A previously healthy 14-year-old female presented with a 5-day history of a sore throat, fever, fatigue and cough.

Clinical examination revealed a slightly painful cervical lymphadenopathy, especially along the posterior cervical chain, slightly painful and pharyngitis. The complete blood count showed: Ht 39%, Hb 13 g/dl, WBC: 9,000/μl (differential count: neutrophils 14%, lymphocytes 72% and monocytes 14%). The peripheral blood smear revealed the presence of atypical lymphocytes. The laboratory examination revealed: ESR 30 mm/1 hour, CRP 22 mg/dl, AST 150 IU/L, ALT 362 IU/L, bilirubin 1.15 mg/dl, alkaline phosphatase 108 IU/L, γGT 352 IU/L, while the serum heterophile antibody was positive. The Gram staining and culture of a throat swab was negative. The patient was diagnosed with infectious mononucleosis and treated symptomatically.

Five days later she presented with severe sore throat, dysphagia and halitosis. Clinical examination revealed unilateral tonsillar ulceration and cervical lymphadenopathy. The complete blood count showed leukocytosis 13,000/μL (differential count: neutrophils 78%, lymphocytes 15%, monocytes 7%). The peripheral blood smear revealed toxic granulation of the neutrophils. A sample was taken from tonsillar ulceration and the microbiology analysis was performed (fig. 1). The patient was treated with clarithromycin. The symptoms and fever were subsided after 5 days.

Comment

Vincent’s angina (Plaut-Vincent angina) is a disease caused by coinciding infections from Fusibacteria and Spirochaeta (obligate anaerobic bacteria). It becomes evident on the mucous membranes of the oral cavity and the oropharynx beside the tonsil. The clinical outcome may be different and pose difficulties in the differential diagnosis. The specific staining is the most suitable procedure for bacteria identification to support the clinical diagnosis of stomatitis ulceromembranacea.