of this abrasion he developed a regional lymphadenitis which was first noted on Labor Day. He came in from playing football and complained of pain in his hip. At this time he was noted to have a temperature of 101 degrees. On the following day he still complained of pain and the fever persisted. He continued to go to school but seemed listless and somewhat anorexic to the mother. He was seen by a physician on [redacted], 1959, because of a persistent temperature up to 101 daily. The physician prescribed a "mycin" suspension 1 teaspoonful every 6 hours. The patient did not improve on this medication and two days later, he was hospitalized. At the time of hospitalization, it was noted that he had a tender area on the undersurface of the great toe which later became purpuric. In the hospital he was given penicillin for 2 days. A blood culture during hospital stay was reported as negative. He was discharged from the hospital after 2 days and continued to take oral medication. Since the beginning of oral medication, his temperature was never over 100 orally. The mother had noted 3 petechial lesions, however, none of these lesions had occurred within the past 2 weeks. The past history was essentially noncontributory.

The physical examination revealed an alert, cooperative child who appeared somewhat pale, but otherwise did not appear ill. Blood pressures in the arms were 150/90 and in the leg 90/75. Temperature on admission was 101 degrees. Examination of the throat revealed enlarged cryptic tonsils. There was hyperplasia of the lymphoid tissue on the posterior pharynx. The lungs were clear to auscultation and percussion. Examination of the heart revealed the left border of cardiac dullness to be just inside the anterior axillary line. There was a thrill over the right second interspace which extended into the neck vessels. There was a grade III, rough, systolic murmur which was loudest over the primary aortic area. There was no diastolic murmur. The second aortic sound was audible. Posteriorly, there was a murmur, loudest to the left of the spine in the interscapular area, which was continuous. The radial pulses were easily palpable and the femoral pulses were felt to be definitely weak. The tip of the spleen was palpable 2 cm. below the left costal margin and the liver edge was 2 cm. below the right costal margin. Careful examination of the skin revealed three petechial lesions located on the right foot.

The x-rays of the heart revealed the cardiac silhouette to be moderately enlarged. The left ventricle appeared to be the disproportionately enlarged chamber although it was thought that there might be some right ventricular enlargement. There appeared to be some increase in pulmonary vascular volume. No rib notching was noted. The electrocardiogram revealed sinus rhythm with left bundle

branch block. No interpretation of ventricular hypertrophy could be made. The initial urinalysis was negative. The initial blood count revealed a hemoglobin of 9.7 gms., with a packed cell volume of 32%. The white cell count was 8,800 with 73 segs, 2 bands, 23 lymphs., 1 eosinophile. Subsequent urinalyses were within the limits of normal. Several blood cultures were taken and at least 2 of these cultures were reported as growing streptococcus viridens. A culture of the urine was negative. During the first 2 hospital days the temperature reached 101 orally each day. On the 3rd day, the patient was started on therapy and the temperature has not been in excess of 100 since that time.