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LETTER TO EDITOR (VIEWERS CHOICE)

NOT JUST A LUNG INFECTION: AN ATYPICAL MANIFESTATION OF MYCOPLASMA PNEUMONIAE

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Mycoplasma pneumoniae is a common cause of pneumonia in children, with extrapulmonary complications in approximately 25%[1] of cases and dermatological manifestations in 1-5%.[2]

Reactive Infectious Mucocutaneous Eruption (RIME), previously referred to as Mycoplasma pneumoniae-induced rash and mucositis (MIRM), is a severe mucocutaneous reaction that predominantly affects children and adolescents, with a mean age of 11.9 years and a male predominance of 66%.[1] It is characterized by prominent mucosal involvement-typically affecting the oral, ocular, and genital mucosa-with minimal or absent cutaneous lesions.[1,3] Although most commonly associated with Mycoplasma pneumoniae, RIME has been increasingly recognized as a broader clinical entity triggered by various pathogens[3], including Epstein–Barr virus, Enterovirus, Influenza virus, Adenovirus, and SARS-CoV-2.[3,4]

We describe the case of an 11-year-old male with no significant medical history who presented with progressively worsening lip discomfort, followed by swelling, sloughing, and crusting of the lips, along with lesions on the tongue and buccal mucosa. These symptoms were associated with dysphagia, sialorrhea, and food refusal over two days. Four days prior, he had been diagnosed with community-acquired pneumonia and started on a 10-day course of oral amoxicillin-clavulanic acid (75 mg/kg/day).

On admission, he was febrile (38°C), with normal vital signs and oxygen saturation above 94% on room air. Physical examination revealed hemorrhagic crusting of the lips (Figure 1), extensive erosions on the tongue and buccal mucosa, and bilateral conjunctival hyperemia without exudate. Pulmonary auscultation showed scattered crackles.

Laboratory tests revealed a white blood cell count of 13,480/µL with 73% neutrophils and a C-reactive protein (CRP) of 21.3 mg/L. Chest radiograph showed bilateral interstitial infiltrates. A respiratory panel by polymerase chain reaction (PCR), including respiratory syncytial virus, adenovirus, influenza A, influenza B, and SARS-CoV-2, was negative. Serology for Mycoplasma pneumoniae IgM and IgG was positive.

Figure 1. Oral mucositis.

The patient required hospitalization due to severe oral mucositis, which impaired oral intake. He was treated with oral azithromycin (10 mg/kg/day) for 5 days and methylprednisolone (1 mg/kg/day) for 7 days, followed by a stepwise dose reduction. Amoxicillin-clavulanic acid was discontinued. Supportive care was provided including pain relief and fluid support.

Eight days after discharge, the patient showed significant clinical improvement, and a visit one month later revealed no recurrence of symptoms. Serology performed at that time showed elevated IgM and IgG titers, confirming Mycoplasma pneumoniae infection.

Diagnostic criteria for RIME include vesiculobullous lesions or scattered, atypical, targetoid lesions on the skin affecting less than 10% of the body surface area, no relevant medication history, prodromal symptoms such as cough, fever, and malaise typically occurring within 7 to 10 days prior to the eruption, and clinical,

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imaging, or laboratory findings suggesting an infectious trigger.[5]

Although a definitive treatment has not been established, management is typically symptomatic, focusing on mucosal care, pain relief, and providing fluids and nutritional support.[3] Systemic corticosteroids are commonly used to alleviate inflammation and pain, especially in cases with extensive mucosal involvement. Additionally, therapy is directed toward the underlying infectious cause. The prognosis of RIME is generally favorable, with most patients achieving full recovery.[1]

Compliance with Ethical Standards
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