TYPHOID AND ENTERIC FEVER;TREATMENT: SEVERE OR COMPLICATED INPATIENT

Topic: TYPHOID AND ENTERIC FEVER | Subtopic: TREATMENT: SEVERE OR COMPLICATED INPATIENT

ENTERIC FEVER Hospitalized children require parenteral antibiotics plus close monitoring and supportive care. A common first-line regimen for severe disease is ceftriaxone 100 mg/kg/day (maximum 4 g/day) given intravenously once daily or in divided doses for 10–14 days, tailored to clinical response and susceptibility results. Cefotaxime (150–200 mg/kg/day in 3–4 divided doses) is a reasonable alternative when ceftriaxone is undesirable (for example, concern for biliary sludging or marked hepatitis) or when local protocols favor it. In severely ill children, combination therapy with azithromycin (20 mg/kg/day, oral or intravenous where available) may be used to augment intracellular activity and potentially hasten fever clearance, especially when reduced cephalosporin susceptibility is suspected. For children with serious beta-lactam allergy, seek specialist input; azithromycin-based regimens may be used when the child is stable and susceptibility is expected. If intestinal perforation is suspected, antibiotics must be broadened to cover secondary intra-abdominal flora (for example by adding anaerobic coverage) and surgical consultation should be immediate. Adjunct corticosteroid therapy is reserved for the sickest patients with shock or encephalopathy: dexamethasone 3 mg/kg as a loading dose, followed by 1 mg/kg every 6 hours for 48 hours. Supportive care includes fluid resuscitation, glucose monitoring, temperature control, early nutrition, and frequent abdominal and neurologic examinations to detect bleeding, perforation, or evolving organ dysfunction promptly.

References:

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