

Chorea—A Rare Complication of Enteric Fever

We report here a rare case of chorea which occurred as a complication of multidrug resistant enteric fever. A 10-year-old female child was admitted with a history of fever for 9 days and abnormal movements of the body for one day. There was no history of drug intake, alteration of sensorium, convulsions, arthritis, breathlessness, palpitation or a similar episode in the past. Salient features on examination were a conscious, toxic and febrile child. The CVS and respiratory system did not reveal any abnormality. Abnormal examination revealed soft splenomegaly and hepatomegaly 2 and 3 cm below the costal margins, respectively. CNS examination revealed chorea which was generalized but involved the face and tongue maximally; deep tendon reflexes and fundi were normal.

Investigations revealed Hb 9.8 g/dl; TLC 7000/cu mm; DLC P60 L36 E4; peripheral smear showed normocytic hypochromic anemia; urine examination and culture did not reveal any abnormality; X-ray chest showed bronchitis and ECG was normal. Widal test done on the day of admission was TH 1/20 and TO nil but repeated after 1 week was TH 1/160 and TO 1/160. Blood culture on the day of admission showed growth of *Salmonella typhi* resistant to ampicillin, amoxycillin, co-trimoxazole and tetracycline but sensitive to ciprofloxacin and furoxone. ASO titre was less than 200 Todds units/ml and C reactive proteins were positive. Initially the patient was given chloramphenicol 100 mg/kg IV in 4 divided doses but on the 6th day as the patient did not show any clinical

response and blood culture revealed multidrug resistance, the chemotherapy was changed to ciprofloxacin 10 mg/kg/day IV in 2 divided doses. The patient became afebrile on fourth day of therapy and chorea gradually disappeared on the tenth day. On follow-up for 14 months after discharge there has been no recurrence of fever or chorea.

Predilection of enteric toxins to CNS is well known. Aphasia, acute cerebellar ataxia, perceptive nerve deafness, Gullaine Barre syndrome, toxic encephalopathy, transverse myelitis and optic neuritis are known neurological complications of enteric fever(1). There have been very few reports of chorea occurring as a complication of enteric fever(2-3). In a large study Scragg *et al.* examined 316 African and Indian children of enteric fever but did not encounter a single case of Chorea(4). With a recent increase in number of multidrug resistant enteric fever the number of its unusual complications has also increased(5). Recently, a case of chorea has been reported in an outbreak of multidrug resistant enteric fever in Bangalore(5). Like the other reports, our case also had a self limiting course without any sequelae or recurrence. We suggest that typhoid fever justifies its enrolment as one of the rare causes of chorea especially in the developing countries where it is much more prevalent.

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Treatment of Inverted Nipples Using Disposable Syringe

Unless recognized and corrected, inverted nipples can result in failure of lactation since, sucking is the most important stimulus for initiating and maintaining adequate breast milk supply. Inverted nipples must be recognized and corrective treatment instituted antenatally. Hoffman's exercise, breast shells, sucking on the nipple by mount and using a breast pump are some of the methods practised. We at the Department of Pediatrics have been using a simple device for the management of inverted nipples.

The Device

The Figure shows how the device is prepared. The nozzle end of a 10 ml disposable syringe is cut off (Step one) and the piston is introduced from the cut end side (Step two), as the cut end is ragged. The mother applies the smooth end to her areola and pulls on the piston gently for about a minute (Step three). Nipple will protrude into the syringe. She releases it reducing

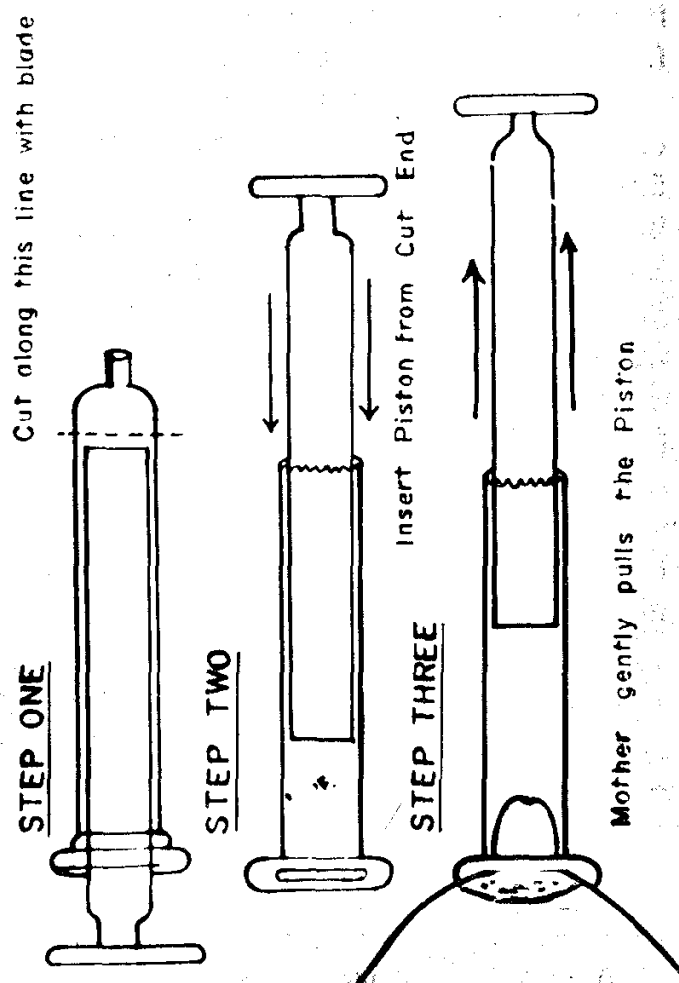


Fig. Step I. Take a 10 ml disposable plastic syringe, remove the piston and cut the nozzle end of the syringe (about 1 cm from nozzle end) as shown along the dotted line in the photograph.

Step II. Insert piston from cut end side.

Step III. Mother applies the smooth end to her nipple and areola and gently pulls on the piston. Nipple everts into the syringe.

the traction. When the nipple has protruded, the baby should be put to breast. The baby can now easily 'latch' on to the breast. The nipple might retract slightly, but with each attempt, nipple protrusion improves.

The procedure should be repeated several times a day for 3 to 5 days. This will