

intervals between affected individuals and apparently healthy subjects. Gollob, *et al.* [2] proposed a diagnostic criterion for SQTS. SQTS is mostly seen in males and common presentation is aborted SCD (24-32%), arrhythmias and syncope [3]. As the risk of SCD is high in SQTS, ICD placement is strongly recommended for secondary prevention. However, role of ICD in primary prevention is not well defined. Information regarding pharmacological therapy for SQTS is fairly limited, and quinidine has been suggested as one of the therapies. SQTS is considered a rare electrical abnormality associated with SCD in individuals with structurally normal heart. Timely diagnosis and optimal treatment can significantly improve the overall prognosis of the patient and family members. There is a scarcity of data about SQTS in terms of its clinical presentation, diagnosis, genotype-phenotype correlation, risk-stratification and treatment. This case aptly highlights the importance of bystander CPR in saving life in such disorders. Basic life support education should be promoted widely to save many more lives.

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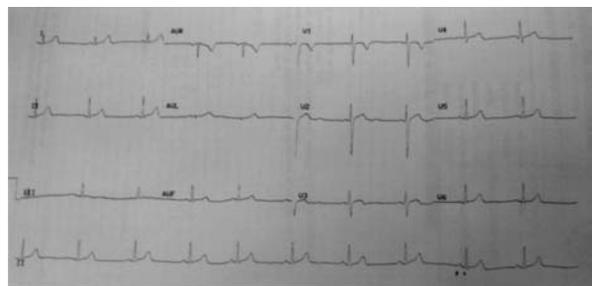


FIG. 1 ECG done at HR-60/min showing QT interval of 280ms.

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Immune Thrombocytopenia Following Diphtheria-Pertussis-Tetanus and Oral Polio Vaccine

Post-vaccination immune thrombocytopenia has been reported to occur with a number of vaccines, of which mumps measles and rubella (MMR) vaccine appear to be most common. We report a case of immune thrombocytopenia following concurrent immunization with diphtheria-pertussis-tetanus (DPT) and oral polio (OPV) vaccines.

A 3.5-month-old boy presented with generalized purpuric rash appearing six days following immunization with third dose of DPT and OPV. There was no history of any rash after previous doses of the same vaccines. On examination, there was non-blanching reddish macular rash over trunk and extremities, but no associated fever, lymphadenopathy, hepatosplenomegaly, sternal tenderness or external bleeding manifestations. Investigations revealed a hemoglobin level of 12.4 g/dL, total leucocyte count $11.3 \times 10^9/L$ (neutrophil 52%, lymphocyte 45%,

eosinophil 2%), and platelet $8 \times 10^9/L$. Liver and renal function tests were normal, and tests for anti-nuclear antibody were negative. Peripheral smear examination revealed no significant abnormality. Bone marrow examination showed normal granulocytic and erythrocytic series, with increased numbers of megakaryocytes. The child was treated with a single dose of intravenous immunoglobulin (1g/kg). The rashes gradually disappeared after 3-4 days. Within 3 days, platelet count increased to $52 \times 10^9/L$ with complete normalization occurring within 7 days. On follow-up, patient was healthy and booster dose of DPT/ OPV at 18 months of age was uneventful.

Immune thrombocytopenic purpura (ITP) is generally rare after immunization. In a study from Canada, 75% of such cases followed a measles-containing vaccine [1]. DTP or OPV vaccines are less commonly associated with ITP. Arya, *et al.* [2] reported thrombocytopenic purpura following DPT vaccination. In their retrospective series of 20 cases, Hsieh, *et al.* [3] also reported 4 cases of ITP after the first dose of diphtheria-tetanus-acellular pertussis-containing vaccine in early infancy. Other authors [4,5] have also

documented the occurrence of ITP after OPV. In our case, it was not possible to implicate the individual vaccine causing thrombo-cytopenia due to concurrent administration of both as per National Immunization schedule.

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Immune Thrombocytopenic Purpura in Typhoid Fever

A 10-year-old boy presented with fever for 5 days along with pain abdomen, headache and anorexia. On examination, there were echymotic spots over soft palate and venepuncture sites. Patient had hepatosplenomegaly; signs of meningeal irritation were absent.

Investigations were as follows: hemoglobin, 11.3 g/dL, total leucocyte count $8.4 \times 10^9/L$ (N83 L15 M2), Platelet: $45 \times 10^9/L$; C-reactive protein: 123 mg/dL, and ALT 110 U/L. Electrolytes and renal function tests were normal. Urine and stool examination showed 10-15 red blood cells/high power field. Coagulation profile was within normal range.

Patient was started on intravenous Ceftriaxone from the day of admission. Widal test showed titre of 1:320 against *S. typhi*. Blood culture also revealed growth of *S. typhi*, sensitive to Ceftriaxone.

From day three of admission, fever spikes started to decrease in severity as well as frequency. On fourth day, platelet count further decreased to $26 \times 10^9/L$ whereas CRP decreased to 23 mg/dL. On day 5, patient became afebrile but there were new echymotic spots around elbow joint with platelet count further reducing to $12 \times 10^9/L$. Bone marrow examination revealed increased numbers of megakaryocytes with other blood cell-precursors in normal ranges; a picture suggestive of Immune Thrombocytopenic Purpura (ITP).

We started oral prednisolone (2 mg/kg/d) with gradual tapering over 4 weeks. On day-10 of admission, platelet count increased to $84 \times 10^9/L$, and at 1-month follow-up, it was $183 \times 10^9/L$.

Hematological changes in typhoid fever constitute of anemia, leucopenia, thrombocytopenia and subclinical disseminated intravascular coagulation [1]. Toxin-mediated bone marrow suppression, chronic granulomatous changes and hemophagocytic histiocytosis are among the reported bone marrow changes [2,3]. Isolated thrombocytopenia in typhoid fever has been reported earlier [4], but documented bone marrow changes suggestive of ITP in blood culture proven typhoid fever is rarely documented.

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