*Interactive case report***Fever of unknown origin: case presentation**

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This is the first of a three part case report where we invite readers to take part in considering the diagnosis and management of a case using the rapid response feature on bmj.com. Next week we will report the case progression and in four weeks' time we will report the outcome and summarise the responses

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A 19 year old university student was admitted to our hospital with history of high grade swinging temperature up to 39°C. She had had a sore throat, which lasted for a few days, accompanied by fever, rigors, and myalgia. Her general practitioner prescribed amoxicillin, and she subsequently developed a macular rash on her wrists, back, and legs associated with the fever spikes. The symptoms were persistent over three weeks, prompting referral to our department. She had travelled to Italy recently and recollected being bitten by mosquitoes. She had no history of recreational drug use or sexual contact and she was not taking any regular medication.

On initial examination she was tachycardic (100 beats/minute) and febrile (37.5°C) with a blood pressure of 108/68 mm Hg. Her oral cavity and cardiovascular, respiratory, abdominal, and nervous

Results of laboratory investigations

White cell count $16.9 \times 10^9/l$ (normal range 4-11) with predominant neutrophilia

C reactive protein 326 (normal 0-10) mg/l

Liver function tests: alanine transaminase 65 (5-55) IU/l, γ glutamyltransferase 227 (12-43) IU/l, alkaline phosphatase 127 (30-115) IU/l

Normal antistreptolysin O titres

Negative blood film for malarial parasites

Negative results for mononucleosis spot test, IgM for Epstein-Barr virus, cytomegalovirus polymerase chain reaction, hepatitis B surface antigen, and serology for hepatitis C, chlamydia, and brucella

Autoantibody screen negative (rheumatoid factor, anti-nuclear antibody, double stranded DNA, extractable nuclear antigen, and antineutrophil cytoplasmic antibodies)

Complement: C3 0.38 (0.8-2.0) g/l, C4 0.1 (0.16-0.4) g/l, cryoglobulins negative

Questions

1 What differential diagnoses would you consider?

2 What further investigations should be carried out?

3 What would you tell the patient and her parents given that tests have not revealed a clear diagnosis at this stage?

Please respond through bmj.com, remembering that this is a real patient and that she and her carers may read your response.

system examinations were normal. There was no lymphadenopathy. Her right knee was tender but she had no swollen joints. Chest radiography and abdominal ultrasonography showed no abnormality. The box lists the results of other investigations.

Blood was sent for culture and she was given parenteral cefuroxime. Preliminary blood cultures raised the suspicion of Gram positive organisms. These later grew coagulase negative staphylococcus. She was prescribed teicoplanin and gentamicin at this stage, but staphylococcus was later thought to be a contaminant. Throat swab culture, fungal blood cultures, serial bacterial blood cultures, and malarial films gave negative results. Transthoracic and transoesophageal echocardiograms appeared normal. A diagnosis remained elusive, and the patient and her parents were becoming frustrated.

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Wrong side surgery—the “code of silence”

I first encountered the “code of silence” as a medical student when I witnessed a burr hole made on the wrong side of the head. The embarrassed consultant mumbled something sheepishly, and the incident was never mentioned again. In my subsequent years of training, I observed several more wrong side errors. The consultants seldom acknowledged these mishaps, and the code of silence was tacitly observed. One cautious surgeon with whom I trained always personally marked the appropriate site before surgery. He chose not to speak of the wrong side surgical error that had undoubtedly inspired this most prudent practice.

Recently I was delayed on my way to surgery for the induction of a patient with numerous bilateral ventriculoperitoneal shunt implants. Thinking the blockage was on the right, I shaved the patient's head, opened the old incision, and found a perfectly functioning shunt. To my horror, I realised I was on the wrong side. I revised the correct side and finished the case in awkward

silence. Although I spoke to the patient and family immediately afterward, I never held any discussion with my residents. The event left me shaken, and I began to ponder my personal reaction to this preventable surgical error. In the unfortunate tradition of my mentors and role models, I too had chosen the code of silence.

The message here is not about immediate disclosure and implementation of preventive measures, but rather our reluctance as surgeons to acknowledge errors. In order to better fulfil our obligation as clinical teachers, we need to put aside our egos and engage in open discussion with our trainees. We are their role models, and they need to learn from our experiences, both good and bad. It is only by breaking this code of silence that some good may come of our mistakes.

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