



Disseminated intravascular coagulation in pneumococemia

Rostane Gaci, Cyril Cadoz, Damien Barraud and Guillaume Louis* 

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A previously healthy 46-year-old woman presented to emergency room with sudden asthenia, fever and diarrhea. Onset of a septic shock with multiple organ failure quickly led to intensive care unit management. On physical examination, she had small purpura lesions on her legs (Fig. 1) and ecchymotic lesions on both facial (Fig. 2) and limb extremities (Fig. 3). There was no meningeal syndrome. Laboratory analyses were notable for disseminated intravascular coagulation with a platelet count



Fig. 1 Purpuric skin lesions of the legs



Fig. 2 Ecchymotic skin lesions of the face

of 23,000 per mm^3 , prolonged prothrombin time, low fibrinogen level (1.5 g per liter), increased D-dimer level ($>20,000$ ng per milliliter) and fibrin degradation products (150 μg per milliliter) without schizocytes. Blood cultures grew *Streptococcus pneumoniae*, confirming the diagnosis of pneumococemia with disseminated intravascular coagulation. Further investigations with full-body CT scan and immunologic screening did not allow identification of the infectious source nor of the immunocompromised underlying condition. The patient recovered well after an antibiotic course of cefotaxime.

*Correspondence: gus_louis@yahoo.fr
Hopital de Mercy service de réanimation polyvalente CHR Metz-Thionville, Ars-Laquenexy, France



Fig. 3 Ecchymotic skin lesions of the hands

Previously described 50 years ago in context of acute defibrination with postabortum septicemia, ecchymotic skin lesions of the face were named “nez noir”, i.e. “Valais blacknose sheep” for the likeness with the so-called specie of sheep.

Compliance with ethical standards

Patient's consent and permission to publish

Consent was obtained from the patient for publication of this case report and of the accompanying images.

Conflicts of interest

There is no conflict of interest.

Received: 25 July 2018 Accepted: 30 July 2018

Published online: 20 August 2018