Case report:

Case of Enteric Fever Paratyphoid with unusual duration of illness:

Still a public health issue

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Abstract:

Chronic fever, caused by the gram negative bacterium Salmonella para typhi may have a wide spectrum of clinical presentation. We report a middle aged man with typhoid fever, who developed pneumonitis an unusual complications in the course of the disease. Keeping respiratory symptoms of paratyphic and ruling out tuberculosis helped us to treat the case.

Introduction:

The largest burden of typhoid fever falls on the developing world which lacks an easy diagnostic test for salmonella infections leading to inadequate importance. Clinical manifestations vary from mild illness to life threatening complications11. The causative agent is increasingly S. Paratyphi (50% of SALMONELLA bloodstream isolates) of enteric fever in Asia. Fever in Asia, the Middle East, Africa and South America are caused by S Typhi and S.Paratyphi in decreasing order.

Case Report:

A 62-year old man from Mudipu presented with fever(100°F) of 20 days with onset since 2 months. Agricultural worker by occupation since the last 30 years, presented with persistent dry cough, weight loss, increased thirst since two months. Low grade pyrexia with morning rise, intermittent in nature was his complaints. Patient had received oral ciprofloxacin, amoxicillin and cefixime for short courses in the last two months. Patient an Arecanut plucker, smoker since 15 years. On admission patient was febrile with dry cough PR 78/min BP 100/70 mmHg. Respiratory examination was normal. Other systems were normal. Recently diagnosed type 2 Diabetes Mellitus on metformin and glimepride. He gave a history of Pneumonia 25 years back and father had succumbed to PTB 12 years back.

Complete blood count were normal about a week back with normal counts and platelets except for an elevated EST of 160mm in 1st hour, WIDAL test was negative, random sugar was 308 during the same time. Malaria, Dengue, Brucella serology was non-reactive. Total count on admission was 15300cell/cumm. Eosinophils 8%, ESR mmin 1st Hr. Blood and sputum culture were sent for culture and was started on ceftriaxone (2 gram/d). Chest x-ray showed minimal non
homogenous opacities in the bilateral lower basal zone suggestive of pneumonitis. He had good glyceimic control with oral hypoglycemic agents in the hospital. Due to the initial classical low grade fever and cough sputum acid fast bacillus (AFB) was sent thrice with a single overnightsample which was negative. His sputum and blood culture was negative for any growth. Pyrexia was persistent low grade intermittent in nature with two spikes (101°F & 100°F) on alternate days. His Mantoux test was negative. 2D ECHO and Ultra sonogram abdomen which was normal. Repeat WIDAL was sent on the 5th day of hospitalization which was positive (O-Negative, H -1:160) Paratyphi positive (AH- 1:320). A stool culture was sent, antibiotics was switched to cefotaxime (4g/d) with azithromycin (500mg/d). Fever subsided within 3 days and was afebrile till discharge.

The stool culture did show isolates of Salmonella Paratyphi A which was sensitive to ceftriaxone and resistant to ciprofloxacin.

**Discussion:**

Rarely being seen in western world hospitals, infection with S. typhi / S paratyphi remains a global health issue and an important public health concern in India. There is estimated 22 million cases with 200,000 deaths per year worldwide as per World Health Organization (WHO) due to enteric fever. Moreover the isolation of S. Paratyphi A was relatively higher than S. Typhi in Karnataka in a study conducted in year 2004 at Manipal hospitals was seen which is line with our case.

The classical picture of typhoid fever has changed with significant atypical presentation currently, which may delay the clinical suspicion of the disease. All patients who visit hospital in an endemic area would have received some treatment, which presumably has altered the presentation of the disease significantly. The clinical history history of weight loss and chronic cough elevated ESR with chest-Xray in a endemic region was leading to a diagnosis of tuberculosis with diabetes causing suspicion since sputum AFB was negative.

Ciprofloxacin was effective but there is resistance seen both in paratyphi and typhoid to the fluoroquinolones .The patient responded well to cefotaxime and was afebrile still 2 weeks after discharge from hospital.

**Conclusion**

Variations in the clinical presentation of enteric fever is still a challenge for physicians with a necessity to be aware of all possible alterations in presentation for early diagnosis and treatment.

**References**


