

HLH with hemolytic anemia and urosepsis

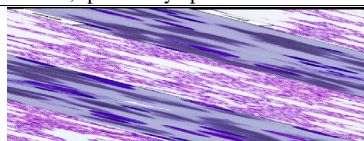
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Hemophagocytic lymphohistiocytosis (HLH) is a rare but potentially life-threatening disease. HLH can be primary (genetic), occurring as a familial disease, or secondary (reactive) disorder. Secondary HLH may develop in association with a variety of triggers, including malignancy, infection, autoimmune disease or drugs. The treatment of patients with sepsis who develop clinical symptoms of HLH using the above HLH protocols is still controversial. A recent review suggest that for patients with an infection or a rheumatologic condition who are clinically stable or improving, it may be possible to treat the triggering condition first without HLH-specific chemotherapy while monitoring patients for clinical deterioration. Herein, we report a case of HLH associated with *Escherichia coli* (E. coli) urosepsis and autoimmune hemolytic anemia and she successfully treated with intravenous antibiotics, IVIG, and steroid therapy. Therefore, clinicians should be aware of the possibility of developing life-threatening HLH with severe anemia and thrombocytopenia in the setting of autoimmune hemolytic anemia and urinary tract infection due to E. coli.

Table 1. Diagnostic criteria for HLH (1.4)

1. Familial disease/known genetic defect or
2. Clinical and laboratory criteria (5/8 criteria should be fulfilled)
 - Fever
 - Splenomegaly
 - Cytopenias ≥ 2 cell lines:
 - Hemoglobin < 90 g/L (below 4 weeks of age, < 100 g/L)
 - Platelets $< 100 \times 10^9/L$
 - Neutrophils $< 1.0 \times 10^9/L$
 - Hypertriglyceridemia and/or hypofibrinogenemia:
 - Fasting triglycerides ≥ 3.0 mmol/L (≥ 265 mg/dL)
 - Fibrinogen ≤ 1.5 g/L
 - Ferritin ≥ 500 μ g/L
 - Soluble CD25 $\geq 2,400$ U/ml
 - Decreased or absent NK-cell activity
 - Hemophagocytosis in bone marrow, spleen or lymph nodes



A Case of Aplastic anemia in a Chikungunya fever patient

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Chikungunya is an arthropod-borne tropical disease whose most common symptoms are fever and arthralgia. Although hematologic abnormal findings, such as anemia and lymphocytopenia, are not uncommon in Chikungunya, aplastic anemia has never been reported in literature. Here, we describe the case of Chikungunya who developed aplastic anemia during the course of disease. A 28-year-old Parkistani man was admitted with two weeks history of fever, headache, and myalgia. His complete blood counts showed pancytopenia with hemoglobin 5.4 g/dL, white blood cell count $3,920/mm^3$, and platelet count $88,000/mm^3$. Chikungunya was diagnosed by positive IgM for chikungunya virus by enzyme-linked immunosorbent assay. Because anemia and thrombocytopenia persisted for about 2 months, the bone marrow examination was performed. After a diagnosis of aplastic anemia was made by a less than 10 percent cellularity on the bone marrow examination, the patient was treated successfully using high dose steroid. Our case suggests that aplastic anemia can be a rare complication of chikungunya virus, and it must be included the differential diagnosis of anemia if the symptom is persistent.