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CASE REPORT

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A case of acute encephalitis syndrome and cranial nerve palsy secondary to scrub typhus: A rare presentation from Western Nepal

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Key Clinical Message: This case report highlights the importance of considering scrub typhus as a differential diagnosis for acute encephalitis with cranial nerve palsy in the region of the tsutsugamushi triangle.

Abstract: Scrub typhus is a zoonotic rickettsiosis caused by the bacterium Orientia tsutsugamushi. This disease is endemic to a region called the tsutsugamushi triangle that extends from Southeast Asia to the Pacific Ocean. We report a 17-year-old girl from western Nepal who presented with fever, headache, vomiting, and altered sensorium, as well as bilateral lateral rectus palsy, dysphagia, regurgitation of food, dysarthria, and left-sided upper motor neuron type facial palsy. Following laboratory and imaging tests, the patient was diagnosed with scrub typhus and was treated successfully with high-dose dexamethasone and doxycycline. This case highlights the importance of considering scrub typhus in the differential diagnosis of encephalitis with cranial nerve palsy, especially in the region of the tsutsugamushi triangle. It also emphasizes the need for timely diagnosis and treatment of scrub typhus to prevent the development of various complications and ensure earlier recovery of patients.

KEYWORDS

acute encephalitis syndrome, cranial nerves, neurological syndromes, scrub typhus

1 | INTRODUCTION

Scrub typhus is a zoonotic rickettsiosis caused by the bacterium Orientia tsutsugamushi. It is transmitted by larvae of the Leptotrombidium mites and is endemic to a region called the tsutsugamushi triangle that extends from Southeast Asia to the Pacific Ocean.[1] Scrub typhus commonly infects farmers and field workers.[1] The central nervous system (CNS) can often be affected in scrub typhus, with neurological manifestations being present in approximately 20% of cases, either in the form of acute encephalitis, meningitis, or meningoencephalitis.[2] The clinical manifestations of scrub typhus are variable, with the involvement of nearly every system and organ, alone or in combination.[3] Recent epidemiological studies suggest that scrub typhus is a major cause of central nervous system infections in endemic areas.[4–6] The neurological manifestation of scrub typhus has become an emerging public

health concern beyond current endemic areas, as ecological changes may increase the prevalence of arthropod-borne CNS-infected populations worldwide.[7] On the other hand, delayed treatment can lead to significant neurological creaks and even death.[8]

2 | CASE PRESENTATION

A 17-year-old girl living in a village in western Nepal was taken to a tertiary hospital, Bir Hospital after being referred from another health center with chief complaints of fever for 17 days and altered sensorium of 4 days duration. She had a low-grade fever initially which got controlled partially with over-the-counter medication. The fever was insidious onset, gradually progressive but this time it was associated with headache, vomiting, and altered sensorium. She had no history of photophobia, ear discharge, convulsions, or focal neurological deficit. She was then taken to a nearby hospital from where she was referred to our hospital with a provisional diagnosis of meningitis. There was no similar history in the past and her family history was non-significant.

When she arrived at the emergency department of Bir Hospital, her axillary temperature was 101.2 °F, pulse was 86/min and blood pressure was 140/100 mm Hg. The respirations were regular with a rate of 18/min, and oxygen saturation was 96%. She had no eschar, rashes, or lymphadenopathy, and pupils were normally responsive. The examination of respiratory system revealed normal vesicular sounds over both lungs without any added sounds. The cardiovascular examination was unremarkable.

On neurological examination, her Glasgow Coma Scale (GCS) was E3V4M6 (i.e., 13/15). She was drowsy and confused. Motor and sensory examination revealed normal findings, superficial and deep tendon reflexes were normal and bilateral planters were flexor. Cranial nerve examination revealed bilateral lateral rectus palsy (Figures 1 and 2), dysphagia, regurgitation of food on attempted feeding, dysarthria, and left-sided upper motor neuron (UMN) type facial palsy (Figure 3).

The complete blood count revealed a total leukocyte count (TLC) of 6000/mm with 40% neutrophils, 50% lymphocytes, 8% monocytes, and 2% eosinophils. The

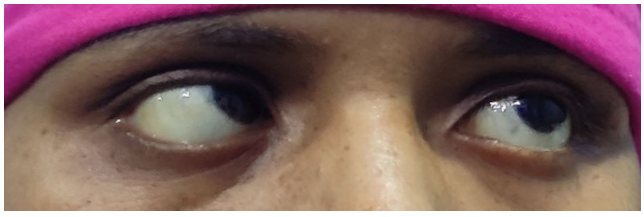


FIGURE 1 Left lateral rectus palsy in left gaze.

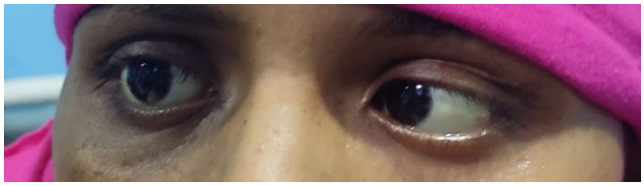


FIGURE 2 Right lateral rectus palsy in right gaze.

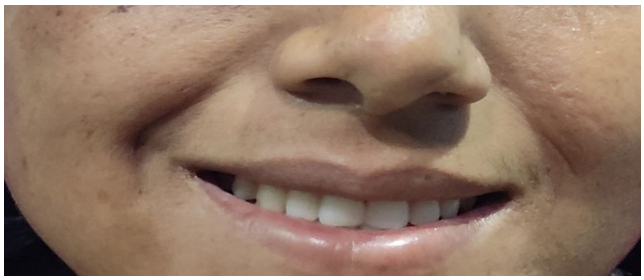


FIGURE 3 Decreased facial crease on left side.

hemoglobin was 9.4 g/L with a mean corpuscular volume of 79 fL and the platelet count was 320,000/μL. There was mild hepatic dysfunction with aspartate transaminase of 63 IU/L and alanine transaminase of 66 IU/L. Total serum bilirubin was 0.5 mg/dL, and albumin was 4 g/dL. Serum sodium, potassium, calcium, and phosphorus were within normal limit. The renal functions were normal with urea of 16 mg/dL and creatinine of 0.8 mg/dL.

Blood and urine cultures were sterile. Serological tests for dengue IgM antibodies and NS1 antigen, herpes simplex, and Japanese B encephalitis IgM antibodies were negative. Simultaneous search for other tropical infections like malaria and leptospirosis were negative; however, scrub IgM was positive. A guarded lumbar puncture was performed and the CSF analysis yielded a cell count of 16 cells μ/L with 80% lymphocytes and 20% neutrophils. Total protein was elevated to 125 g/dL, glucose was 82 mg/dL, and adenosine deaminase was 2.5 IU/L. No organism was seen on the Gram stain, Ziehl-Neelsen stain, and India ink stain. CSF cultures were sterile, and PCR was negative for herpes simplex virus (HSV) and Mycobacterium tuberculosis. The magnetic resonance imaging (MRI) of brain was done and MRI of brain reveled multiple mildly increased T2DM/FLAIR signal in midbrain, pons and in left middle cerebellar peduncle, insular lobe, and adjacent thalamus. (Figures 4–6).

Ceftriaxone, which was already started at the center where she was referred, was continued and the dose was doubled to 2 g two times per day. Acyclovir was added intravenously at a dose of 500 mg three times per day and was discontinued after exclusion of herpes simplex encephalitis. Dexamethasone was started at a high dose (1 g) to ease cerebral edema. Ceftriaxone was substituted with doxycycline

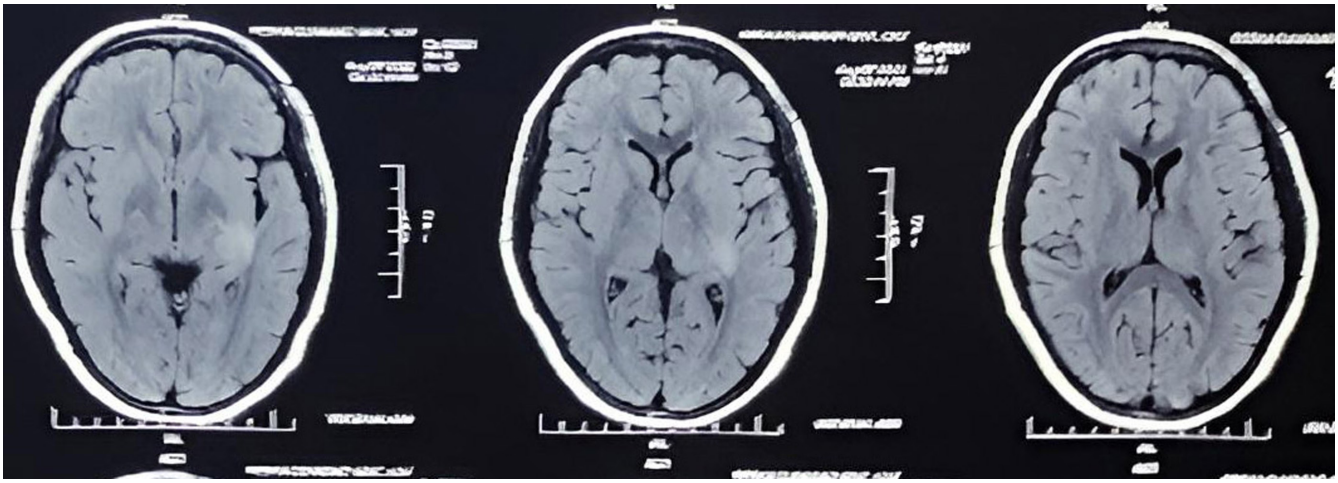


FIGURE 4 Hyperintense T2/FLAIR Axial images on left insular lobe and adjacent thalamus.

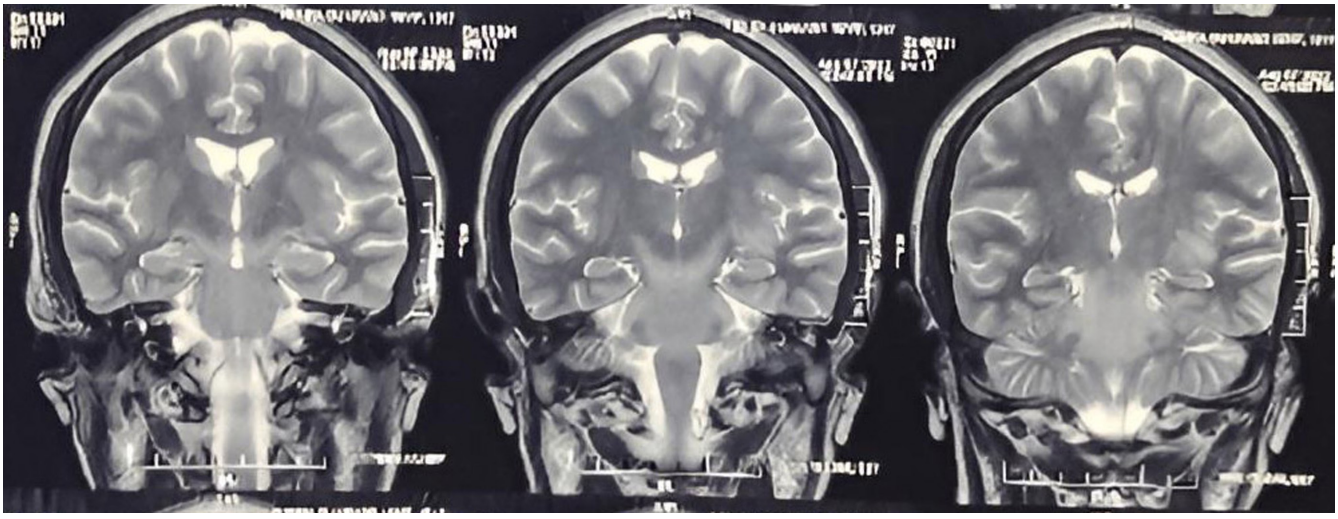
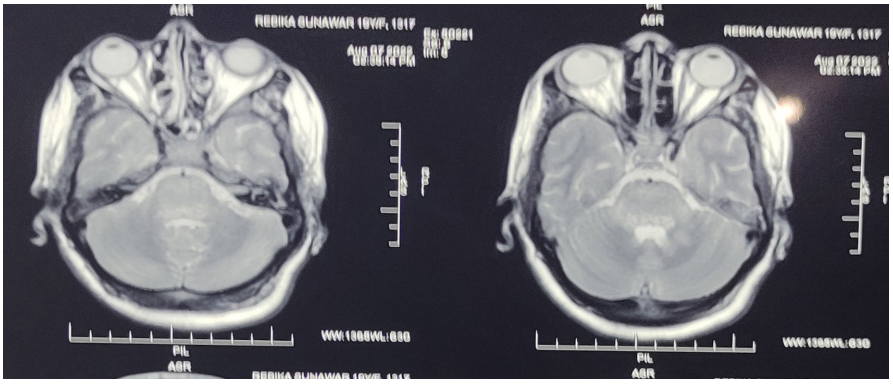


FIGURE 5 Hyperintense T2/FLAIR coronal images on pons and in left middle cerebellar peduncle, insular lobe, and adjacent thalamus.

FIGURE 6 Hyperintense T2 Axial images with mildly increased signal in pons.



100 mg two times per day intravenously after scrub typhus was diagnosed. Two days later, the fever subsided, and gradually she was able to communicate verbally and eat on her own. Objective improvement was documented on MRI. Doxycycline was administered for a total of 2 weeks.

3 | DISCUSSION

There have been few attempts to study scrub typhus in Nepal. In 1981, a high probability of scrub typhus was identified in Nepal by detecting high antibody titers (10%)

in healthy adults. IgM antibodies to O. tsutsugamushi were positive in samples from various regions, including 30 districts in Nepal. Positive cases have been found in different ecological regions of Nepal.[9]

Humans are infected by the bite of the larvae of the leptothrombidium mite. From the bite site, bacteria are distributed throughout the body via blood and lymph. It induces endothelial injury, leukocyte perivascular infiltration, increased vascular permeability, and an vasculitic response with severe microvascular thrombosis leading to organ damage.[1,10] Classically, scrub typhus presents with fever, headache, cough, myalgia, arthralgia, lymphadenopathy, and maculopapular rash that begins from the trunk and spreads to the limbs.[11–13] The "eschar," which are thought to be the hallmark of the disease, are the bites of these chiggers that creates wound similar to "cigarette burns".[1,10] "Characteristic" symptoms of scrub typhus have been occasionally reported, with the characteristic crust occurring in only 20% of patients and lymphadenopathy in 24%. Nevertheless, the eschar occurs more frequently in adults, and conversely, and conversely organanomegaly can occur in children. However, the absence of these signs should not rule out scrub typhus infection, as these features are present in only 1 in 4–5 patients with confirmed CNS scrub typhus. Given its potential impact on long-term morbidity, clinicians should be alert to the possibility of acute convulsive activity in children with central nervous system scrub typhus.[14] The microbe has an increased propensity of infecting organs that are highly vascularized, like the liver, brain, heart, and lungs.[11] Hence, beginning from second week, the infection, if untreated, progresses to complications like acute diffuse encephalomyelitis, encephalopathy, meningitis, cranial nerve palsies, congestive heart failure, vasculitis, myocarditis, pneumonia, acute respiratory distress syndrome, acute renal failure, gastrointestinal bleeding, alterations in liver functions, and pancreatitis.[11–13,15] Among the complications, myocarditis and encephalitis are the most life-threatening ones.[16] Doxycycline is the drug of choice and azithromycin is the drug of choice for children and pregnant women.[17]

Despite the growing number of clinical studies addressing the neurological complications of tsutsugamushi disease, there are surprisingly few studies to clarify the underlying mechanisms of neuroinvasion and neuroinflammation.[8] Spread of bacteria from the periphery to the central nervous system occurs by hematogenous spread.[18,19]

Although the exact mechanism of entry into the central nervous system is unknown, there is evidence that direct entry may occur through damage to the microvascular endothelium or disruption of the blood–brain barrier through transcellular translocation of bacteria, which can occur independently or by way of macrophages that have engulfed the bacterium. After entering the central nervous system, it activates specific transcription factors, such as the nuclear factor kappa B, which causes inflammation.[14] Orientia tsutsugamushi has an endothelial cell tropism and invades dendritic cells, monocytes, and tissue macrophages. Endothelial invasion causes vascular injury with intestinal perivascular mononuclear infiltration leading to complications.[20]

Several neurological syndromes have been reported in association with scrub typhus. Literature review reveals case reports of acute transverse myelitis, myoclonus, parkinsonism, and acute disseminated encephalomyelitis.[21–23] Solitary or multiple cranial neuropathy is an uncommon neurological manifestation of scrub typhus infection.[2] Cranial nerve disorders such as facial paralysis, sensorineural hearing loss, trigeminal neuralgia, and diplopia due to abduction paralysis were observed.[24–27] Few authors suggest that scrub typhus should be considered as a differential diagnosis in all patients with aseptic meningitis with renal or hepatic impairment living in endemic areas.[28] They found that the CSF profile mimics tuberculous meningitis or viral meningitis. CSF had predominantly lymphocytic pleocytosis, elevated protein with low or normal glucose.

As per the definition, acute encephalitis syndrome presents with the fever in association with seizure, altered mental status and the focal neurological signs like ataxia, aphasia, cranial nerve palsy, or hemiparesis.[12] Our patient presented with the symptoms of fever, headache, vomiting, and altered mental status associated with the signs of bilateral lateral rectus palsy, dysphagia, regurgitation of food, dysarthria, and left-sided UMN type facial palsy that is suggestive of acute encephalitis syndrome with cranial nerve palsy.

The neuroimaging findings for meningoencephalitis due to scrub typhus are quite limited. There have been reports of radio imaging findings of lesions on a white matter involving the subcortical, periventricular deep white matter, corpus callosum, cerebellar peduncles, brain stem, and basal ganglia, as well as gray matter lesion and microhemorrhages.[29] Kar et. al.[12] have reported the presence of diffuse cerebral edema along with T2-weighted and FLAIR hyperintensities in the putamen and thalamus, suggesting brain parenchymal involvement. The diagnosis of encephalitis in our case was further supported by the multiple mildly increased T2DM/FLAIR signal in the midbrain, pons, and left middle cerebellar peduncle.

4 | CONCLUSION

In conclusion, we report a case of scrub typhus presenting as acute encephalitis and cranial nerve palsy treated

successfully with high-dose dexamethasone and doxycycline. The unique feature in our case was the unusual involvement of cranial nerves due to scrub typhus. Therefore, while evaluating a case of AES with cranial nerve palsy with suspected infectious disease etiology, it is essential to consider scrub typhus among differential diagnoses, especially in the region of the tsutsugamushi triangle. A timely diagnosis and treatment can help prevent the development of various complications and can help with earlier recovery of patients.

AUTHOR CONTRIBUTIONS

Seshkanta Lamichhane: Conceptualization; data curation; formal analysis; methodology; validation; visualization; writing – original draft; writing – review and editing. **Eliz Achhami:** Conceptualization; data curation; methodology; project administration; resources; visualization; writing – original draft; writing – review and editing. **Satyam Mahaju:** Conceptualization; formal analysis; methodology; writing – original draft; writing – review and editing. **Rabin Gautam:** Formal analysis; methodology; supervision; writing – review and editing. **Amrit Adhikari:** Methodology; validation; writing – review and editing.

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CONFLICT OF INTEREST STATEMENT

The authors would like to declare that they have no competing interests.

DATA AVAILABILITY STATEMENT

All the data generated or analyzed during this study are included in the manuscript.

CONSENT

Full written informed consent was obtained from the patient for the publication of her case, clinical images, and radiographic images. A copy of written consent can be made available to the editor in chief of this journal upon request.

ETHICAL APPROVAL

As case reports are exempt from ethical approval in our institution, our article which describes a case report does not require additional permissions from the Ethics committee.

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