

## **UC Davis**

### **UC Davis Previously Published Works**

#### **Title**

Concurrent sweet's syndrome and erythema nodosum

#### **Permalink**

<https://escholarship.org/uc/item/4149g02m>

#### **Journal**

Journal of General Internal Medicine, 26(2)

#### **ISSN**

0884-8734

#### **Authors**

Harris, T  
Henderson, MC

#### **Publication Date**

2011-02-01

#### **DOI**

10.1007/s11606-010-1536-1

Peer reviewed

## Clinical Images

# Concurrent Sweet's Syndrome and Erythema Nodosum

Tracie Harris, MD and Mark C. Henderson, MD

The Department of Internal Medicine, University of California Davis Medical Center, Sacramento, CA, USA.

**KEY WORDS:** Sweet's syndrome; erythema nodosum.

J Gen Intern Med 26(2):214-5

DOI: 10.1007/s11606-010-1536-1

© The Author(s) 2010. This article is published with open access at Springerlink.com

A 29-year-old Mexican man was admitted to the hospital with fever, cough, sore throat, and red, tender leg nodules suggestive of erythema nodosum (Fig. 1). The white blood cell count was 35,000. Several days later, annular plaques and pustules developed on his face, neck, and forearms (Figs. 2 and 3). Facial skin biopsy showed neutrophilic dermatitis without evidence of infection or vasculitis consistent with Sweet's syndrome. Biopsy of the thigh was non-diagnostic, but showed a mixed neutrophilic and granulomatous dermatitis.

Erythema nodosum (EN) is a form of panniculitis characterized by painful red nodules over the pretibial area. Sweet's syndrome (SS) is an acute febrile neutrophilic dermatosis characterized by fever, leukocytosis, and erythematous plaques involving the arms, trunk, and neck. Vesiculopustules, nodules, and ulcers may also occur. Simultaneous occurrence of EN and SS has been increasingly reported, and both appear to be reactive dermatoses with overlapping clinical and histopathologic features. Although often idiopathic, both disorders have been associated with upper respiratory infections, medications, hematologic malignancies, and autoimmune disease (e.g., rheumatoid arthritis and inflammatory bowel disease). Treatment includes corticosteroids, potassium iodide, or colchicine. SS generally responds well to therapy, but recurs in up to 25% of patients; 15% have a chronic relapsing course.

Extensive evaluation was unrevealing, including chest and abdominal imaging, bone marrow biopsy, endoscopy, and serologies for hepatitis, syphilis, recent Streptococcal infection, and rheumatologic disorders. He responded well to oral prednisone. The underlying cause was presumed to be an antecedent upper respiratory tract infection.

Received June 8, 2010

Revised September 20, 2010

Accepted September 22, 2010

Published online October 16, 2010



Figure 1. The patient's legs show red, tender nodules suggestive of erythema nodosum.



Figure 2. Annular plaques and pustules developed on the patient's face.



Figure 3. Annular plaques developed on the patient's hands.

---

**Open Access:** This article is distributed under the terms of the Creative Commons Attribution Noncommercial License which permits any noncommercial use, distribution, and reproduction in any medium, provided the original author(s) and source are credited.

**Corresponding Author:** Mark C. Henderson, MD, The Department of Internal Medicine, University of California Davis Medical Center, 4150 V Street, Suite 3100, Sacramento, CA 95817, USA (e-mail: mark.henderson@ucdmc.ucdavis.edu).