TYPHOID AND ENTERIC FEVER;CONTROVERSIES, PEARLS, AND PITFALLS

Topic: TYPHOID AND ENTERIC FEVER | Subtopic: CONTROVERSIES, PEARLS, AND PITFALLS

A frequent pitfall is equating persistent fever with antibiotic failure. Fever may take up to a week to resolve on effective therapy, especially with cephalosporins; judge response by toxicity, intake, and hemodynamics, and change antibiotics early only when the child is worsening or clearly not improving by day 5–7. Another common pitfall is diagnostic overconfidence based on serology. A "Widal-positive" result does not confirm typhoid in endemic areas and can distract from malaria, dengue, rickettsioses, tuberculosis, malignancy, or inflammatory disease; culture-first diagnosis and scheduled diagnostic time-outs reduce this harm. Classic findings such as rose spots and relative bradycardia are supportive when present but are often absent in children; their absence should not lower suspicion when the overall syndrome fits. Stewardship requires resisting unnecessary broad-spectrum escalation and using susceptibility data to de-escalate; renewed susceptibility to older agents in some regions creates an opportunity to spare azithromycin and third-generation cephalosporins when culture confirms sensitivity. Empiric fluoroquinolones are generally avoided in children because of resistance and safety considerations, despite occasional debate about their role in exceptional circumstances. Corticosteroids have a narrow indication: reserve high-dose dexamethasone for enteric fever with shock or encephalopathy, not for routine cases. Finally, remember that vaccination reduces typhoid but not paratyphoid; do not dismiss enteric fever in vaccinated children, and maintain WASH measures as the durable prevention layer.

References:

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