SECTION EDITOR: SAMIR S. SHAH, MD

Picture of the Month

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A PREVIOUSLY HEALTHY 3-YEAR-OLD GIRL HAD 3 days of fever, decreased activity, and a limp. There was no antecedent trauma. She reported left hip pain and her mother noted an abnormal gait. On examination, the patient's temperature was 39.2°C. She had bilateral cervical lymphadenopathy with a prominent right-sided 2×2-cm anterior cervical lymph node with mild tenderness but no warmth or erythema. At her left hip, there was no tenderness to palpation, but range of motion was limited. The patient's peripheral white blood cell count was 13 400/μL (to convert to $\times 10^9$/L, multiply by 0.001) with 36% segmented neutrophils. Her erythrocyte sedimentation rate was 72 mm/h, and C-reactive protein concentration was 3.2 mg/dL. Urinalysis, basic chemistry, and hepatic function testing results were within normal limits. Serologic tests for *Bartonella henselae* antibodies did not reveal evidence of acute infection (IgM<1:16; IgG, 1:128).

Computed tomography of the neck demonstrated multiple lymph nodes with focal necrosis (**Figure 1**). Computed tomography of the abdomen showed no hepatosplenic changes. However, magnetic resonance imaging revealed myositis of the left obturator internus and adductor longus muscles with abscess formation and bone marrow edema and enhancement in the left acetabulum (**Figure 2**). The patient was treated with intravenous clindamycin for presumed acute hematogenous bacterial osteomyelitis. During the next week, the patient's leg pain decreased and her gait improved. However, she remained febrile and her C-reactive protein concentration increased to 6.8 mg/dL. Biopsies of the lymph node (**Figure 3**A) and intramuscular fluid collection (Figure 3B) revealed the diagnosis.

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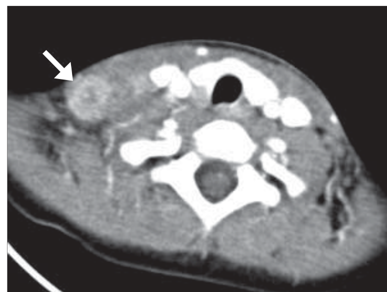

Figure 1. Computed tomography of the patient's neck with contrast. Multiple enhancing enlarged lymph nodes (arrow) with central necrosis and loss of tissue planes surrounding the nodes.

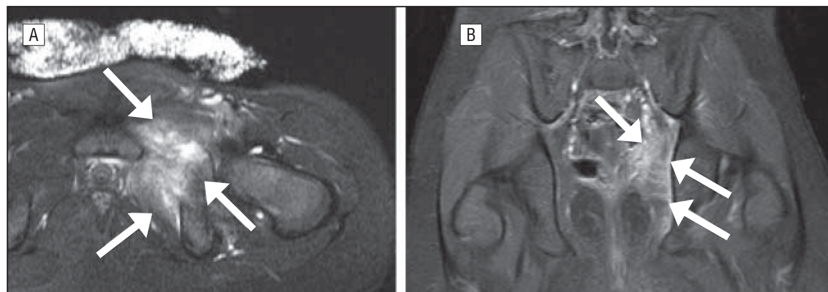

Figure 2. Magnetic resonance imaging of the pelvis with contrast. A, Axial view. B, Coronal view. Myositis of muscles adjacent to left acetabulum (arrows) with osteomyelitis.

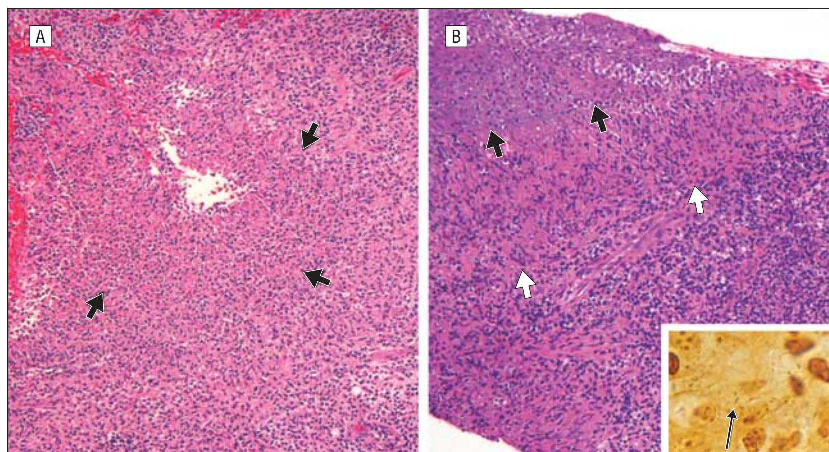

Figure 3. A, Histologic section of the lymph node biopsy specimen showing effacement of normal lymph node architecture and replacement by granulomatous inflammation characterized by an outer rim of small lymphocytes and collections of epithelioid histiocytes with a pale eosinophilic appearance surrounding areas of suppurative necrosis (arrows) (hematoxylin-eosin staining, original magnification ×100). B, Histologic section of the needle biopsy specimen of left pelvic tissue showing a dense mixed inflammatory infiltrate composed of lymphocytes (far right) and collections of palisading epithelioid histiocytes (white arrows) surrounding areas of suppurative necrosis (black arrows) (hematoxylin-eosin staining, original magnification ×100). Inset, Warthin-Starry silver staining was performed and showed a few small rod-shaped organisms (arrow) (original magnification ×1000).

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