Enteric With Twist – A Case of Enteric Fever with Multiple Complications

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Introduction: Enteric fever is a systemic infection caused by Salmonella enterica. It has a wide spectrum of clinical presentation. The rare manifestations include gastrointestinal bleeding, intestinal perforation, pancreatitis, endocarditis, orchitis, myocarditis, parotitis, pneumonia, arthritis, and osteomyelitis. A rare presentation of enteric fever with multi organ failure in a 10 year old girl is reported here.

Case Report: A 10 year old girl with high grade fever, vomiting, loose stools of 4 days, positive widal and S. typhi positive blood culture was diagnosed as enteric fever, managed with ciprofloxacin, was ventilated, dialysed and on inotropic support for 2 days due to ARDS and ARF before transferring to our hospital for further management. She was not vaccinated against typhoid. She was continued on ventilator and inotropic support, was started on IV Ceftriaxone. Prolonged dialysis was required due to severe metabolic acidosis, low urine output, high S.creatinine (3.7). CPK level was 6039. Peripheral smear was suggestive of microangiopathic haemolytic anemia with thrombocytopenia. The serum LDH level was high (3947). Initial echocardiography showed myocarditis. Patient developed one episode of seizures. MRI brain showed PRES changes with old infarct in posterior fossa and left frontal lobe. She developed left sided consolidation with pleural effusion, ICD was inserted. The pleural fluid revealed WBC 1150,N3,L97,RBC 1000, with no growth in culture. In view of abdominal distension, CT abdomen was done, showed bulky pancreas. S-amylase was 147IU/microl. After a month stay in PICU she was maintaining saturation in room air. Her serial echo was normalized, urine output improved. Physiotherapy was given and she was discharged only on antiepileptic drugs

Discussion: Enteric fever with multiorgan failure is being reported in adults rarely seen in children. She presented with toxic myocarditis, hemolytic uremic syndrome, rhabdomyolysis, pneumonia and pancreatitis. Hypovolemia, metabolic acidosis, acute kidney injury and disseminated intravascular coagulation were due to rhabdomyolysis.

Conclusions: This is a rare case where multiple complications are seen in a single patient. Early diagnosis and interventions, high level of critical care were key factors for favourable outcome in this patient. A high level of suspicion required for all probable complications. Proper and timely vaccination would have averted these complications.