Key Points:
- Sweet’s syndrome is an acute febrile neutrophilic dermatosis characterized by tender, erythematous plaques +/- pustules or vesicles; most commonly occurs in middle-aged women after a URI.
- Sweet’s is associated with underlying malignancy in 20-25% of cases and with underlying infectious, rheumatologic, or other systemic disease in another 25% of cases.
- Diabetic amyotrophy is the most common polyneuropathy in diabetics; it presents with painful unilateral thigh weakness.

1. What is Sweet’s syndrome? By definition, a febrile neutrophilic dermatosis with four hallmark clinical features (below). Vast majority are middle-aged women with antecedent URI.
   a. Rash: tender, erythematous plaques and papules; may have associated pustule or vesicle formation; found on face, neck and upper extremities most commonly. When the rash occurs on the lower extremities, it may mimic erythema nodosum.
   b. Classic neutrophilic, nonvasculitic infiltration on skin biopsy.
   c. Systemic symptoms: Fever in 40-80% of cases; may also see ocular involvement (conjunctivitis, episcleritis), arthritis/arthralgias, myaglias, neutrophilic alveolitis, sterile osteomyelitis, acute renal failure, oral ulcers.
   d. Peripheral neutrophilia.

2. With which underlying diseases is Sweet’s syndrome associated? Underlying condition found in 50% of cases.
   a. Malignancy: 20-25% of patients with Sweet’s have an underlying malignancy, most commonly hematologic.
   b. Infection: bacterial, particularly streptococcal, or viral.
   c. Rheumatologic: RA, SLE, MCTD, Behcet’s, Sjogren’s.
   d. IBD.
   e. Drugs: Lithium, lasix, minocycline, OCP’s, TMP/SMX.
   f. Other: sarcoïd (especially when E. nodosum is present), pregnancy.

3. What diseases mimic Sweet’s syndrome?
   b. Infectious: Septic vasculitis, deep fungal infections, leprosy.
   c. Neoplastic: Lymphoma cutis, metastatic carcinoma.

4. What is diabetic amyotrophy?
   - Lumbar polyradiculopathy involving the L2, 3, and 4 roots.
   - Clinical presentation: thigh pain followed by painful proximal weakness in one leg; course usually over about 6 months. Diagnosis made by history, exam, and EMG. Usually occurs in the setting of patients with pre-existing peripheral neuropathy.
   - Etiology most likely inflammatory (polymorphonuclear vasculitis).

5. Femoral nerve vs. lateral femoral cutaneous nerve compression? How to tell the difference?
   - Femoral nerve compression: Quadriceps weakness with sparing of adduction function; some may have associated iliopsoas weakness. Sensory loss over anterior and medial thigh; patellar reflex diminished.
     -- Caused by hip or pelvic fractures or hematoma within iliacus muscle. Patients with diabetes may develop spontaneous femoral neuropathy.
   - Lateral femoral cutaneous nerve compression: a.k.a. meralgia paresthetica. Causes pain and diminished sensation over lateral aspect of thigh radiating down towards knee. May be caused by compression by anything from a large pannus or tight fitting seat belt to a retroperitoneal bleed.