mens that test positive for influenza A (H5N1) must be confirmed by the National Microbiology Laboratory or its designate.

Given the increased likelihood of seasonal influenza infections, these guidelines for H5N1 testing in humans should be applied only to patients who have a history of travel, or contact with a traveller, to areas affected by outbreaks of avian influenza[8] *and* a significant clinical and exposure history. The need exists for increased vigilance for the surveillance, recognition, reporting and prompt investigation of patients with severe influenza-like illness or severe respiratory illness (see Box 1).

To establish your patient's risk of avian influenza A (H5N1) infection based on travel and exposure history and for guidance on further actions, contact your local medical officer of health. For additional information on avian influenza testing, contact your provincial public health laboratory.

Anna Majury
Queen's University
Kingston, Ont.
Judy Ash
Ontario Association of Medical Laboratories
Toronto, Ont.
Baldwin Toye
The Ottawa Hospital
Ottawa, Ont.
Gerald Evans
Kingston General Hospital
Hotel Dieu Hospital
Kingston, Ont.
Tony Mazzulli
Mount Sinai Hospital
Toronto, Ont.
Anne-Luise Winter
Infectious Disease Branch
Ministry of Health and Long-Term Care
Toronto, Ont.
Greg Gamble
Thunder Bay Regional Health Sciences Centre
Thunder Bay, Ont.

Competing interests: None declared.

REFERENCES

1. Perdue ML, Swayne DE. Public health risk from avian influenza viruses. *Avian Dis* 2005;49:317-27.
2. Writing Committee of the World Health Organization (WHO) Consultation on Human Influenza A/H5. Avian influenza A (H5N1) infection in humans. *N Engl J Med* 2005;353:1374-85.
3. Avian influenza — situation in Indonesia — update 29. In: Epidemic and pandemic alert and response (EPR). Disease outbreak news. Geneva: World Health Organization. Available: www.who.int/csr/don/2006_08_23/en/index.html (accessed 2006 Sept 21).
4. Tran TH, Nguyen TL, Nguyen TD, et al. Avian influenza A (H5N1) in 10 patients in Vietnam. *N Engl J Med* 2004;350:1179-88.
5. Cumulative number of confirmed human cases of avian influenza A/(H5N1) reported to WHO. Epidemic and pandemic alert and response. Geneva: World Health Organization. Available: www.who.int/csr/disease/avian_influenza/country/cases_table_2006_08_21/en/index.html (accessed 2006 Sept 21).
6. WHO recommendations on the use of rapid testing for influenza diagnosis. Epidemic and pandemic alert and response. [Web site of the World Health Organization]. Available: www.who.int/csr/disease/avian_influenza/guidelines/rapid_testing/en/ (accessed 2006 Sept 21).
7. Containment facilities. Ottawa: Public Health Agency of Canada. Available: www.phac-aspc.gc.ca/ols-bsl/containment/index.html (accessed 2006 Oct 14).
8. Current avian influenza (H5N1) affected areas. Ottawa: Public Health Agency of Canada. Available: www.phac-aspc.gc.ca/h5n1/index.html (accessed 2006 Oct 14).

Clinical Vistas

Silent menace: septic abdominal thrombophlebitis

A 69-year-old man presented with fever and chills of acute onset without any localizing complaints. He was previously generally well, but had a history of dyslipidemia and benign prostatic hypertrophy. The findings of his examination and laboratory tests were normal, and he was discharged.

He was admitted again after 3 days, during which he felt only lassitude and experienced recurring severe shaking chills. His vital signs were normal except for elevated temperature (38.5°C) and heart rate (103 beats per minute). A meticulous examination again revealed little except for the discovery of a moderate, non-tender enlargement of the prostate. The findings of electrocardiography, chest radiography and abdomi-

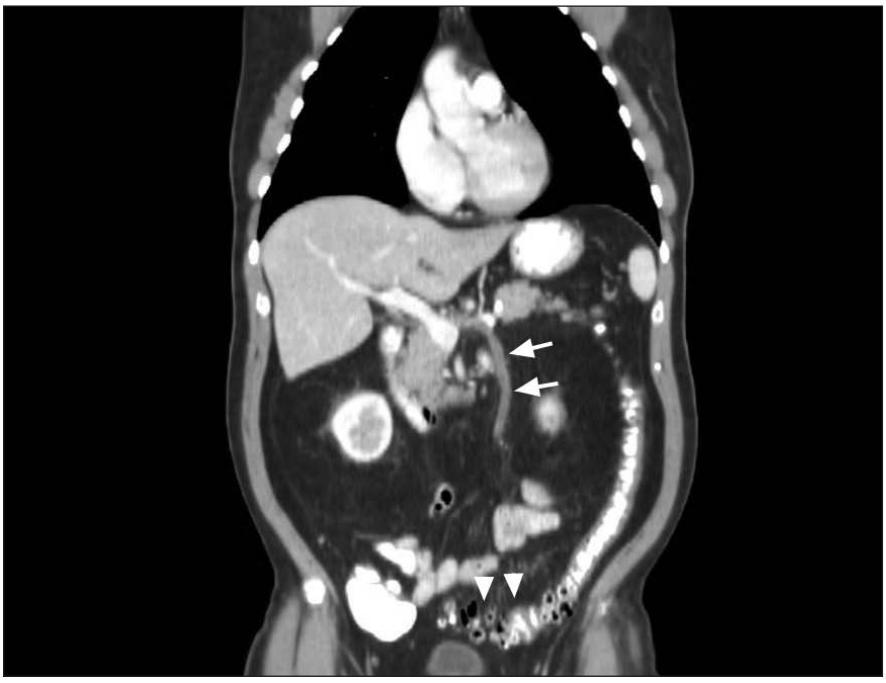

Fig 1: Coronal contrast-enhanced computed tomographic image of the abdomen showing a filling defect within the inferior mesenteric vein (arrows) projecting into the splenic vein lumen with adjacent diverticulosis (arrow heads).

DOI:10.1503/cmaj.060786

nal ultrasonography were normal. His hemoglobin (Hb) level was 8.8 µmol/L, the leukocyte count was 9.35 × 10^9/L (0.84 neutrophils) and the platelet count was 113 × 10^9/L. Prothrombin time, activated partial thromboplastin time and urinalysis were normal. Liver enzymes were minimally elevated (aspartate aminotransferase [AST] 38 U/L, alanine aminotransferase [ALT] 52 U/L), and the erythrocyte sedimentation rate (ESR) was 33 mm/h.

After 24-h observation, the patient was diagnosed with viral infection and again discharged only to be readmitted 4 days later with continued fever (39.4°C) and anorexia, but no new physical findings. His Hb level was preserved; leukocytes increased to 14.5 × 10^9/L and platelets to 613 × 10^9/L. The serum creatinine level was 129 µmol/L (previously 102.5 µmol/L). Liver enzymes had increased: AST 60 U/L; ALT 130 U/L; alkaline phosphatase 300 U/L; gamma-glutamyl transpeptidase 500 U/L. ESR was now 141 mm/h, and the C-reactive protein (CRP) level 105 mg/L. All cultures, serologic and autoantibody tests, and purified protein derivative skin test were negative, but the patient remained febrile.

Computed tomography (CT) of the patient's abdomen and chest revealed large intraluminal filling defects in the inferior mesenteric vein and splenic vein (Fig 1). Extensive colonic diverticulosis with mild diverticulitis in the adjacent descending mesocolon was the only other pathologic finding. A careful workup for thrombophilia was unequivocally negative. Meanwhile, the patient made a spontaneous recovery, and all blood parameters returned to normal. He was discharged after 2 weeks of anticoagulant treatment, until an elective laparoscopic partial colectomy could be scheduled.

Septic thrombophlebitis (pylephlebitis) of the inferior mesenteric and splenic veins is an uncommon and often fatal complication of intra-abdominal infections.[1] Septic venous thromboses associated with adjacent acute infections have also been reported in the pelvic veins, internal jugular vein and dural sinuses. Our patient presented with recurrent fever, rigors and blood tests that were only subtly abnormal at first, but later became characteristic of sepsis (leukocytosis, thrombocytopenia, acute renal failure, abnormal liver function tests and CRP). The absence of any abdominal symptoms, normal findings on abdominal ultrasonography and negative cultures led to a potentially dangerous diagnostic delay. In a retrospective series of 19 cases of septic thrombophlebitis of the portal vein, diverticulitis of the colon (or ileum) was identified as the most common focus of infection.[2] Fewer than a dozen other cases involving the mesenteric veins had been reported.[3] Either the portal vein or its tributaries may be involved. Patients usually present with fever, chills and abdominal pain, and CT is a powerful diagnostic modality. However, a high index of suspicion is required, especially as silent presentation of diverticulitis can occur[3] and was also reported as causing fever of unknown origin. Although spontaneous resolution of these episodes can occur, broad-spectrum antibiotics are usually indicated (including coverage of *Bacteroides fragilis*)[1–3] and possibly anticoagulants and later surgical resection of the offending tissue.

Ami Schattner
Meital Adi
Joel Cohen
Departments of Medicine and Radiology
Kaplan Medical Centre
Rehovot
Hebrew University Hadassah Medical School
Jerusalem, Israel

Competing interests: None declared.

REFERENCES

1. Saxena R, Adolph M, Ziegler JR, et al. Pylephlebitis: a case report and review of outcome in the antibiotic era. *Am J Gastroenterol* 1996;91:1251-3.
2. Plemmons RM, Dooley DP, Longfield R. Septic thrombophlebitis of the portal vein (pylephlebitis): diagnosis and management in the modern era. *Clin Infect Dis* 1995;21:1114-20.
3. Sywak M, Romano C, Raber E, et al. Septic thrombophlebitis of the inferior mesenteric vein from sigmoid diverticulitis. *J Am Coll Surg* 2003;196:326-7.