

Detrimental effects of Enteric Fever in pregnancy: A case report

Background:

Enteric fever in pregnancy is known to cause severe perinatal complications. Salmonella typhi and paratyphi bacteria can cross the placenta and can cause vertical transmission resulting in early and late fetal demise. Negative changes to maternal immunity during pregnancy results in more disseminated maternal disease affecting multiple organs with significant risk of maternal mortality. We present a case of salmonella gastroenteritis in pregnancy complicated by direct antibody test negative hemolytic anemia and intrauterine fetal death (IUFD) in third trimester of pregnancy.

Case report

A 29 year old previously healthy primigravida of 32weeks of gestation presented with a 3 days history of watery greenish stools , vomiting and intermittent spiking fever for one day. She was admitted as a case of acute gastroenteritis and underwent comprehensive sepsis work up including stool culture. Ceftriaxone and metronidazole were started empirically, dehydration was corrected and other supportive measures were employed. Blood investigations showed anemia with hemoglobin of 7.9 gm/dl on admission which further dropped to 6.6gm/dl within 24 hours. Further blood investigations confirmed hemolytic anemia. Stool culture was positive for Salmonella paratyphi B. Antibiotics was continued for a week accompanied by blood transfusion. However, her hemoglobin continued to drop significantly even after the resolution of acute infection. Subsequently, she was initiated on parenteral methyl prednisolone and immunoglobulin. The patient received immunoglobulin for four days and steroids were gradually tapered off. Her condition gradually improved and she was discharged from the hospital after 20 days on stable condition with haemoglobin of 11 gm%. Fetal growth and well being were confirmed during the hospital stay and at the time of discharge. Later, after 2 weeks the patient presented with decreased fetal movement and was diagnosed to have IUFD at 36 weeks of gestation. She underwent induction of labour and delivered a macerated baby girl weighing 3.15 kg vaginally. Routine IUFD investigations including screening for thrombophilia, placental histopathology and maternal tissue cultured revealed no significant findings.

Discussion

In this case, despite a quick and accurate diagnosis and antibiotic therapy and supportive treatment there was a IUFD after the disease had been successfully treated. The IUFD may have been coincidental, specifically as there was no evidence of active intrauterine infection. Furthermore, the fetal growth was also normal. Previous reports have indicated that the acute infection causes a fetal demise or premature delivery however this case may indicate a longer latency period for fetal complications to develop.

