Papillitis in a Typhoid fever patient with toxic encephalopathy and septic shock: a rare complication?

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INTRODUCTION

In developing countries including Indonesia, typhoid fever remains as an important public health problem. The disease is endemic and new cases can be seen all year long. In Indonesia each year about 640,000 - 1,500,000 cases of typhoid fever are reported with mortality rate of 1.6 - 3 %. In West Java; where this case took place; in 1995, 25,877 typhoid fever cases were reported and 9,887 cases were hospitalized with CFR of 3.74 % (West Java Health Profile, 1996).

Typhoid fever complication may involve both intestinal and extra intestinal. Among extra intestinal complications, acute confusional state is the most prevalent2.

We report a typhoid fever case with toxic encephalopathy complicated with septic shock and visual disturbance.

CASE REPORT

A 22 years old housewife was admitted to the Hasan Sadikin hospital with 6 weeks history of high fever, headache and nausea. Few days later she also experienced productive cough and then sought medication. The symptoms were gradually disappeared but remained subfebrile. Twelve days before admission the body temperature suddenly rose and ten days later she became delirious.

On admission (May 15, 1997) the patient was observed as severely ill with fever and delirium. The blood pressure was 105/60 mmHg, pulse rate 116/min, respiratory rate 24/min, and body temperature 38.1°C. Neither splenomegali nor hepatomegali was detected. Pathological reflexes and neck rigidity were not found. Laboratory tests revealed a haemo-
globin of 12.6 g/dl, white blood cell count was 5700/mm³, platelet 142,000/mm³. Ureum was 27.9 g/dl, creatinine 1.4 mg/dl, random blood sugar was 127 mg/dl. ECG showed sinus tachycardia and chest X-ray was within normal limit. We suspected typhoid fever with toxic encephalopathy as a working diagnosis with tuberculosis meningitis as differential diagnosis. The Neurologist found bilateral papilledema with suspected pseudotumor or papillitis as a cause. Liquor cerebrospinalis was normal and also head CT scan. Intravenous chloramphenicol 500 mg 4 times a day was administered, dexamethasone 3 mg/kg body weight followed with 1 mg/kg body weight every 6 hours was also given. On May 17, 1997 the patient fell into septic shock and supportive treatments (dopamine etc.) were given. On May 19, 1997 the patients gained consciousness and became alert, hemodynamic was stable and ophthalmologist was consulted due to visual disturbance on day ten. The visus was 5/12 in both eyes, and papillitis ODS was confirmed. Blood culture was positive for Salmonella typhi.

After 19 days of hospitalization the patient was discharged from hospital with normal both clinical and laboratory profile. On follow up 3 months later the visus was almost normal (VOD 6/7 and VOS 6/7).

DISCUSSION

Extra intestinal complication of typhoid fever have been reported with various organ involvement including neuropsychiatric, musculoskeletal, haematological, renal, ovary, joint, bone, spine etc. Acute confusional state is the most common neurological manifestation.

In this case the length of fever prior to admission is quite unusual for typhoid fever, perhaps there was some recovery after receiving treatment but due to inadequacy of treatment it relapsed (12 days before admission). The patient was severely ill, delirious and although treatment was given still developed septic shock. Although multidrug – resistant Salmonella typhi have been widely reported, in our hospital 94.4% of S. typhi isolates are sensitive to chloramphenicol which is still a drug of choice for typhoid fever. Chloramphenicol 500 mg was given intravenously 4 times a day combined with high dose dexamethasone as previously reported.

After consciousness was gained, both neurological and ophthalmological examinations showed the evidence of bilateral papillitis. CT scan of the head showed no intracranial masses. On 3 months follow up the visual sight was almost normal.

According to our knowledge it has not been reported earlier a typhoid fever with toxic encephalopathy, septic shock and bilateral papillitis. Since we could not confirm any other possibilities which might have caused papillitis and it recovered with the improvement of the disease, we conclude that it was a complication of typhoid fever.

REFERENCES