

## A Case of Lemierre Syndrome with a recent history of COVID 19 infection

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Le mierre syndrome is presented as a clinical disease of both head and neck infections as well as para-pharyngeal abscess formations along with septic thrombophlebitis. Despite its rarity nowadays, its life-threatening quality still entails prompt diagnosis and treatment. In this case report, we describe a female patient with an exhibition of atypical symptoms of Le mierre syndrome with a recent history of COVID 19 infection. A 28-year-old female patient was admitted to the hospital via ER on October 1st, 2022 with mere symptoms of mental change and fever. She had been healthy formerly with no underlying diseases except for the recent COVID 19 infection. She had dyspnea in room air, requiring 3L of nasal oxygen supply. Her COVID 19 RT PCR result was found indeterminate. Chest CT revealed bilateral mass like lesions with peribronchial infiltration, patchy opacities and ground glass opacity, suggestive of a diagnosis of septic emboli. Blood tests affirmed leukocytosis with predominance of neutrophil count with elevated C-reactive protein. Neck CT demonstrated swelling and infiltration in left palatine tonsil and parapharyngeal fat, along with thrombophlebitis of left proximal internal jugular vein. Correlating both clinical and radiological findings in addition to the blood culture test report of *Fusobacterium Necrophorum*, Le mierre syndrome was diagnosed. Throughout her clinical course, she had been prescribed with oral Ampicillin/potassium clavulanate for two weeks while pulmonary septic emboli was managed with 2.5mg Apixaban every 12 hours for 16 days. Le Mierre syndrome could be difficult to be diagnosed promptly for its complex clinical manifestations including fever, neck pain and edema, cervical lymphadenopathy, and respiratory problems, usually preceded by the recent history of pharyngitis. But the definitive diagnosis can be made with CT or simple echography of the cervical region, properly showing internal jugular vein thrombophlebitis, and adjacent soft tissue swelling or fat stranding. Once diagnosed, it must be treated with systemic antibiotics, drainage of abscess fluids and perhaps, anticoagulant despite its controversy over actual efficacy.

