abnormalities were noted and intelligence quotient was normal for age.

Serum IgE level was elevated [4624 IU/ml (0-175 IU/mL], hemogram revealed eosinophilia (7%), and chest *X*-ray showed calcified opacities in the left hilum and the right paratracheal region suggestive of healed pulmonary tuberculosis. Thyroid function tests, serum cortisol, vitamin D and parathyroid hormone levels were normal. Pus culture showed *Staphylococcus aureus*. Needle cytology from cervical lymph nodes revealed reactive lymph node hyperplasia. She received topical antibiotics and oral and topical antifungals. Her skin lesions resolved in two weeks and scalp scales cleared over a period of one month with hair growth.

Most patients of Job syndrome present early in life with severe skin and lung infections [1,2]. Sporadic and autosomal dominant Hyper IgE syndrome have additional features like scoliosis, retained primary teeth, hyper extensibility and moderate eosinophilia. Autosomal recessive form lacks these features and presents with recurrent viral infections and severe eosinophilia [1]. The index patient probably had the sporadic form.

Most cases that have been reported so far had a very early onset of disease [1-3]. Wu, *et al*. [3] reported onset of disease before two years in 85.7% of patients. Antoniades, *et al*. [4] reported an overlap of Job syndrome and Dubowitz syndrome unlike the index patient who had no particular features of Dubowitz syndrome to explain her growth retardation. Investigations to rule out on endocrine cause were also normal. Repeated immunological stimulation, infections and prolonged drug intake could be a reason for her growth retardation. We report this case to highlight that Job syndrome should be kept as a differential in patients presenting late with multiple infections and growth retardation.

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Subsultus Tendinum in a Child with Typhoid Fever

A 5-year-old male child with blood culture confirmed typhoid fever presented with twitching over the left scapular region. Contrast computerized tomography and electroencephalogram were normal. Following treatment with azithromycin and clonazepam, the twitching subsided. Subsultus tendinum, a rare neurological complication of typhoid fever, resolves spontaneously with treatment.

Keywords: Enteric fever, Movement disorder, Neurological complications.

Neurological complications, including Guillain-Barre syndrome and acute transverse myelitis [1,2] following typhoid fever have been reported from typhoid endemic settings. We report a rare complication of subsultus tendinum (an involuntary twitching of the muscles of the limbs) in a young boy with blood culture-confirmed typhoid fever.

A 5-year-old boy, residing in a semi-urban settlement of Vellore town, presented to the community clinic in the area with a history of three days of fever associated with sore throat, malaise, cough, nausea, and headache. The highest temperature recorded during the episode was 103.8 °F. As a part of the SEFI (Surveillance for Enteric Fever in India) protocol, a blood culture is performed for all study children who present with three or more days of fever, and hence the child's blood culture was sent to the laboratory [3]. Blood culture grew *Salmonella enterica* serovar Typhi. Following the culture result, oral azithromycin (20 mg/kg body weight) was initiated and continued for 10 days.

Fever abated on the third day following the initiation of azithromycin. Four days following fever defervescence, the child was brought back with pain in the left side of the neck and shoulder spreading down to the scapular region, with no swelling, warmth or tenderness. Two days later, the child developed twitching movements over the left shoulder and scapular region

which increased over the next few days and was observed even while the child was asleep. There was an associated worsening of pain in the left neck and shoulder. There was no history of seizures, abnormal movements or loss of consciousness. There was no history of seizures in the family. His general and systemic examination including a complete neurological examination was normal except for the persistent twitching over his left shoulder and scapular regions. His investigations showed serum creatinine (0.39 mg/dL) and sodium (138 mmol/L) to be within the normal range. Given the persistent twitching, he was suspected to have epilepsia partialis continua. However, MRI of the brain with contrast and EEG were normal. He was evaluated by a pediatric neurologist and was started on clonazepam at a dosage of 0.25 mg twice daily. The twitching movements continued to persist during sleep; however, with decreased intensity and frequency. The twitching persisted for five weeks from the onset of his symptoms and then subsided. He was followed up again at eight weeks and 20 weeks after discharge, and was asymptomatic. In view of this clinical course, a diagnosis of subsultus tendinum complicating typhoid fever was made.

The burden of typhoid fever continues to remain high in India, especially in the pediatric population [4]. Complications that ensue following an episode of enteric fever are protean including neurological conditions [5]. These neurological complications can present as delirium, drowsiness, seizures, tremors, chorea, cranial nerve palsies, and even blindness. However, sparse literature mentions subsultus tendinum as a complication of typhoid fever in children. It is defined as the involuntary twitching of muscles, typically of fingers and wrists, and is classically described as one of the components of 'typhoid state', that occurs rarely in association with typhoid fever and occasionally with typhus fever and other bacteremias. Typhoid state is defined as a febrile state of semi-consciousness accompanied by delirium [6]. Typhoid state can be associated with carphology, which is the picking of clothes and floccillation, the state of picking at imaginary objects with the patient often found motionless and exhausted [6]. Subsultus tendinum has also been described along with the typhoid state. In this child, the twitching was not associated with delirium and it involved the muscles around the shoulder girdle rather than the fingers or wrists. Hence, we propose that subsultus tendinum need not present with the typical 'typhoid state', but can rarely present as localized twitching of the skeletal muscles around the limb-girdle, even without delirium. The condition may persist for a few weeks, and abates gradually with the treatment of typhoid fever. It is not clear if anti-seizure medication is mandated in this situation; however, it can be supportive in relieving the symptoms temporarily, with timely and appropriate anti-microbial therapy being the mainstay of management.

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