TYPHOID AND ENTERIC FEVER;CLINICAL VIGNETTES AND DECISION POINTS

Topic: TYPHOID AND ENTERIC FEVER | Subtopic: CLINICAL VIGNETTES AND DECISION POINTS

Vignette 1: A 7-year-old with 6 days of continuous fever, mild abdominal pain, and splenomegaly is drinking well and has stable vital signs. Blood culture is obtained and oral therapy is started. The key decision is outpatient versus inpatient care; because the child has no danger signs and follow-up is reliable, outpatient treatment with cefixime or azithromycin is reasonable, with review in 48 hours and clear return precautions. Vignette 2: A 3-year-old presents after 10 days of fever with vomiting, lethargy, delayed capillary refill, and abdominal distension. This is severe disease until proven otherwise. Obtain cultures immediately, begin parenteral ceftriaxone, aggressive fluids, and close monitoring. If shock or encephalopathy is present, add high-dose dexamethasone while evaluating for co-infections and complications. Escalate promptly if peritonitis is suspected. Vignette 3: An adolescent treated empirically as “typhoid” on the basis of Widal remains febrile on day 6 of oral cefixime with minimal clinical improvement. The decision point is to avoid reflex antibiotic switching without reassessment. Recheck dosing and adherence, repeat a focused examination, obtain blood culture if not already done, and evaluate for rickettsial disease, malaria, dengue, or focal complications. If culture confirms reduced susceptibility or the child worsens, escalate therapy according to susceptibility and local resistance patterns. Vignette 4: A vaccinated child develops enteric-fever syndrome. Do not assume vaccine failure or exclude the diagnosis; obtain cultures and treat based on severity, recognizing that paratyphoid and other febrile illnesses remain possible despite TCV.

References:

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