ciated with IgM antibodies specific to *C. burnetii* antigen [1]. The woman was treated with doxycycline (200 mg/d). Three days later, she became afebrile and since then has remained well.

Acute pancreatitis is usually a sterile inflammatory process mostly associated with alcoholism, trauma, metabolic abnormalities, and biliary or gastrointestinal diseases. About one-third of cases remain idiopathic [2, 3]. It is generally accepted that parasites (*Ascaris lumbricoides* and *Opisthorchis sinensis*) and viral agents, including mumps virus, Coxsackie B viruses, Epstein-Barr virus, and herpes simplex virus, can cause acute pancreatitis [2, 3]. Bacterial pathogens, such as *Campylobacter fetus*, *Mycobacterium tuberculosis*, *T. pallidum*, *Leptospira* species, *L. pneumophila*, *Salmonella* species, and *Y. enterocolitica*, have previously been reported to cause acute pancreatitis [2, 3]. Q fever, a zoonosis due to the obligate intracellular bacterium *C. burnetii*, may be acute or chronic. Acute Q fever presents generally as a self-limited acute febrile illness associated with atypical pneumonia or hepatitis [4, 5]. Both the shepherdess and her husband were probably infected during the delivery of the kid by inhalation of contaminated aerosols generated from the heavily infected placenta (the major mechanism whereby Q fever is transmitted to humans) [6]. Whether her husband presented with a clinical picture suggestive of acute Q fever, the shepherdess had "query" acute pancreatitis.

To our knowledge, this is the first case report indicating that acute Q fever may present as acute pancreatitis. *C. burnetii* should be added to the list of microorganisms capable of inducing acute pancreatitis since Q fever requires specific antibiotic treatment. Moreover, systematic screening for Q fever may explain some of the idiopathic cases of acute pancreatitis.

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Prolonged Fever Caused by Parvovirus B19–Induced Meningitis: Case Report and Review

Parvovirus B19 is a DNA virus that causes erythema infectiosum, transient aplastic crisis in patients with hemolytic anemia, arthropathy, chronic anemia in immunosuppressed patients, and fetal hydrops [1]. Meningitis due to parvovirus B19 is a rare entity, and to our knowledge, only five cases have been reported in the literature since 1990 [2–6]. Although arthritis due to parvovirus B19 has been reported, meningitis has not been reported as a cause of fever of unknown origin [7]. We describe a case of aseptic meningitis caused by parvovirus B19 in an immunocompetent patient with prolonged fever.

A previously healthy 17-year-old female was admitted to the hospital with fever (temperature, 39.6°C), myalgia, headache, nausea, and vomiting. Physical examination revealed normal mentation, neck stiffness, and several pink macules on the trunk. Laboratory studies disclosed the following: erythrocyte sedimentation rate, 25 mm/h; C-reactive protein level, <3.4 mg/dL; and negative PPD reaction. The WBC count was 5,800/mm^3 with a normal differential cell count. Biochemical and hematologic parameters were normal. MRI of the head revealed no focal abnormalities.

Analysis of CSF obtained by lumbar puncture showed a high opening pressure (440 mm of H_2O), elevated WBC count (253/mm^3) with predominance of lymphocytes (95%), increased total protein level (210 mg/dL), and decreased glucose level (43 mg/dL; blood glucose level, 105 mg/dL). Acid-fast, gram, and India ink staining and culture of CSF revealed negative results. Three additional blood cultures remained negative. Serological tests for Lyme disease, brucellosis, syphilis, and infections with Epstein-Barr virus, cytomegalovirus, herpes simplex virus, mumps virus, and HIV were negative. ELISAs for IgM and IgG antibodies to parvovirus B19 in serum were positive. PCR analysis detected parvovirus B19 DNA in CSF but not in blood on the 17th day of hospitalization.

Her fever persisted for 20 days with a continuous pattern. The fever and other constitutional symptoms abated completely at the end of 1 month.

A MEDLINE search of the literature for meningitis due to parvovirus B19 showed only five cases [2–6]; the clinical and laboratory characteristics of the patients are shown in table 1. Two of six cases occurred during early adulthood, and one of these patients had sickle cell anemia; this patient died on the sixth day as a result of aplastic crisis. The present case differs from the other cases by the long duration of fever (30 days) with a continuous pattern. In addition, our case fulfills the criteria of fever of unknown origin that were defined by Petersdorf and Beeson [8]. The duration of fever is usually short (a few days to 7 days). The absence of the typical rash in adult as well as pediatric cases should be emphasized. CSF glucose levels were normal in all cases except the present case.

According to available reports, the prognosis of meningitis due

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Table 1. Clinical and laboratory characteristics of patients with meningitis due to parvovirus B19.

Case no. [reference]	Age/sex	Underlying disease	Typical rash	Duration of fever (d)	WBC count (/mm^3) in CSF (differential cell count)	CSF protein level	CSF glucose level (blood level)	Finding in serum: IgM to parvovirus B19	Finding in serum: IgG to parvovirus B19	Finding in serum: Parvovirus B19 DNA	Parvovirus B19 DNA in CSF
1 [2]	7 y/F	None	Present	7	339 (91% lymphocytes)	High	66 mg/dL (98 mg/dL)	+	NA	NA	NA
2 [3]	7 y/M	None	Present	A few days	112 (39% lymphocytes)	High	3.3 mmol/L (NA)	+	+	+	+
3 [4]	35 y/M	None	Absent	NA	3 (2 lymphocytes)	High	4.3 mmol/L (NA)	+	+	+	+
4 [5]	20 d/F	None	Absent	4	861 (57% lymphocytes)	High	2.7 mmol/L (NA)	+	+	NA	NA
5 [6]	26 y/M	Sickle cell anemia	Absent	6*	10 (90% lymphocytes)	High	4.71 mmol/L (NA)	+	+	+	+
6 [PR]	17 y/F	None	Absent	30	253 (95% lymphocytes)	High	43 mg/dL (105 mg/dL)	+	+	−	+

NOTE. NA = not available; PR = present report; + = positive; − = negative.
* Patient died on day 6.

to parvovirus B19 in immunocompetent persons appears to be good. The clinical course of parvovirus B19 meningitis will be better understood as more cases are reported. These cases demonstrate that parvovirus B19 infection should be considered in the differential diagnosis of all patients who present with aseptic meningitis.

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Cardiac Cirrhosis with Cellulitis Caused by *Burkholderia cepacia* Bacteremia

Burkholderia cepacia is a phytopathogen that causes onion bulb rot in plants and foot rot in humans. It has emerged as an opportunistic pathogen in immunocompromised patients, particularly individuals with chronic granulomatous disease [1] and cystic fibrosis [2]. *B. cepacia* has been implicated in nosocomial outbreaks via contaminated fluid [3, 4]. Community-acquired bacteremia due to *B. cepacia* has been reported, but none of the cases were associated with cellulitis. We report a case of cardiac cirrhosis with cellulitis due to *B. cepacia* bacteremia.

A 49-year-old man presented with a 2-day history of left thigh erythematous swelling. He had no history of chronic hepatitis or cigarette smoking. He had a 13-year history of chronic lower extremity edema caused by valvular heart disease. Echocardiography showed severe tricuspid valve regurgitation and mild mitral valve regurgitation. Abdominal sonography demonstrated an uneven liver surface and hepatosplenomegaly with prominent dilatation of both the inferior vena cava and intrahepatic veins. Cardiac cirrhosis was diagnosed with a waxing and waning course of lower leg edema.

Physical examination revealed an afebrile man with a blood pressure of 140/80 mm Hg, pulse rate of 86, and respiratory rate of 20. Chest examination was unremarkable. Jugular vein pulsation was about 4 cm above the sternal angle (~9 cm H_2O). A pansystolic murmur with an irregular heart beat was heard. There was hepatosplenomegaly with a positive sign of shifting dullness. Hyperpigmentation of both lower legs that was caused by chronic venous stasis as well as pitting edema was found. Mild left thigh erythematous swelling with no lymph node enlargement was noted.

No bullous formation was seen. There was no skin defect or tinea pedis. Laboratory studies showed a WBC count of 22,000/mm^3, with 92% neutrophils. Results of liver function

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