Fever in the returning traveler is a common but challenging clinical scenario. Leptospirosis is an underdiagnosed and potentially severe disease. The evaluation should focus on clinical presentation, detailed travel history, potential exposures, incubation period, vaccines, and malaria prophylaxis. The most common clinical findings include fever, malaise, weakness, and low blood pressure for three days duration. The patient had just returned from a ten day Caribbean cruise at the time of symptom onset. He participated in numerous activities, mostly drank bottled water, avoided street food, and denied any significant animal exposures.

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A high index of suspicion is required to make the diagnosis in view of non-specific clinical findings and the biphasic nature of the illness. Weil’s disease, Leptospirosis’ severe form, is potentially fatal. It is not a common finding in other infectious diseases. Affected persons often share occupational or recreational exposure to fresh water sources contaminated by spirochetes shed from infected animal urine. A 64-year-old male with medical history of hypertension presented to the emergency department complaining of fever, chills, nausea, vomit, diarrhea, dyspnea, and severe headache. He participated in numerous activities, mostly drank bottled water, avoided street food, and denied any significant animal exposures.

Blood, sputum, urine, and stool cultures were negative. Stool O&P, Clostridium difficile toxin, as well as stool antigens for Cryptosporidium, Campylobacter, and Norovirus were not detected. Zika, Dengue, and Chikungunya viruses were ruled out by PCR and serology. Malaria, Influenza, pneumococcal studies were negative. Leptospira IgM was negative. However, Leptospira DNA was detected in urine. Serology obtained during the convalescent period confirmed the presence of Leptospira interrogans-Caniola-Caniola-Ruebsch (titer 1:320). There was concern for aseptic meningitis given agitation and altered mental status which caused delayed weaning off mechanical ventilation. However, lumbar puncture could not be performed. He completed a course of intravenous Ceftriaxone and Doxycycline which resulted in cure and was weaned off mechanical ventilation after tracheostomy placement. He participated in inpatient rehabilitation and was subsequently discharged home off antibiotics.

**Diagnosis**


Leptospirosis diagnosis confirmed.

**References**