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Enteric Fever Presenting As Diarrhoea and Thrombocytopenia: A Case Report

Dr. S. Rajendra Prasad[1], Dr. Subash Chandra B J[2], Dr. Bhanukumar M[3], Dr. M. G. Mahesh[4], Dr. Ashok P[5], Dr. Abhithraj K[6]

[1]Assistant Professor, Department of Medicine, JSS Medical College, JSS University, Mysuru, Karnataka, India

[2]Professor, Department of Medicine, JSS Medical College, JSS University, Mysuru, Karnataka, India

[3]Associate Professor, Department of Medicine, JSS Medical College, JSS University, Mysuru, Karnataka, India

[4]Assistant Professor, Department of Medicine, JSS Medical College, JSS University, Mysuru, Karnataka, India

[5]Assistant professor, Department of Medicine, JSS Medical College, JSS University, Mysuru, Karnataka, India

[6]Resident, Department of Medicine, JSS Medical College, JSS University, Mysuru, Karnataka, India

Abstract: ***Enteric fever presenting as Thrombocytopenia is not so common. It usually presents as a complication of Enteric fever. We are reporting a case of Enteric fever in an 18 year old male who presented with diarrhea and thrombocytopenia. The patient ultimately responded to Inj.Ceftraixone and Inj.Ciprofloxacin. The platelet count started increasing towards normal levels at the time of discharge.***

Keywords: Fever, Diarrhoea, Thrombocytopenia, Salmonella Typhi

1. Introduction

Enteric fever is one of the commonest infectious diseases seen in tropical countries, including India. It usually presents with prolonged fever. The Peripheral blood smear usually described is leucopenia with lymphocytosis. Enteric fever presenting as Thrombocytopenia is not so common as it usually presents as a complication.[1,2] Here we are presenting a case of Enteric fever with Thrombocytopenia.

2. Case

An 18 year old male presented to our hospital with the history of fever along with loose stools and vomiting for 7 days. The fever was intermittent in nature, moderate degree, more during evening time not associated with chills and rigors. The loose stool was 3 to 4 episodes per day, watery, not associated with blood or mucus. There was history of pain abdomen.

Widal came as positive with the H titre being more than 1:320. QBC-MP came as negative. The patient was also started on Inj. Ceftriaxone 2 gm. IV BD. The patient had high fever in the evening and became delirious in the night. Ceftriaxone was suspected to be the cause and the dose of Ceftriaxone was reduced to 1 gm. IV BD. Inj.Ciprofloxacin was continued along with Ceftriaxone. The vitals were stable throughout the patient's stay in the hospital. The vomiting subsided on the 2nd day, but the loose stools persisted. Stool examination report came as normal. The blood culture report came as positive to Salmonella Typhi which was sensitive to Ampicillin, Piperacillin/Tazobactum, Ceftriaxone,Ciprofloxacin,Cefaperazone/Sulbactum, Cefepime, Ertapenem, Imipenem, Meropenem, Tigecycline and Trimethoprim/Sulfamethoxazole. Since the patient was already on Ceftriaxone and Ciprofloxacin, the same antibiotics were continued. USG Abdomen showed Hepatosplenomegaly, Fatty Liver, Inflamed bowel loop in Right Iliac fossa, to rule out retrocaecal appendicitis. Surgical opinion was again taken and they asked to continue the same line of management. On the 5th day of admission, patient complained of black colored stools and the stool was sent for occult blood, which came as positive. The platelet count was repeated and it had dropped to 33,000. On the 7th day of admission, patient complained of Bloody diarrhea and the platelet count was 45,000. The patient continued to have fever. The platelet count was monitored daily. In view of Thrombocytopenia, 4 bags of platelet were transfused.

There was history of vomiting which was non bilious. He also complained of discomfort in the perianal region. He had consulted various general practitioners before coming to our hospital. The patient came from an area which was endemic to malaria.

On examination there was no other localizing signs. Surgical opinion was taken for perianal discomfort and it was diagnosed as pilonidal sinus. Surgeons advised to start antibiotics since no surgical intervention was needed. Routine investigations in the form of complete haemogram, QBC-MP, Blood Culture, Urine routine, Chest X-ray, Widal, ESR were sent and the patient was started on Inj.Ciprofloxacin 200 mg BD along with Inj.Metronidazole. TC came as 7750 cells/cu.mm, RBS 107mg/dl, Urea 28mg/dl, Creatinine 1.2 mg/dl. The platelet count was 1.55 lacs/cu.mm at the time of admission. Urine routine was normal.

Dengue,Leptospira antibody, Brucella Agglutination, HIV test and Weil-Felix Test were done and all of them turned out to be negative.Inj.Artisunate was started empirically on the 7th day of admission, since the patient had persistent

fever and thrombocytopenia. On the 9th day, bloody diarrhea stopped and platelet count started increasing. Patient continued to have fever. Fundoscopy was done to rule out choroid tubercles. Montoux test was negative and the 2D-ECHO was also normal. On the 10th day loose stools subsided and the degree of fever started coming down. The fever subsided completely on the 13th day of admission and the patient requested for discharge since he had examination. Patient was discharged on request. The platelet count at the time of discharge was 1.30 lacs/cu.mm. The patient was advised to continue IV Ceftriaxone for another 2 days and T.Ciprofloxacin 500 mg for 5 days and was asked to come for follow up on OPD basis.

4. Conclusion

Enteric fever can present as Thrombocytopenia. The treating physician has to be aware of this condition. Antibiotics hasto be started as per the Blood culture report along with symptomatic management whenever such cases are encountered.

5. Acknowledgement

I would like to thank the patient and his mother for having given consent to share the details of the case.

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3. Discussion

Enteric fever presenting as fever with gastrointestinal symptoms is a known phenomenon (Enterotyphoid). But enteric fever presenting with the above symptoms along with thrombocytopenia is uncommon.[1,2]There are only few reported cases where enteric fever has presented with Thrombocytopenia[3,4]Most of the time it will be part of some other associated complications.[5,6]Our patient not only presented asEnterotyphoid, but also presented with thrombocytopenia. Toxic suppression of the bone marrow is said to be the cause of thrombocytopenia.[4]The patient had to be given platelet transfusion and the patient responded to our treatment on the 13th day after starting treatment.