

Common Fevers seen by Family Physicians, where A normal looking Patient can die within a Few Days

OP Kapoor

There are certain fevers, which can be fatal for example haemorrhagic dengue, severe falciparum malaria, and very severe infection of salmonella. But in these conditions, the patient looks very toxic, often has impaired sensorium, apathy, delirium, etc, where the GP would warn the family members, in advance.

I would like to draw the attention of family physicians to two examples of common fevers, where the patients really look normal, but if the diagnosis is missed, the patient can die.

1. **Infective Endocarditis** : This condition is being seen more and more because of better diagnosis. Though endocarditis can involve even normal valves, it usually involves the abnormal valves. The diagnosis is definitely very tricky as all the signs described in books, like clubbing of nails, splinter haemorrhages and palpable spleen are often not seen.

The only signs, which will draw your attention, are presence of fever (any type of low/high or intermittent fever) associated with severe anaemia and a murmur in the precordium. If the patient has an abnormal valve of heart the diagnosis becomes easier. Four to six blood cultures and 2 D Echo Cardiography of the valves often help to make a diagnosis of the patient, and he responds to modern antibiotics, given intravenously. In the past, majority of the patients used to die

of brain complications.

In the last few weeks, I saw two patients of infective endocarditis. The first was a young man, whose fever lasted for 12-13 days, but could not be diagnosed by the family physician. The patient had a cerebral haemorrhage and was hospitalised, but died. The relatives of the patient blamed the family physician. In case of patient having fever of so many days duration, with no diagnosis, responsibility should be shared by asking for a second opinion.

The second case was easier to diagnose. A female patient having a prosthetic valve developed fever, for which there was no obvious cause, but the patient had severe anaemia with Hb of 8 G. Although 2 hourly blood cultures were asked for, they were all negative. The patient had remission of fever even after some antibiotics. After five days, she developed severe pain in both the calves due to emboli in the arteries which was confirmed by Doppler studies. The diagnosis of culture negative infective endocarditis was made and 2 D Echo (TEE) showed some vegetations on the prosthetic valve. Currently, she is being treated, following which the valve will have to be replaced.

2. **TB Meningitis** : TB Meningitis is another condition, which if missed can lead to either death or severe morbidity due to brain complications like hydrocephalus. The problem is that these patients do not present with straightforward symptoms and signs like severe headache, vomiting, marked neck stiffness and rigidity. Since the diagnosis

Ex. Hon. Physician, Jaslok Hospital and Bombay Hospital, Mumbai. Ex. Hon. Prof. of Medicine, Grant Medical College and JJ Hospital, Mumbai 400 008.

cannot be made with routine blood and urine tests, is often missed. In TB meningitis often the fever is not very high or the headache is not very severe but dull, like in a case of viral fever or typhoid. Often the neck rigidity is only mild and felt only in the terminal phase. The moment you come across a patient like this where the fever continues for more than

10-12 days with no diagnosis, a CSF examination must be asked for, to rule out TB meningitis.

I have not discussed the causes of PUO, nor patients of severe falciparum malaria, Haemorrhagic dengue, or severe salmonella infection, which can be easily diagnosed with the help of common investigations.

ASTHMA : STILL MORE QUESTIONS THAN ANSWERS

First, what is asthma? With every now piece of the puzzle, the notion of asthma as one unifying disease concept is disappearing further into the realm of historical oversimplification. We made a plea to abandon asthma as a disease concept. Asthma is at best a syndrome with different risk factors, different prognoses, and different responses to treatment.

In practice, although this is achievable in most patients with mild asthma, many patients with more severe disease will not be optimally controlled. Treatment success varies from patient to patient, can change rapidly with exposure to environmental triggers and depends highly on the correct use of guidelines by primary-care physicians and adherence to treatment by patients.

Adherence is dependent on many factors, including the affordability of expensive inhalers.

Whether busy primary-care physicians will have the time and expertise for such an approach is questionable.

Progress in understanding asthma and its underlying mechanisms is slow; treatment can be difficult and response unpredictable; and prevention or cure is still a pipedream. Asthma, one of the most important chronic diseases, remains a genuine medical mystery.

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