



# Case Report on Presentation of Scrub Typhus with Acute Respiratory Distress Syndrome

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## Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

## Article Information

DOI: <https://doi.org/10.9734/ijmpcr/2024/v17i3386>

## Open Peer Review History:

This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: <https://www.sdiarticle5.com/review-history/119143>

Case Report

Received: 20/04/2024  
Accepted: 25/06/2024  
Published: 28/06/2024

## ABSTRACT

The present study reports a case of scrub typhus with acute respiratory distress syndrome. In India, Scrub typhus has been endemic for many years. Scrub typhus is an acute febrile illness caused by the *Orientia tsutsugamushi*. The primary pathological change observed here is focal or disseminated vasculitis caused by endothelial cell destruction and perivascular leukocyte infiltration. We report a case of a 23-year-old female with nil comorbidities was referred from an outside hospital with complaints of high-grade fever, which was remittent in nature. Accompanied with symptoms such as abdominal pain which aggravated on food intake, cough without

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expectoration, nausea, vomiting, headache generalized myalgia and loose stools. This case of scrub typhus was chosen due to the wide variation in the clinical manifestations seen. It is important to determine the predictors that identify markers of severe disease in order to arrive at an early diagnosis, reduce the mortality, complications and the delay in the overall treatment.

**Keywords:** Scrub typhus; clinical manifestations; abdominal pain; febrile illness.

## 1. INTRODUCTION

Fever is a typical symptom of any infectious systemic illness and can contribute significantly to morbidity. Depending on the duration of the fever, febrile illness can be defined as acute febrile illness (AFI). AFI is defined as any illness characterized by fever lasting two weeks or less, rapid onset, and caused by a variety of pathogens with no indication of organ or system-specific etiology [1]. Acute febrile illness epidemics have caused considerable concern in India. Dengue, malaria, typhoid fever, and scrub typhus have all been documented during such outbreaks. Scrub typhus is an acute febrile illness caused by the *Orientia tsutsugamushi*. The primary pathological change observed here is focal or disseminated vasculitis caused by endothelial cell destruction and perivascular leukocyte infiltration. Scrub typhus is diagnosed based on the patient's exposure history, clinical symptoms, and serologic test results [2]. The disease is endemic throughout India and has been documented in various states, including Haryana, Jammu & Kashmir, Himachal Pradesh, Uttaranchal, West Bengal, Assam, Maharashtra, Kerala, and Tamil Nadu [3-5].

Scrub typhus has resurfaced in India in recent years, and it is now a leading cause of acute undifferentiated febrile infections (AUI) with substantial morbidity and mortality [6]. Scrub Typhus's symptomatology are diverse, ranging from a generic febrile illness to a severe multi-organ failure with fatal complications, with an overall mortality of 6-24% [7]. Acute Respiratory Distress syndrome (ARDS) is a serious manifestation of Scrub Typhus. This report highlights the need to investigate risk factors, to study the clinical course and to monitor the outcome of scrub typhus patients complicated with ARDS.

## 2. CASE REPORT

### 2.1 Presenting Symptoms

A 23-year-old female with nil comorbidities was referred from an outside hospital with complaints

of high-grade fever, which was remittent in nature. Accompanied with symptoms such as abdominal pain which was aggravated on food intake, cough without expectoration, nausea, vomiting, headache generalized myalgia and loose stools. There was no history of any rash, bleeding manifestations, hematochezia, joint pain or swelling, abdominal distension, loss of weight and appetite. She had no recent history of travel or outside food intake or a known case of Tuberculosis (TB) or Bronchial asthma. A general examination indicated a febrile patient with a temperature of 101.1°F. On examination, the patient's vitals were stable.

During the course in hospital, Patient developed complaints of severe breathing difficulty. Her Respiratory System examination showed Bilateral Basal crepitations. In addition, her complaints of loose stools have become more frequent. An Abdominal examination revealed mild tenderness localized across all quadrants of the abdomen.

### 2.2 Laboratory Findings

The hemogram revealed anemia as her hemoglobin levels were only 9.6 mg/dl. A peripheral blood smear confirmed anemia and demonstrated relative lymphocytosis. Her platelet count was normal. As far as her Liver function tests were concerned, her serum bilirubin level was normal. However her liver transaminases were exceeding the normal limits, with Serum Glutamic-oxaloacetic transaminase (SGOT) 168 IU/L and Serum Glutamate-pyruvic transaminase (SGPT) 252 IU/L. Her renal parameters were found to be normal. The blood and sputum samples were sent for culture, which revealed no growth of any bacteria. As a case of acute febrile illness, she was worked up for other tropical diseases, such as leptospirosis & dengue but reports proved otherwise.

### 2.3 Imaging Studies

A Chest X-Ray revealed a Bilateral Basal homogenous opacity (As seen as Fig. 1).

Additionally, a Computed Tomography (CT) Chest and an Ultrasound Abdomen was taken to evaluate further. The Ultrasound revealed minimal B/L Pleural effusion and mild splenomegaly. CT Chest revealed a B/L consolidation with minimal effusion in the base of the lungs (As seen as Fig. 2). These radiological features are consistent with presentations of acute respiratory distress syndrome (ARDS). Owing to her complaints, a Computed Tomography (CT) Abdomen and a 2D-Echocardiogram were taken. Her CT Abdomen revealed mild splenomegaly and ascites which correlated with her elevated liver parameters. (As seen as Fig. 3 and Graph 1). Her 2D

Echocardiogram showed no abnormality other than trace pericardial effusion.

## 2.4 Diagnosis and Treatment

Finally, the patient was diagnosed as a case of scrub typhus on clinical and serological grounds (IGM ELISA) (As seen as Table 1). Patient was already getting treated prophylactically with Doxycycline 100 mg twice daily. The patient was continued with her course of antibiotics as doxycycline is the main drug of choice for a case of Scrub Typhus. Additional supportive treatment for her ARDS and pleural effusion were also given during her stay in the hospital.

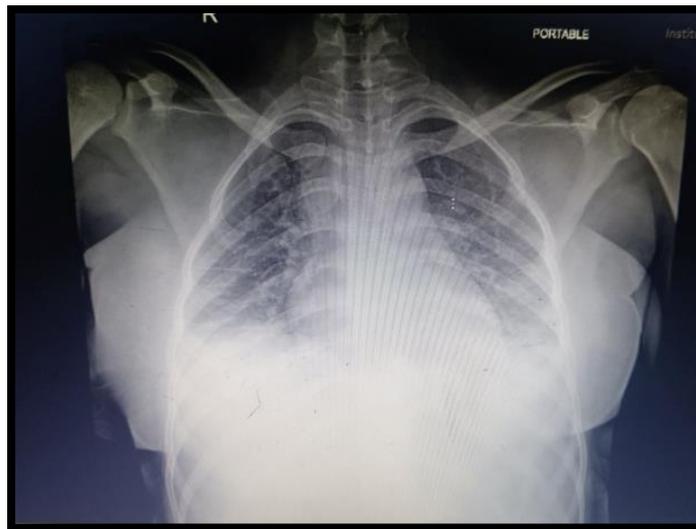


Fig. 1. Chest X-Ray – B/L Basal homogenous opacities

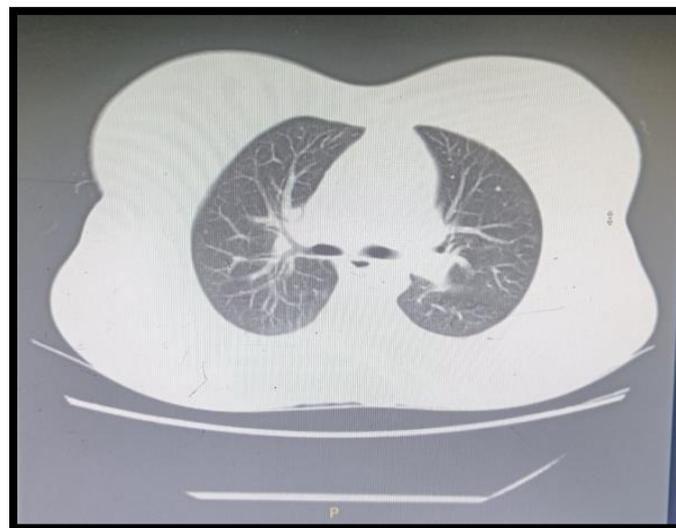
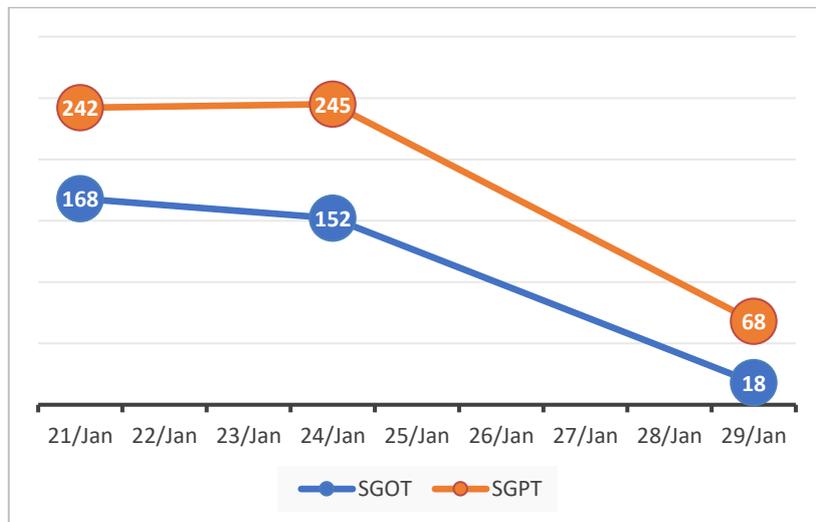


Fig. 2. CT Chest – B/L Consolidation with minimal effusion in base of lower lobe



Fig. 3. CT Abdomen – Mild splenomegaly and ascites



Graph 1. Liver function tests – Elevated SGOT & SGPT levels  
(Normal ranges: SGOT <45 & SGPT < 42)

Table 1. IgM ELISA– Positive for scrub typhus

Test	Method	Result
SCRUB TYPHUS IgM	ELISA	Positive

Her primary treatment was given based on her symptomatic presentation which involved assisted Oxygen support, Intra-venous Antibiotics, analgesics, antiemetics, Proton-pump inhibitors (PPIs), nebulization, probiotics, bronchodilators, chologogues, vitamins and other supportive measures. Subsequently, she responded well to the treatment with subsidence of both the fever and other symptoms.

### 3. DISCUSSION

Scrub typhus is a mite-borne infection that is endemic throughout Southeast Asia. Clinical symptoms include fever, chills, skin rash, eschar at the bite site, and other indicators of acute febrile illness [8]. Scrub typhus, caused by the arthropod-borne gram-negative obligately intracellular bacillus *Orientia tsutsugamushi* and transmitted by *Leptotrombidium* mites, is a potentially fatal tropical infection, with approximately a million cases recorded each year.

The clinical picture is characterized by sudden onset of fever with chills, headache, shortness of breath, cough, nausea, backache, and myalgia, profuse perspiration, vomiting, and enlarged lymph nodes [9]. Common laboratory findings are elevated liver transaminases, thrombocytopenia, and leukocytosis [10]. If not recognized and treated promptly, the infection can progress from a self-limiting disease to a fatal illness in about 35-50% of cases, resulting in multiorgan failure. Life-threatening complications such as acute respiratory distress syndrome (ARDS), hepatitis, renal failure, meningoencephalitis, and myocarditis with shock can occur in various proportions of patients [9]. Because of the vast range of clinical symptoms, scrub typhus is frequently overlooked or misdiagnosed [11].

An eschar at the location of chigger feeding site is a trademark clinical sign of scrub typhus. It starts as a papule near the chigger's feeding location, then ulcerates and creates a black crust. When it appears, it emerges before fever and other symptoms manifest. Eschar is seen in 1% to 97% of scrub typhus patients, depending on geographic area and study [12]. However, our patient did not present with the classical features of scrub typhus. She had no previous history of rashes or unknown insect bites. But clinically looking into the other clinical features and investigations, her symptoms and presentations were suggestive of scrub typhus.

The laboratory-based diagnosis of scrub typhus is based on serological tests such as the Weil-Felix test, indirect immunofluorescence assays, PCR, enzyme-linked immunosorbent assay (ELISA), and immunochromatographic testing (ICT), among others. The IgM ELISA-based approach for diagnosing scrub typhus is the most reliable of all serological assays. Our patient was diagnosed by this test, it has approximately a 91% sensitivity and 99% specificity rate [13,14]. Our case was associated with mainly associated with ARDS. The bacteria causes widespread vasculitic and perivascular inflammatory lesions, which lead to severe vascular leakage and end-organ damage [3]. Acute respiratory distress syndrome (ARDS) is an uncommon but fatal consequence of scrub typhus. It is critical to understand how ARDS can arise in scrub typhus and the potential risk factors, because the illness is curable if detected and identified early [15].

#### **4. CONCLUSION**

This case of scrub typhus was chosen due to the wide range of clinical manifestations seen. It is

important to determine the predictors that identify markers of severe disease by means of thorough history-taking and clinical examination in order to arrive at an early diagnosis. Thereby, reducing the mortality, preventing fatal complications such as ARDS and to avoid any delay in the treatment.

#### **DISCLAIMER (ARTIFICIAL INTELLIGENCE)**

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc) and text-to-image generators have been used during writing or editing of manuscripts.

#### **ETHICAL APPROVAL**

As per international standards or university standards written ethical approval has been collected and preserved by the author(s).

#### **CONSENT**

As per international standards or university standards, patient(s) written consent has been collected and preserved by the author(s).

#### **COMPETING INTERESTS**

Authors have declared that no competing interests exist.

#### **REFERENCES**

1. Shelke YP, Deotale VS, Maraskolhe DL. Spectrum of infections in acute febrile illness in central India. *Indian Journal of Medical Microbiology*. 2017 Oct 1;35(4): 480-4. Availabl:<https://pubmed.ncbi.nlm.nih.gov/29405137/>
2. Jeong YJ, Kim S, Wook YD, Lee JW, Kim KI, Lee SH. Scrub typhus: Clinical, pathologic, and imaging findings. *Radiographics*. 2007 Jan;27(1):161-72. Availabl:<https://pubmed.ncbi.nlm.nih.gov/17235005/>
3. Rapsang AG, Bhattacharyya P. Scrub typhus. *Indian Journal of Anaesthesia*. 2013 Mar 1;57(2):127-34. Availabl:<https://pubmed.ncbi.nlm.nih.gov/23825810/>
4. Kim DM, Kim SW, Choi SH, Yun NR. Clinical and laboratory findings associated with severe scrub typhus.

- BMC Infectious Diseases. 2010 Dec;10:1-7.
5. Rajapakse S, Rodrigo C, Fernando D. Scrub typhus: Pathophysiology, clinical manifestations and prognosis. Asian Pacific Journal of Tropical Medicine. 2012 Apr 1;5(4):261-4.
  6. Devasagayam E, Dayanand D, Kundu D, Kamath MS, Kirubakaran R, Varghese GM. The burden of scrub typhus in India: A systematic review. PLoS Neglected Tropical Diseases. 2021 Jul 27;15(7):e0009619. Availabl:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8345853/>
  7. Sahoo JN, Gurjar M, Harde Y. Acute respiratory failure in scrub typhus patients. Indian Journal of Critical Care Medicine: Peer-reviewed, Official Publication of Indian Society of Critical Care Medicine. 2016 Aug;20(8):480. Availabl:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4994130/>
  8. Liu X, Zhang Y, Zhang J, Lou Z, Xia H, Lu Z. The early diagnosis of scrub typhus by metagenomic next-generation sequencing. Frontiers in Public Health. 2021 Nov 11;9:755228. Availabl:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8632043/>
  9. Varghese GM, Trowbridge P, Janardhanan J, Thomas K, Peter JV, Mathews P, Abraham OC, Kavitha ML. Clinical profile and improving mortality trend of scrub typhus in South India. International Journal of Infectious Diseases. 2014 Jun 1;23:39-43. Availabl:<https://pubmed.ncbi.nlm.nih.gov/24661931/>
  10. Peter JV, Sudarsan TI, Prakash JA, Varghese GM. Severe scrub typhus infection: clinical features, diagnostic challenges and management. World journal of critical care medicine. 2015 Aug 8;4(3):244. Availabl:<https://pubmed.ncbi.nlm.nih.gov/26261776/>
  11. Rajapakse S, Rodrigo C, Fernando D. Scrub typhus: Pathophysiology, clinical manifestations and prognosis. Asian Pacific Journal of Tropical Medicine. 2012 Apr 1;5(4):261-4. Availabl:<https://pubmed.ncbi.nlm.nih.gov/22449515/>
  12. Xu G, Walker DH, Jupiter D, Melby PC, Arcari CM. A review of the global epidemiology of scrub typhus. PLoS Neglected Tropical Diseases. 2017 Nov 3;11(11):e0006062. Availabl:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5687757/>
  13. Kispotta R, Kasinathan A, Kumar Kommu PP, Mani M. Analysis of 262 Children with Scrub Typhus Infection: A Single-Center Experience. The American Journal of Tropical Medicine and Hygiene. 2021; 104(2):622-627. DOI: 10.4269/ajtmh.20-1019 Availabl:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7866334/>
  14. Kala D, Gupta S, Nagraik R, Verma V, Thakur A, Kaushal A. Diagnosis of scrub typhus: Recent advancements and challenges. 3 Biotech. 2020 Sep;10(9):396. Availabl:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7431554/>
  15. Venkategowda PM, Rao SM. Acute respiratory failure in scrub typhus patients. Indian Journal of Critical Care Medicine: Peer-reviewed, Official Publication of Indian Society of Critical Care Medicine. 2016 Dec;20(12):749. Availabl:<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5225780/>

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