A 65-year-old man presented to the emergency department complaining of 1-month history of back pain. He also noted fatigue, night sweats, blurry vision and 10 lb weight loss. He recalls dental cleaning recently, but denied any other medical history. He was afebrile and hemodynamically stable. Physical examination showed non-tender maculopapular rash on his palm, finding consistent with Janeway lesions (Figure 1A, arrow). Cardiac examination revealed 3/6 diastolic murmur at the left sternal border. He had pain in the left sacroiliac joint with no paraspinal tenderness. Labs showed leukocytosis and anemia. Electrocardiogram showed no conduction abnormalities. Blood cultures were positive for *Streptococcus mitis/oralis* on three sets. Fundoscopic examination showed Roth spots (Figure 1B, arrow), which are white-centered retinal hemorrhages from capillary rupture and fibrin deposition. A transesophageal echocardiogram showed 1.4 cm vegetation at the aortic valve (Figure 1C, arrow) with left coronary cusp perforation (Figure 1D, arrows). Intravenous ceftriaxone
was started, and patient underwent replacement of the aortic valve and root with no complications.

Janeway lesions and Roth spots have been historically described in infective endocarditis. Although far less frequently seen nowadays, they still could be an invaluable clue leading to earlier treatment.¹

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Reference