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Indian Academy of Pediatrics
Infectious Diseases Chapter

Clinical Grand Rounds in PEDIATRIC INFECTIOUS DISEASES



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JAYPEE

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CHAPTER 13

An Infant with Recurrent Infection

Ilin Kinimi, Ayesha Thanvi

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HISTORY

A 5-month-old male, 2nd born out of nonconsanguineous marriage, with unremarkable antenatal, natal, and postnatal history, *partially immunized* (14 weeks pending), was brought with a history of *on and off fever and cough* since past 1 and a half months. Starting at 3 and a half months, he had two discrete episodes of fever and cough—1st episode lasting for 5 days and 2nd episode associated with fast breathing, which required admission and intravenous (IV) medications.

He currently presented with high spiking fever for 10 days, insidious onset, 101–103°F, 3–4 times/day, frequency progressively increasing, no diurnal variation. He developed a *rash* since the past 4 days, that appeared 4–5 days after fever onset, was pinkish red, slightly elevated—on the face, trunk, and extremities, not involving palms and soles, no pruritus, having no relation with fever/drugs as shown in **Figure 1**. Rash was still persisting. He was also having *cough* since the past 5 days that was present throughout the day, wet type, with no post-tussive vomiting. *Fast breathing with chest retractions* were also observed since 3 days, progressively worsening, with associated history of noisy breathing, poor feeding, and lethargy.

There was no history of bluish discoloration, abnormal suck rest cycle, failure to gain weight, ear discharge, or choking episodes.

THOUGHTS AT THE END OF HISTORY

Here is an apparently well-thriving baby, partially immunized with history of recurrent respiratory tract infections (2 in 5) months, with current severe pneumonia (?bacterial, ?viral) with respiratory distress. Causes can be respiratory or nonrespiratory—upper (cleft lip/palate) and lower [tracheoesophageal fistula (TEF), congenital pulmonary airway malformation (CPAM)] jaw malformations, aspiration, pathological gastroesophageal reflux disease (GERD), cardiac (left to right shunts), cystic fibrosis, or immunodeficiency.



Fig. 1: Clinical photograph showing maculopapular erythematous rash over the trunk.

EXAMINATION

The baby was drowsy, tachycardic, tachypneic, with severe suprasternal, subcostal, and intercostal retractions, and poor perfusion and saturation 80% in room air. After stabilization, he was subsequently examined. There was pallor, nodular erythematous rashes over trunk, face, and lower extremities. Bacillus–Calmette–Guerin (BCG) scar was present.

Respiratory examination revealed decreased air entry into left infra-axillary area, crepitations in left mammary area with bronchial breathing in infrascapular area. Abdominal examination revealed hepatosplenomegaly.

THOUGHTS AT THE END OF EXAMINATION

Very severe pneumonia with respiratory failure and septic shock, nodular skin rash (?drug rash,?infections), and hepatosplenomegaly with background history of recurrent respiratory tract infection. Differential diagnoses (DDs) at this point included current infection—?bacterial, ?congenital, ?human immunodeficiency virus (HIV), ?cryptococcal, ?hematological malignancy, ?Langerhans cell histiocytosis (LCH), and ?immunodeficiency.

INVESTIGATIONS

Total leukocyte count was 8,210/mm^3, neutrophils 96.7%, lymphocytes 0.6%, platelets 810,000/mm^3, and hemoglobin 8.1 g/dL. C-reactive protein (CRP) was 132 mg/L, procalcitonin 29 ng/mL, and absolute lymphocyte count was 58/mm^3. Liver function and renal function were normal. Chest X-ray revealed left sided consolidation and absence of thymus **(Fig. 2)**.

Child was worked up for immunodeficiency and revealed low levels of immunoglobulin (Ig) G, IgM, and IgA. Lymphocyte flow cytometry could not be processed because of depleted lymphocyte count.

Ultrasound (USG) abdomen revealed a hypoechoic lesion in the liver.

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Fig. 2: Chest X-ray showing left sided consolidation and absence of thymus.

COURSE IN THE HOSPITAL

Child was stabilized on ventilator support and inotropes. He was started on higher end antibiotics—vancomycin and meropenem. Blood culture revealed no growth. Child failed to respond even after escalating antibiotics and adding empirical antifungal with persisting fever spikes and hemodynamic instability. IV immunoglobulin was also given. Skin biopsy revealed acid fast bacilli. USG guided liver biopsy showed epithelioid granuloma.

FINAL DIAGNOSIS

Severe combined immunodeficiency (SCID) with disseminated BCG infection.

DISCUSSION

Severe combined immunodeficiency is a pediatric emergency. Disseminated BCG infection occurs in 50% of SCID patients, most commonly due to disseminated BCGiosis.[1]

TAKE HOME MESSAGE

Any severe, persistent, unusual, or recurrent infection should prompt an evaluation for immunodeficiency.[2] History, examination, and a simple complete blood count can give clue to diagnosis.

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CHAPTER 14

Typhoid Fever Presenting as Urinary Tract Infection

Abhay K Shah

HISTORY AND PHYSICAL EXAMINATION

A 9-month-old Radhika presented with a history of fever without apparent focus since 10–12 days. Fever was occasionally with chills and in range of 101–102°F, as documented by parents. She was vaccinated as per age, including pneumococcal and rotavirus vaccines. Family history, past history, and developmental history were not significant. She was treated by the family physician after some reports with cefixime–clavulanate, and amikacin for 5 days, to which she responded well and got symptomatic relief. But the child again started having high fever after 15 days with vomiting and poor oral intake. She was brought to us on the 6th day of fever during the second episode.

On clinical examination, she was conscious, oriented, but ill-looking. Her weight was 7.3 kg, and height 70 cm. Vital parameters showed temperature was 102.6°F, heart rate 112/min, respiratory rate 28/min. Child was having pallor and some dehydration also. Anterior fontanel (AF) was normal. Rest of the clinical examination was normal. There was no icterus, rash, lymphadenopathy, edema or clubbing, or organomegaly. Central nervous system (CNS) examination was normal. On systemic examination, all systems were normal. Child was admitted and managed as discussed further.

THOUGHT PROCESS

This is a case of febrile ill-looking child without any apparent focus. This can be any undifferentiated viral illness including dengue or dengue-like illness, or it can be one of the bacterial infections like otitis media, urinary tract infection (UTI), typhoid fever, occult bacteremia, hidden abscess, malaria in endemic regions, or it can be meningitis as a young infant would not have positive signs of meningeal irritation. Absence of irritability/excessive crying almost rules out conditions like otitis media, and intracranial infections can also have irritability, altered sensorium or other CNS manifestation which were not present here. After taking appropriate samples including culture samples, intravenous (IV) ceftriaxone and IV fluids along with symptomatic treatment was started.

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Investigations done before presenting to us by a family physician were as follows:

- *Complete blood count (CBC):* Hemoglobin (Hb) 9.8 g%, total leukocyte count (TLC) 12,600/mm^3, neutrophils 72%, lymphocytes 26%, eosinophils 1%, monocytes 1%.
- *Urine:* 10–12 pus cells/hpf.
- Repeat investigations at our hospital revealed anemia with Hb 8.71 g%, leukocytosis (TLC 20,100/mm^3, neutrophils 74%, lymphocytes 23%, eosinophils 0%, monocytes 3%), and thrombocytopenia (platelet count 63,000/mm^3). Her C-reactive protein (CRP) was very high (133.9 mg/L) and alanine transaminase (SGPT) 54 IU/L. Routine urine examination showed presence of 50–55 pus cells/hpf, with mild albuminuria (1+), and no red blood cells (RBCs), and no cast. Blood urea was 56 mg/dL and serum creatinine was 0.8 mg/dL. X-ray chest was normal. Ultrasound (USG) revealed normal corticomedullary differentiation with normal shape and size of both the kidneys, normal ureters, and changes of mild cystitis.

All these primary investigations suggested that this child had a complicated UTI. However, this needs to be confirmed microbiologically. One should not treat it as UTI only on basis of leukocytouria without culture. To our surprise, urine culture grew significant growth of gram-negative bacteria *S. typhi* which were sensitive to ceftriaxone (remember that common bugs responsible for UTI are *E. coli*, *Klebsiella,* and *Proteus*, but not the *Salmonella*).

Blood culture grew *S. Typhi* sensitive to ceftriaxone. Widal sample was sent retrospectively which had titers of H 1:1280, O 1:320.

COURSE IN THE HOSPITAL

Child responded well to IV fluids and ceftriaxone. Improvement started in the form of improving oral intake; by day 3, spikes started coming down. By day 4, toxemia disappeared and child was discharged on day 6 with oral cefixime for next 8 days.

DISCUSSION

The typhoid is usually associated with disease of the intestinal tract, yet many instances occur wherein it localizes and causes infection elsewhere in the body. The frequency with which typhoid bacilli invade the blood during typhoid fever accounts for their dissemination to other parts of the body, and when localization does occur elsewhere it is usually regarded as a complication.

Fever, toxemia and constipation in the first week, leading to abdominal discomfort, rose spots on trunk, splenomegaly, diarrhea and vomiting in the second week.

Leukopenia and eosinopenia are quite characteristic of typhoid fever. Of late we see number of cases where such typical clinicolaboratory features may not be there.

In any febrile child without any apparent focus, one should always consider possibilities of UTI as well as typhoid fever. Both conditions are to be diagnosed by culture only. Presence of mere pus cells in urine is not equivalent to diagnosis of UTI. *Salmonella* in urine culture is an unusual bug.

Typhoid fever has many common and uncommon manifestations as described in **Table 1**.

It is also important not to miss any unusual manifestation in a day-to-day illness like typhoid fever.

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TABLE 1: Common and uncommon manifestations of typhoid fever.

Common	*Uncommon*
Fever Gastrointestinal (GI) symptoms Hepatitis Respiratory complains Acalculous cholecystitis Reactive arthritis Meningismus Leukopenia	Cardiac—myocarditis Encephalopathy Delirium Aphasia Ataxia Splenic and hepatic abscess Hemophagocytic lymphohistiocytosis (HLH), disseminated intravascular coagulation (DIC), bone marrow granuloma, hemolytic uremic syndrome (HUS) Genitourinary Cystitis Urinary tract infection (UTI) Pyelonephritis Renal abscess Nephrotic syndrome like presentation

WHAT IS UNUSUAL?

- Typhoid is usually uncommon below the age of 1 year. Here the child was only 9 months. There was marked leukocytosis and not leukopenia. *Salmonella typhi* was isolated not only in blood but also in urine which itself is quite uncommon (common bugs responsible for UTI are *E. Coli*, *Klebsiella* and *Proteus,* and not *Salmonella*). *Salmonella* UTIs are extremely rare and generally symptomatic. *Salmonella* UTIs may complicate an enteric *Salmonella* infection. Prolonged antibiotic therapy (2 weeks or longer) and follow-up urinary cultures are necessary due to recurrence or chronic asymptomatic bacteriuria.

FINAL DIAGNOSIS

Typhoid fever presenting as UTI.

TAKE HOME MESSAGE

Typhoid fever is an important public health problem caused by Salmonella typhi and Salmonella paratyphi. All patients of typhoid fever do not have typical features and atypical presentations are not uncommon. Typical presentation of typhoid fever has changed over the years. Atypical presentations can delay the clinical suspicion, diagnosis and treatment.

SUGGESTED READING

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Clinical Grand Rounds in
Pediatric Infectious Diseases

Salient Features

- The book is an ambitious project of Indian Academy of Pediatrics Infectious Diseases Chapter
- More than 35,000 copies of First edition have been sold since 2019
- Chapters are contributed by clinicians and infectious diseases specialists, with great expertise in diagnosing and managing pediatric infectious diseases
- Comprises of interesting cases in pediatric infectious diseases with presentations of uncommon manifestation of uncommon diseases, common manifestation of uncommon diseases, complicated cases where clinical acumen was used
- Each chapter does not claim to be exhaustive and does not cover every conceivable situation
- Cases that are commonly encountered in day-to-day practice have been selected. Some uncommon cases have also been included because of the interest it generates
- All the materials have been derived from cases that have been encountered and managed by the authors, mainly from their personal practice
- It will enrich the knowledge and approach of the reader, when encountered with an ambiguous and unsolved case of pediatric infectious disease
- This revised edition contains many more interesting cases and learning experiences from renowned clinicians and academicians across the country
- This fascinating collection of cases serves as a valuable reference and learning tool for pediatricians.

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