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Janeway Revisited: Recognising an Uncommon Clinical Stigmata in Modern Practice

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1. Abstract

A 64-year-old male presented with fever and palpitation for 10 days, and was having a systolic murmur on auscultation, and a Janeway lesion in his hand. The initial echocardiography showed only mitral valve regurgitation, and blood cultures turned out to be negative. but in view of a high index of suspicion due to the classical skin lesion, repeat echocardiography was done, and it showed vegetation in the anterior mitral leaflet. The antibiotic course was completed, and on follow-up patient improved symptomatically and skin lesions resolved.

2. Case Report

A 64-year-old male presented with complaints of intermittent high-grade fever for 10 days along with palpitation. On examination, pulse rate was 124 beats/min and BP was 130/80 mmHg. On auscultation, a systolic murmur was present in the mitral area. Local examination showed non-tender macular Janeway lesions in the palm (Figure 1) and purpura in the anterior aspect of the leg (Figure 2). Initial echocardiography showed prolapse of the anterior mitral valve leaflet and moderate mitral regurgitation, and no vegetation. However, in view of the persistent fever and characteristic Janeway lesions, echocardiography was repeated, which showed a 12x14 mm vegetation on the anterior leaflet of the mitral valve. The diagnosis of infective endocarditis was made, and the patient was treated with antibiotics. Culture did not yield growth; this may be because the antibiotic was initiated before the culture was taken. On follow-up after 2 weeks, there was resolution of symptoms and disappearance of the skin lesions.

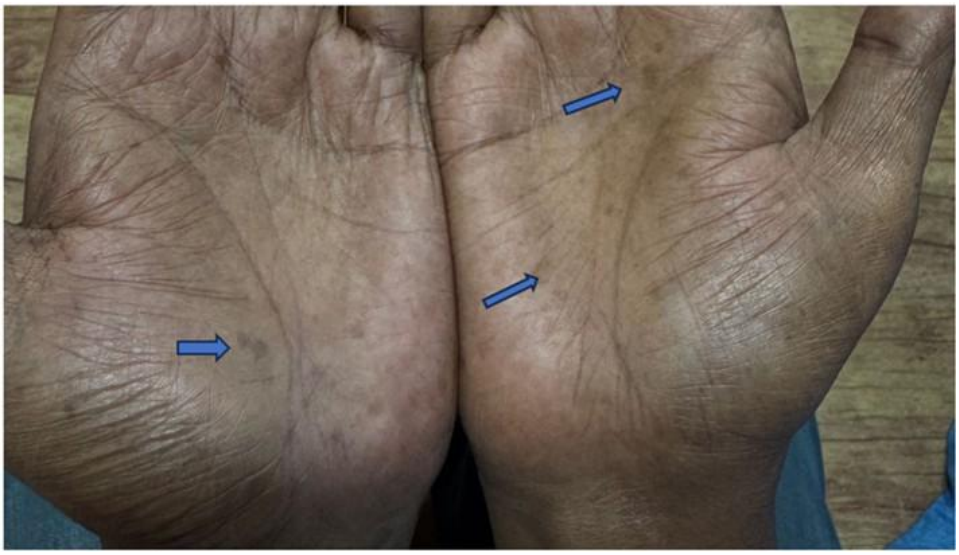

Figure 1: Macular Janeway lesions in the palm.

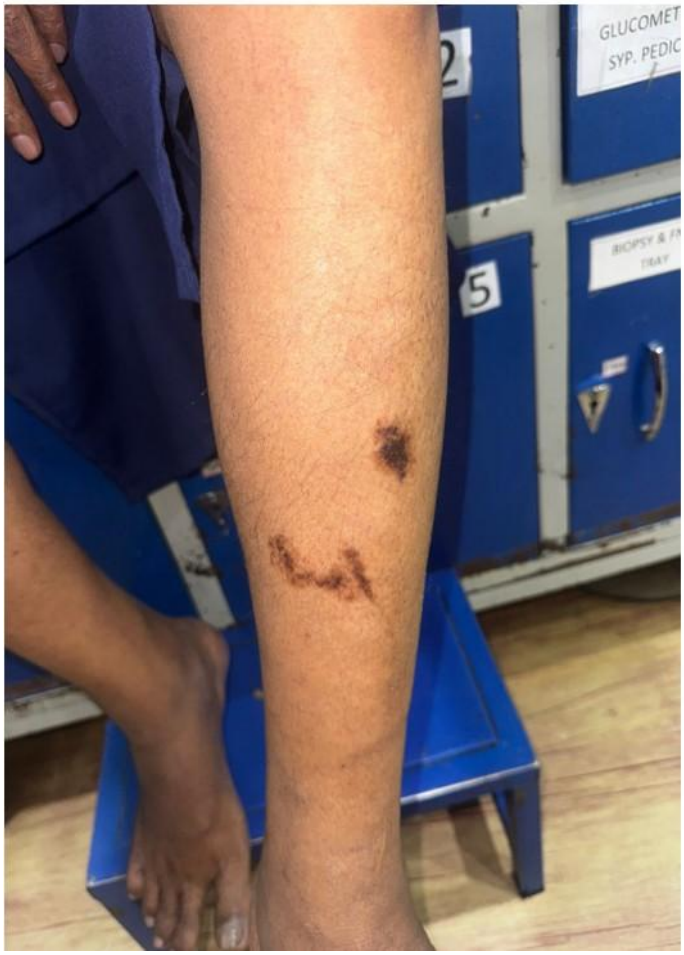

Figure 2: Purpura in the anterior aspect of the leg.

3. Discussion

Up to 30% of IE cases could have a culture-negative result, which is frequently connected to fastidious organisms or previous antibiotic treatment [1]. Skin manifestations were commonly seen in infective endocarditis, with a prevalence of up to 40–90% in the pre-antibiotic period [2]. However, recent evidence particularly a study by servy A et al. show that at least one of the four skin manifestations of IE was present in fifty-eight patients (11.9%), including three (0.6%) with conjunctival haemorrhages, eight (1.6%) with Janeway lesions, thirteen (2.7%) with Osler nodes, and 39 (8.0%) with purpura. Two skin signs were seen in five patients [3].

It's not always easy to tell Osler nodes from Janeway lesions. Osler nodes are characterised as painful, purple nodules that are primarily found on the fingertips, toe pulp, palms, soles, and occasionally the ears. Sometimes in a few hours, but usually within a few days, lesions go away without any sequelae. Janeway lesions found on the palms or soles are frequently tiny, nontender, erythematous, painless papules or macules, occasionally purpuric or haemorrhagic. They usually take a few days to a few weeks to fully recover [4].

Vascular purpura is typically necrotic. Usually found on the lower body (legs and back), purpura can also occasionally be found on the mucosa (mouth and conjunctiva) or close to the clavicles [5]. The emergence of particular IE dermatological lesions and a causative microbe has not been clearly linked.3 Traditional IE skin manifestations indicate the severity of the infection and are linked to an increased risk of complications, which should warn clinicians to watch for further complications.

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