**Introduction**

Sweet syndrome is a rare inflammatory condition characterized by painful, erythematous plaques or nodules, fevers and neutrophilic dermatosis. The “classical” and more prevalent form includes development of cutaneous lesions in addition to systemic symptoms, without the presence of an underlying malignancy or drug exposure. Less frequently Sweet syndrome develops in association with certain drugs and malignancies.

**Case Presentation**

- A 63-year-old male with history of large granular lymphocytic leukemia (LGL) diagnosed two years prior, chronic pancytopenia and cryptogenic organizing pneumonia (COP) presented with a five day history of headache, subjective fevers, new rash (Image 1; A and C) over face, chest and extremities, and progressive generalized weakness and confusion.
- For treatment of COP our patient was on 30mg prednisone daily with trimethoprim-sulfamethoxazole (TMP-SMZ) and acyclovir for antimicrobial prophylaxis.
- Initial bloodwork and imaging including CT head, chest, abdomen and pelvis were unremarkable.

**Clinical Course**

- Patient was started on empiric broad spectrum antibiotics and stress dose steroids. Lumbar pucture was performed. Results of cerebral spinal fluid studies were ultimately unremarkable.
- He subsequently developed hemodynamic decompensation requiring transfer to ICU and vasopressor support.
- Punch biopsies were taken revealing neutrophilic dermatoses with hemorrhage consistent with Sweet syndrome, Sweet’s-like drug reaction, or occult infectious etiology (Image 1; B and D).
- Ultimately the patients condition improved. Antibiotics were discontinued. He was discharged on 60mg prednisone daily and TMP-SMZ was discontinued.

**Discussion**

- Our patient developed Sweet syndrome in the setting of TMP-SMZ use, a known drug etiology.
- The addition of TMP-SMZ prophylaxis for long term steroid use lowered the threshold further in a patient already at risk with his history of LGL.
- An atypical feature of this case was the patient’s profound confusion necessitating the need to rule out meningocencephalitis.

**Conclusion**

One may not readily associate the manifestation of raised, painful plaques with a systemic inflammatory condition but when accompanied by sepsis signs without evidence of an infectious source, Sweet syndrome should be included on one’s differential with a careful review of the patient’s past medical history and drug exposures.

**References**