



# An Unusual Manifestation of a Common Tropical Infection: Correspondence

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*To the Editor:* We read with interest the article by Elwadhi et al. published in IJP [1]. Scrub typhus, a severe rickettsial endemic disease, is known for its varied presentation and multi-systemic involvement [2]. We appreciate the authors on adding to the literature-the unusual manifestation of scrub typhus, which sensitises clinicians regarding myriad presentations of scrub typhus.

The case report tells about a 15-y-old girl presenting with fever for 3 d with no significant focus and diagnosed to have scrub typhus. She was treated with intravenous ceftriaxone and was afebrile in 48 h. Drug of choice to treat scrub typhus irrespective of age is doxycycline, with typical response in 48 h [2]. Alternative effective drugs include macrolides (Clarithromycin or Azithromycin), Chloramphenicol and Rifampicin [2]. Adhikari et al., asserts that in scrub meningitis, prompt treatment with doxycycline responds well but not to ceftriaxone [3]. Notably, this child has received inappropriate treatment with ceftriaxone. Ceftriaxone-doxycycline combination therapy can only be considered when scrub typhus is associated with enteric fever, leptospirosis, and urinary tract infection as literature shows suboptimal efficacy on combination of ceftriaxone with doxycycline [4]. We contemplate this to be the norm for the antibiotic stewardship in a teaching institute.

Authors have described a rare idiopathic intracranial hypertension occurring in scrub typhus. However the evidence of CNS infection by scrub typhus in CSF analysis was not demonstrated. As the symptoms were noted to be 1 wk after the initial afebrile period, it questions the definitive association of this rare manifestation to disease

*per se* as certain viruses and other microorganisms and medications may play a role in triggering the condition which is not fully explained in this case report. We would suggest that a prompt initiation of appropriate treatment would have prevented the CNS involvement and appropriate demonstration of the organism/IgM in the CSF would have helped in definitive association with intracranial hypertension.

## Declarations

**Conflict of Interest** None.

## References

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