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We declare that we have no conflicts of interest.

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Mycoplasma pneumoniae infection with incomplete Stevens-Johnson syndrome

We read with interest the case report by Parham Sendi and colleagues[1] on *Mycoplasma pneumoniae* infection complicated by severe mucocutaneous lesions. We would like to draw attention to the possibility of a special presentation of this syndrome. Recently we were presented with a case of *M pneumoniae* infection-induced Stevens-Johnson syndrome with complete absence of skin lesions—one of the syndrome's defining characteristics. This presentation is more common in children, but as our case illustrates, can also be seen in adults. The atypical presentation can delay diagnosis, stressing the importance of awareness among physicians of this manifestation.

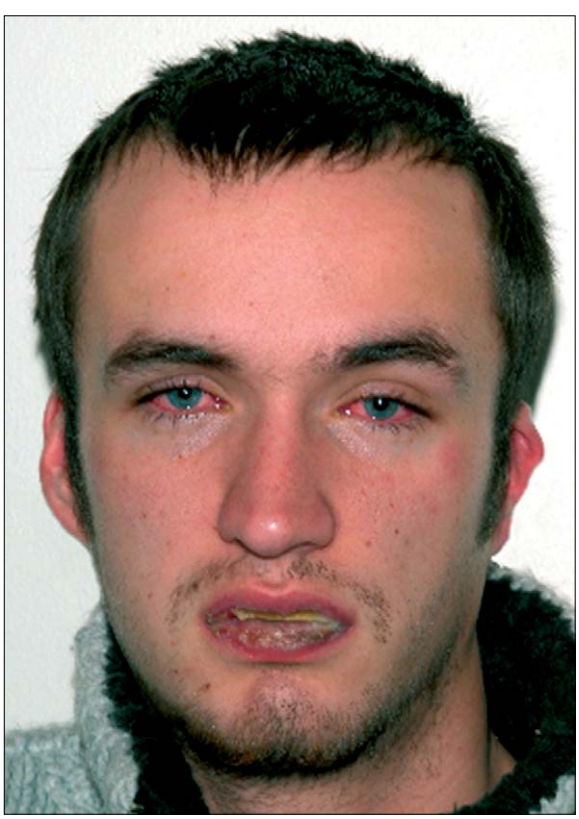

Figure: **Photograph of patient taken on day of admission, showing purulent conjunctivitis and swollen lips with ulcerations**

A 23-year-old man was admitted with fever and a non-productive cough. Symptoms had started 7 days earlier on return from a trip to Hungary. On physical examination conjunctivae were hyperaemic with purulent discharge. Buccal mucosa and lips showed painful ulcerative lesions covered with yellowish serofibrinous exudates (figure). Skin and genital mucosa were unremarkable. Lung auscultation revealed minor crackles with a mild bilateral interstitial pattern on chest radiograph.

Amoxicillin–clavulanic acid (625 mg three times a day) was started on the suspicion of secondary impetiginised herpetic stomatitis. Plaut-Vincent angina was excluded by Gram staining of material obtained from an oral laceration. Herpes simplex virus PCR was negative. On the second day of admission the patient developed purulent urethral discharge and a small, non-painful ulcer on his glans penis. A single dose of

azithromycin (1 g) was given for possible chlamydial infection with Reiter's syndrome. PCR for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* from urethral swab was negative, dark field microscopy of the ulcer did not show spirochetes. HIV viral load, *Treponema pallidum* haemagglutination test, and Venereal Disease Research Laboratory test were negative, as was the test for HLA B27.

Although skin lesions were absent, the combination of stomatitis, conjunctivitis, and urethritis was suggestive for Stevens-Johnson syndrome. Incomplete presentation of this syndrome associated with *M pneumoniae* infection has been reported,[2,3] but exclusively in children. Because of the atypical pneumonia in combination with incomplete Stevens-Johnson syndrome, a PCR was done on oral swab material taken on the day of admission. This showed the presence of *M pneumoniae* DNA. Diagnosis was confirmed by serology (agglutination IgM/IgG titre 1/20 480). The patient recovered completely after additional azithromycin therapy. There was no relapse and currently he is in excellent clinical condition.

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We declare that we have no conflicts of interest.

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Rocky Mountain spotted fever in the USA: a benign disease or a common diagnostic error?

A recent Review[1] and comment[2] on Rocky Mountain spotted fever (RMSF), a tickborne infection caused by *Rickettsia rickettsii*, outlined several important aspects of this severe disease; absent, however, was a discussion about the apparent and striking decline of the US case-fatality rate of RMSF during the past 25 years. Since its initial description in the late 19th century, RMSF has been described consistently as a remarkably lethal infection. Indeed, 96 (63%) of 153 patients from Montana diagnosed with RMSF during 1904–13 died from this disease.[3] Even with advances in supportive medical care, the aggregate case-fatality rate of RMSF was approximately 23% in the decade preceding the discovery of appropriate antimicrobial therapy for this disease in the late 1940s.[4] Case-fatality rates that exceed this percentage are still reported from many South American countries, including Argentina, Brazil, and Colombia.[5] Since 2000, the number of reported cases of RMSF in the USA has increased during all but a single year, with a peak in 2006 (2288 cases; figure). However, in 1997–2002, the overall case-fatality rate was estimated at 1·4% (range 0·7–2·9%).[6] Furthermore, in the recently published *Summary of notifiable diseases—United States, 2006*, a total of 3908 cases of RMSF were notified in 2002–04, including 22 deaths—that is a case-fatality rate of 0·7%.[7] This is much lower than the case-fatality rates

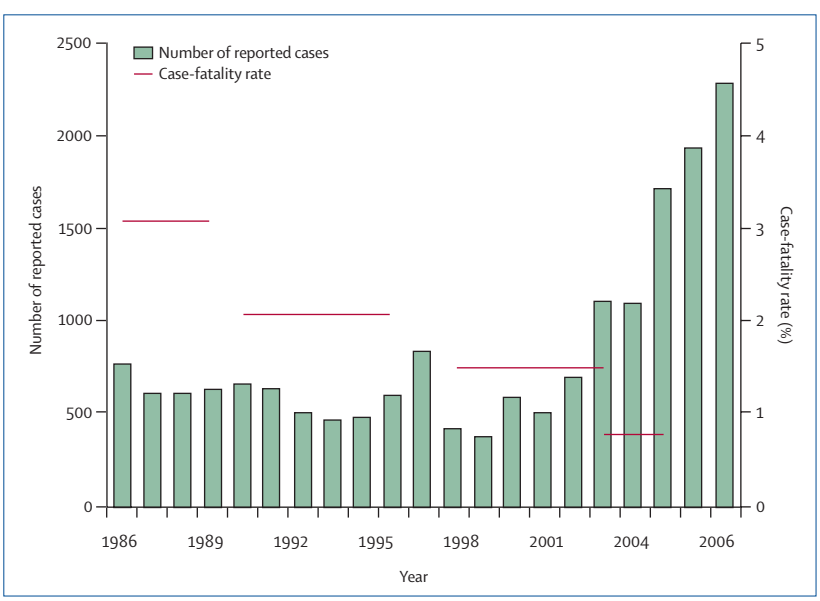

Figure: **Reported cases of so-called Rocky Mountain spotted fever and case-fatality rates in the USA**
From data in reference 7.