

Five Challenging Cases of Fever other than Covid

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Introduction

Five challenging cases of fever treated successfully are presented. The challenging cases with very difficult diagnoses and treatment and unexpected turn of events have been described.

- Case 1 A case of metastatic endophthalmitis from a prostatic abscess
- Case 2 A rare combination of pulmonary thromboembolism, Guillen barre syndrome with cortical venous thrombosis.
- Case 3 A case of cecal growth with bilateral deep vein thrombosis of lower limbs with pulmonary thromboembolism, IVC filter insertion, and tumor excision.
- Case 4 A case of necrotizing pancreatitis with bleeding from splenic artery pancreatectomy done with embolization of the splenic artery
- Case 5 Enteric fever diagnosed by culture of mesenteric nodes, growing Salmonella typhi.

Warning signals in cases of prolonged undiagnosed cases of fever

- Loss of appetite, nocturnal headache, flashes of light
- Gross loss of weight, gross anemia
- Bleeding per rectum, altered bowel habits
- Nonhealing ulcer
- Change of voice, personality changes
- Dysphagia, very little food causing fullness
- Change in size and color of moles/lymph nodes
- Blood-stained sputum, unexplained dyspnea
- Post-menopausal bleeding-lump in the breast

William Osler said humanities have three enemies -

- fever
- famine
- wars

19th century 2/3 deaths due to fever, due to the advent of modern methods of diagnosis, invasive, noninvasive methods, PET scan diagnosis can be made and cure patients. Undiagnosed fever lasts more than 3 weeks with temperature more than 38.3°C Durack and Street-48hr culture-negative and gave the classification.

Case 1

Metastatic Endogenous Endophthalmitis: A Rare Presentation with MRSA Prostatic Abscess

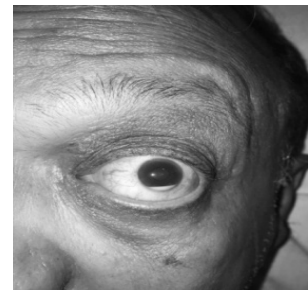


Figure 1

- L/E – Hypopyon, only Light perception
- R/E- 6/18

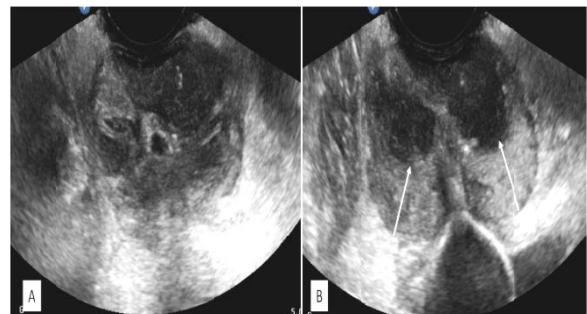


Figure 2: Transrectal Ultrasound (TRUS) Revealed Multiple Small Prostatic Abscesses.

MRSA bacteremia with prostate abscess and endophthalmitis

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Figure 3

Extremely rare, and only one case reported till date. Patient a known diabetic. He was given IV and vancomycin without surgery, prostatic abscess and hypopyon ulcer and endophthalmitis disappeared.

Case 2

A rare combination of pulmonary thromboembolism, Guillen barre syndrome with cortical venous thrombosis.



Figure 4: Bilateral Lower Limb Swelling



Figure 5

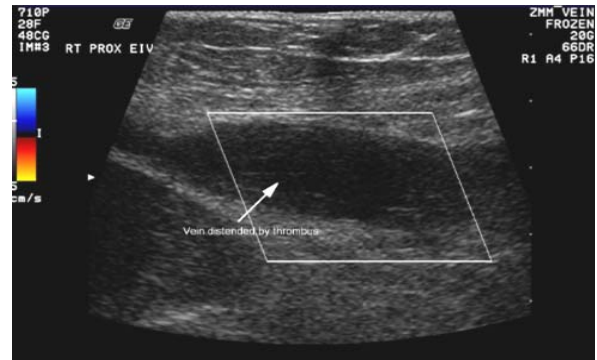


Figure 6: Venous Thrombosis Both Lower Limbs

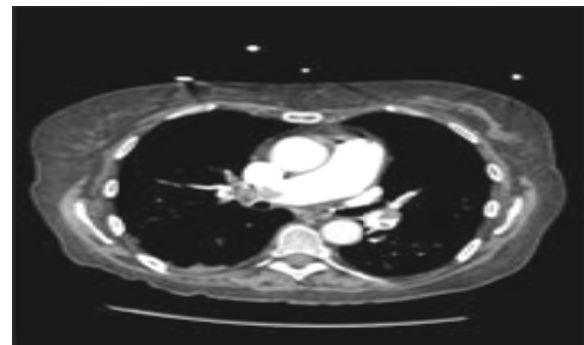


Figure 7: Hrcr - Chest Showing Pulmonary Embolism

This lady known case of endogenous depression came to the emergency breathless, ECG showed features of pulmonary thromboembolism S1 Q3 T3.

PTE was confirmed with HRCT and started on heparin. Under observation getting ready to get discharged developed Guillen barre syndrome with quadriplegia requiring IV immunoglobulin. Two days later, when she was recovering developed convulsions; MRI with MRA and MRV revealed cortical venous thrombosis. She had protein C deficiency; she recovered and was discharged. This is a rare combination of events successfully managed.

Case 3

Case summary - 80-year-old male - low-grade fever one month, known case of intracerebral bleed taken treatment in the past now came to the hospital for bilateral lower limb swelling with pyrexia venous doppler revealed deep vein thrombosis up to the

inguinal region and HRCT – chest revealed pulmonary thromboembolism.

Cases of cecal growth with bilateral deep vein thrombosis of lower limbs with pulmonary thromboembolism with IVC filter insertion and excision of the tumor.



Figure 8: Mass – Right Lower Abdomen

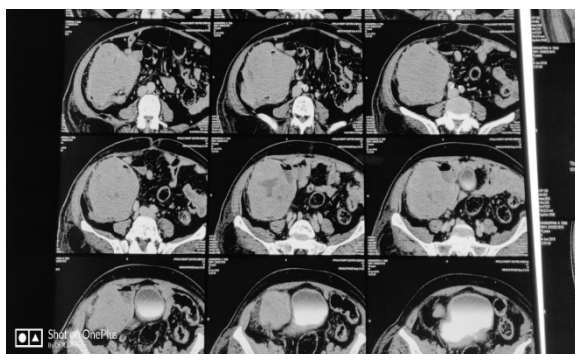


Figure 9: CT-Abdomen Showing Cecal Growth

Pre-Operative Preparation

Prophylactic IVC filter to prevent pulmonary thromboembolism.

Colonoscopy with biopsy after stopping anti-coagulation followed by surgery.



Figure 10: IVC Filter

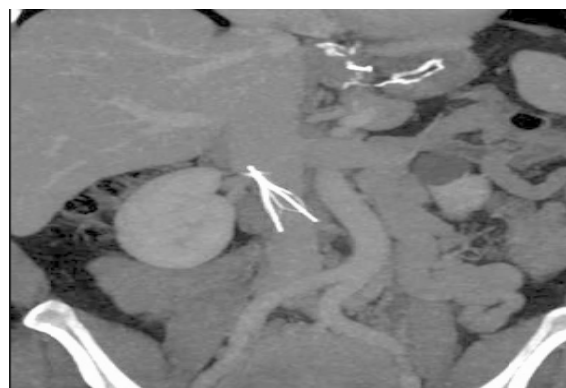


Figure 11: IVC Filter Insitu



Figure 12: Laparotomy Showing the Caecal Mass



Figure 13: Operated Specimen



Figure 14: At the Time of Discharge

Final Diagnosis

Bilateral extensive deep venous thrombosis in both lower limbs, Pulmonary thromboembolism, old case of intracerebral bleed, B-cell lymphoma of the cecum with luminal narrowing.

Purpose of presentation – prolonged fever, asymptomatic pulmonary embolism, heparin in spite of old brain bleeding, stopping heparin 2-3 times for the investigations and surgery.

Case 4

A case of necrotizing pancreatitis with bleeding from splenic artery pancreatectomy done with embolization of the splenic artery

Summary

32 years male, was admitted with fever, abdomen pain, vomiting, a state of shock. Investigations revealed necrotizing pancreatitis, ketoacidosis.

He developed ARDS treated with broad-spectrum antibiotics; Laparotomy revealed complete necrotizing pancreatitis



Figure 15: In the ICU



Figure 16: CT showing necrotizing pancreatitis

He underwent a total pancreatectomy and continued on IV antibiotics and insulin. In the postoperative period, he developed abdominal distension. Tapping showed blood in the peritoneal cavity; he was rushed to the Main hospital with blood transfusion support. The splenic artery was found to be opened up with bleeding, which was embolized, brought back to the First med, and later discharged.



Figure 17: ARDS



Figure 18: Excised specimen of necrosed pancreas



Figure 19: Abdominal distension due to blood from bleeding splenic artery



Figure 20: Blood drawn from peritoneal cavity



Figure 21: At the time of discharge

Case 5

Enteric fever diagnosed by culture of mesenteric nodes growing *Salmonella typhi*. Common fever diagnosed by uncommonly done investigation.

19-year-old male, one month fever on and off, headache, body pain, dry cough

treated outside with antibiotics on admission febrile, coated tongue, just enlarged liver and spleen no other abnormalities.



Figure 22: CT abdomen showing mesenteric adenopathy gall bladder wall thickening and ileocecal thickening

He underwent laparoscopic mesenteric lymph node biopsy – HPE result came as non-specific granuloma. He had a course of IV ceftriaxone and azithromycin with a diagnosis of enteric fever with a label of clinical enteric fever. Since blood culture was negative. To get proof of diagnosis, one test was done.

What test? Mesenteric lymph node which grew *Salmonella typhi*



Figure 23: Lymph node culture grew *Salmonella typhi*.



Figure 24: Biochemical positiveness

Ultrasound diagnosis of Typhoid Fever

On the 3rd day of fever, typhoid can be diagnosed by ultrasonogram, which shows ileocaecal thickening mesenteric nodes and gall bladder thickening. One test we did was to culture the mesenteric nodes that grew *Salmonella typhi*. *Salmonella typhi* reaches the mesenteric nodes from Peyer's patches, then stay there and occasionally cause a relapse of enteric fever

Conclusion

The above five Challenging cases of fever treated in the Advance fever clinic were very difficult to diagnose. They were treated with a successful outcome. We used a protocol for investigating difficult prolonged cases of fever by stages 1-4, First stage basic investigations including blood and urine culture—next stage CT scan. Vasculitis and transoesophageal ECHO, 3rd stage PET scan and sophisticated tests, and finally invasive procedures like biopsy, laparoscopy, endoscopy, mediastinoscopy, liver, spleen, bone marrow biopsy, pleural biopsies were done.

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