Case Presentation

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HOPI.

- 13 years old Malay boy
- Presented in April 2018 with history of fever and epigastric pain for 1 day duration associated with shortness of breath and palpitation
PMH

- HbH disease
- Non transfusion dependent
- Required transfusion 2-3 times/year (53ml/kg/yr) – usually when symptomatic with a Hb level less than 7g/dL
- Iron overload
  - On iron chelation therapy since June 2017 (T. deferiprone 500mg TDS: 50mg/kg/day)
  - 1417 (June 2017) → 1154 (April 2018)
  - MRI T2* in Jan 2018: moderate liver iron overload, no cardiac iron overload
    - Liver 2.4 ms, LIC 12.9mg/g
    - heart 43.8 ms, MIC 0.4mg/g
Physical examination

• Pallor
• Not septic looking
• Temperature: 38.8°C. Other vital signs stable
• Abdomen: non-tender, 2cm palpable liver, 4cm palpable spleen (increased 2cm from usual 2cm)
• Other system examination was normal
• FBC Hb 9, HCT30, TWC 9.1, plat 147
He was treated as viral fever with symptomatic anaemia
- Antipyretics

Fever persisted. Other complaints resolved.
Dengue NS1, IgM, IgG: negative  
UFEME: normal  
Hep B/C: non reactive  

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Blood C&S (23/4/18 & 26/4/18) : no growth  
Fungal C&S : no growth  
Urine C&S: NG  
• USG Abdomen
  – Splenomegaly with microabscesses

  ❖ Spleen is enlarged measures 14.4cm with multiple tiny hypoechogenic lesions within the spleen
  (Spleen enlargement 1.6cm more compared to 1 year ago)
  ❖ Liver is normal in size and in echogenicity with smooth echotexture and regular border. No focal liver lesion appreciated.

No screening for meliodosis done (fever persisted but patient stable and not septic looking)
Final diagnosis: Splenic abscess

Treatment

- IV fluconazole 435mg (12mg/kg/dose) loading dose, then 215mg (6mg/kg/dose) Daily
- IV Ceftriaxone 1.7g (50mg/kg/dose) BD
CEPT brain, thorax, abdomen and pelvis (after 1 week of antibiotic)

- Mild splenomegaly. No focal splenic lesion.
- Mild ascites.
- No focal enhancing brain lesion.
- No demonstrable lung cavitation.
• Completed Ceftriaxone and Fluconazole for 1 week duration
• Fever resolved, spleen smaller in size (2cm palpable below subcostal margin)
• CRP reduced 0.64
• Blood culture no growth
Repeated USG abdomen after 1 month

- Splenomegaly, resolved splenic microabscess
Case discussion.

- How common is severe bacterial infection in NTD thalassemia?
- How common is splenic abscess in NTD?
- Any ways to prevent such incidence?
- Any possibility of recurrence? If yes, what should we do?
Thank you