



FIGURE 26-1 Structured approach to patients with FUO. ALT, alanine aminotransferase; AST, aspartate aminotransferase; CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; FDG-PET/CT, ^{18}F -fluorodeoxyglucose positron emission tomography combined with low-dose computed tomography; LDH, lactate dehydrogenase; PDCs, potentially diagnostic clues (all localizing signs, symptoms, and abnormalities potentially pointing toward a diagnosis); NSAID, nonsteroidal anti-inflammatory drug.

diagnostic pointers are numerous and diverse but may be missed on initial examination, often being detected only by a very careful examination performed subsequently. In the absence of PDCs, the history and physical examination should therefore be repeated regularly. One of the first steps should be to rule out factitious or fraudulent fever, particularly in patients without signs of inflammation in laboratory tests. All medications, including nonprescription drugs and nutritional supplements, should be discontinued early in the evaluation to exclude drug fever. If fever persists beyond 72 h after discontinuation of the suspected drug, it is unlikely that this

drug is the cause. In patients without PDCs or with only misleading PDCs, funduscopy by an ophthalmologist may be useful in the early stage of the diagnostic workup. When the first-stage diagnostic tests do not lead to a diagnosis, scintigraphy should be performed, especially when the ESR or CRP level is elevated.

Recurrent Fever In patients with recurrent fever, the diagnostic workup should consist of thorough history-taking, physical examination, and obligatory tests. The search for PDCs should be directed to clues matching known recurrent syndromes (Table 26-3). Patients