TROPICAL MEDICINE QUESTIONS AND ANSWERS

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Questions and Answers

Question 1

RUGARAMA SCHOOL OF NURSING AND MIDWIFERY - N0.75

- List 5 cardinal signs and symptoms of cholera.

- Outline 10 specific nursing care in an outbreak of cholera.

ANSWER: Examination Script

1. Profuse, Watery Diarrhea ("Rice-Water Stools"): This is the hallmark symptom. Stools are typically voluminous, painless, and have a pale, milky, or cloudy appearance resembling water in which rice has been washed. May occur suddenly and very frequently.

2. Vomiting: Often occurs after the onset of diarrhea, can also be profuse, and is usually clear or watery.

3. Severe Dehydration: Rapid loss of large volumes of fluid and electrolytes through diarrhea and vomiting leads quickly to signs of dehydration: Intense thirst. Dry mucous membranes (mouth, tongue). Sunken eyes. Loss of skin elasticity (skin tents when pinched and returns slowly). Decreased urine output (oliguria) or no urine output (anuria). Weakness, lethargy.

4. Muscle Cramps: Painful cramps, especially in the legs and abdomen, due to significant loss of electrolytes like sodium, chloride, and potassium.

5. Signs of Hypovolemic Shock (in severe cases): If dehydration is severe and not corrected, shock develops: Rapid, weak pulse (tachycardia). Low blood pressure (hypotension). Cool, clammy skin. Altered mental status (restlessness, irritability, progressing to lethargy or coma).

6. Fishy Odor to Stools: Some sources describe a distinctive fishy smell to the cholera stools. (Mentioned in PDF for Rugarama NO.75)

7. Wrinkled "Washerwoman's Hands": Skin on hands and feet may appear shriveled due to severe dehydration.

1. Rapid Rehydration Therapy: This is the most critical intervention. Oral Rehydration Solution (ORS): For mild to moderate dehydration, administer ORS frequently in small sips. Intravenous (IV) Fluids: For severe dehydration or if patient cannot take ORS (e.g., due to persistent vomiting, shock), administer IV fluids (e.g., Ringer's Lactate or Normal Saline) rapidly according to WHO plans or physician orders to correct shock and deficits.

2. Strict Infection Prevention and Control Measures: Cholera is highly transmissible via contaminated food/water. Hand Hygiene: Meticulous handwashing with soap and clean water by staff, patients, and caregivers, especially after contact with patient, feces, vomitus, or contaminated items, and before handling food. Isolation Precautions: If hospitalized, contact precautions (gloves, gown) when dealing with patient or contaminated materials. Isolate patient if possible, or cohort with other cholera patients. Safe Disposal of Excreta and Vomitus: Disinfect feces and vomitus (e.g., with chlorine solution) before disposal in a latrine or designated area. Use dedicated bedpans/containers and disinfect them thoroughly. Disinfection of Contaminated Surfaces and Linen: Clean and disinfect patient care areas, bedding, and clothing with appropriate disinfectants (e.g., chlorine solution).

3. Monitoring Fluid Balance and Hydration Status: Accurate Intake and Output Charting: Record all fluids given (oral, IV) and all losses (diarrhea stools - estimate volume/frequency, vomitus, urine). A "cholera cot" (bed with a hole and calibrated bucket underneath) can help measure stool output. Regular Assessment of Dehydration Signs: Monitor skin turgor, mucous membranes, sunken eyes, pulse, blood pressure, level of consciousness, urine output. Daily Weights (if feasible).

4. Administration of Antibiotics (if prescribed): Antibiotics (e.g., Doxycycline, Azithromycin, Ciprofloxacin, depending on local resistance patterns) can shorten the duration of diarrhea and reduce fluid loss, and reduce shedding of Vibrio cholerae. Not a substitute for rehydration.

5. Nutritional Support: Encourage continued feeding (including breastfeeding for infants) as soon as the patient can tolerate food, usually after initial rehydration and cessation of vomiting. A normal diet can be resumed.

6. Zinc Supplementation (especially for children): WHO recommends zinc supplementation for children with diarrhea as it reduces duration and severity.

7. Health Education to Patient and Family/Community: Safe Water Practices: Drink only boiled, chlorinated, or bottled water. Food Safety: Cook food thoroughly and eat it while hot. Wash fruits/vegetables with safe water. Avoid raw or undercooked seafood or street-vended food during an outbreak. Handwashing with Soap: Emphasize critical times. Sanitation: Use latrines or designated toilets for defecation. Safe disposal of human waste. How to prepare and use ORS at home. Recognizing danger signs and seeking prompt care.

8. Monitoring for Complications: Such as hypokalemia (low potassium), hypoglycemia (especially in children), renal failure (due to severe dehydration), pulmonary edema (from overzealous IV fluid replacement).

9. Comfort Measures: Keep patient clean and dry. Provide oral care. Manage muscle cramps.

10. Surveillance and Reporting (in an outbreak context): Accurately document and report cases as per public health requirements to help track and control the outbreak. Participate in contact tracing if needed.

11. Safe Waste Management in the Health Facility: Ensure all contaminated waste (dressings, gloves, body fluids) is handled and disposed of according to infection control protocols to prevent spread within the facility. (PDF point)

12. Ensure Sterilization/Disinfection of Used Articles: Properly disinfect or sterilize any reusable items that have come into contact with the patient or their excreta before they are used for another patient. (PDF point)

Question 2

LYANTONDE SCHOOL OF NURSING AND MIDWIFERY - NO.74

- List 5 clinical features of measles.

- Outline 5 causes of measles in infants. (Interpreted as risk factors/reasons for susceptibility)

- Describe the management of measles in children.

ANSWER: Examination Script

1. High Fever: Often one of the first signs, can rise to 39-40.5 degC (103-105 degF).

2. The "3 Cs": Cough: A persistent, dry, hacking cough. Coryza: Runny nose, similar to a common cold. Conjunctivitis: Red, watery eyes, often with photophobia (sensitivity to light).

3. Koplik's Spots: Small, white or bluish-white spots with a red base found on the inside of the cheeks (buccal mucosa) opposite the molars. These are pathognomonic (specifically characteristic) and appear 1-2 days before the skin rash.

4. Maculopapular Rash: A characteristic red, blotchy rash that starts on the face (behind ears, along hairline) and spreads downwards over the body. It consists of flat red spots (macules) that become raised bumps (papules) and may merge (become confluent). Fades after 5-6 days, often with brownish discoloration and fine skin peeling.

5. Malaise and Fatigue: General feeling of being unwell, tired, and irritable.

(Additional common features) Anorexia (loss of appetite), sore throat, lymphadenopathy.

1. Lack of Vaccination / Incomplete Immunization: This is the primary reason. Infants who have not received the measles vaccine (or have not completed the recommended two doses) are highly susceptible if exposed to the virus.

2. Waning Maternal Antibodies: Infants born to immunized mothers receive some passive immunity through placental transfer of IgG antibodies, but this protection wanes over the first 6-9 months of life, leaving them vulnerable until they receive their own first dose of vaccine.

3. Exposure to an Infected Individual: Measles is extremely contagious. Close contact with someone who has measles (e.g., in the household, daycare, or community) is a direct cause of infection in a susceptible infant.

4. Malnutrition (especially Vitamin A Deficiency): Malnourished infants, particularly those deficient in Vitamin A, are at higher risk of contracting measles and experiencing more severe complications, including blindness and death.

5. Immunocompromised State: Infants with weakened immune systems (e.g., due to HIV infection, certain congenital immunodeficiencies, or immunosuppressive therapy) are more susceptible to measles and can have very severe or atypical presentations.

6. Crowded Living Conditions / Outbreak Settings: Overcrowding facilitates the rapid spread of airborne viruses like measles. During outbreaks, even partially immunized infants or those with some maternal antibody might be at risk due to high viral load in the environment.

7. Travel to Areas with Ongoing Measles Transmission: Unvaccinated infants traveling to or living in regions where measles is endemic or outbreaks are occurring are at high risk.

1. Supportive Care: Fever Reduction: Administer antipyretics like paracetamol to control fever and improve comfort. Tepid sponging can be used for very high fever. Hydration: Encourage frequent oral fluids (breast milk, ORS, water, juice) to prevent dehydration, especially if there is fever, diarrhea, or poor intake. IV fluids if severe dehydration. Nutrition: Offer appealing, nutritious foods. Continue breastfeeding. If mouth sores are present, offer soft foods. Rest: Encourage rest in a comfortable environment.

2. Vitamin A Supplementation: WHO recommends Vitamin A for all children diagnosed with measles, regardless of nutritional status, as it reduces severity, complications (especially eye damage and pneumonia), and mortality. Given as two doses on consecutive days (age-appropriate dosage).

3. Management of Symptoms: Cough: Humidified air may soothe the cough. Avoid cough suppressants unless specifically advised by a doctor. Conjunctivitis: Clean eyes gently with normal saline. Dim lights if photophobic. Oral Lesions (Koplik's spots/sore throat): Good oral hygiene. Soft diet.

4. Isolation: Isolate the child (e.g., keep home from school/daycare) for at least 4 days after the onset of the rash to prevent spread to susceptible individuals. Use airborne precautions if hospitalized.

5. Monitoring for and Management of Complications: This is crucial as complications are common and can be severe. Pneumonia: Most common cause of measles-related death. Watch for fast/difficult breathing, cough, chest indrawing. Treat with appropriate antibiotics if bacterial pneumonia develops. Otitis Media (Ear Infection): Common. Watch for earache, ear discharge. Treat with antibiotics. Diarrhea and Dehydration: Manage with ORS, continued feeding, zinc supplementation (for diarrhea). Encephalitis (Brain Inflammation): Rare but serious. Watch for convulsions, altered consciousness, neurological deficits. Requires supportive care, sometimes anticonvulsants. Corneal Ulceration/Blindness: Vitamin A helps prevent this. Refer to ophthalmologist if eye problems occur. Severe Malnutrition: Measles can worsen nutritional status. Laryngotracheobronchitis (Croup).

6. Antibiotics (Only for Secondary Bacterial Infections): Antibiotics do not treat the measles virus itself but are used to treat bacterial complications like pneumonia, otitis media, or severe skin infections.

7. Health Education to Caregivers: Explain the illness, home care (fluids, nutrition, fever control), importance of Vitamin A, signs of complications requiring immediate return to health facility, and crucial importance of completing immunizations for this child (if not fully immunized) and other children in the family.

Discharge: When child is afebrile, eating and drinking well, rash is fading, and no acute complications are present. Ensure follow-up plan if needed.

Question 3

EVELYNE SCHOOL OF NURSING AND MIDWIFERY - NO.76

- List 5 examples of diarrheal diseases.

- Outline 6 causes of diarrhea.

- Describe the management of diarrhea until discharge.

- List the complications of diarrhea.

ANSWER: Examination Script

1. Cholera: An acute, severe watery diarrheal illness caused by the bacterium Vibrio cholerae, leading to rapid dehydration.

2. Rotavirus Gastroenteritis: A very common viral cause of severe diarrhea and vomiting in infants and young children globally. Vaccine-preventable.

3. Shigellosis (Bacillary Dysentery): Bacterial infection caused by Shigella species, characterized by frequent, small-volume, bloody and mucoid stools, abdominal cramps, and fever.

4. Amoebic Dysentery (Amoebiasis): Caused by the parasite Entamoeba histolytica, often presenting with bloody diarrhea, abdominal pain, and sometimes liver abscesses.

5. Giardiasis: An intestinal infection caused by the protozoan parasite Giardia lamblia (Giardia intestinalis), leading to diarrhea (often greasy, foul-smelling), abdominal cramps, bloating, and malabsorption.

6. Escherichia coli (E. coli) Gastroenteritis: Certain strains of E. coli can cause diarrhea, e.g., Enterotoxigenic E. coli (ETEC - common cause of traveler's diarrhea), Enterohemorrhagic E. coli (EHEC - e.g., O157:H7, can cause bloody diarrhea and HUS).

7. Salmonellosis (Non-typhoidal Salmonella): Bacterial infection typically causing diarrhea, fever, and abdominal cramps, often from contaminated food.

8. Campylobacter Enteritis: Common bacterial cause of diarrhea, often from contaminated poultry.

1. Infections (Gastroenteritis): This is the most common cause globally. Viruses: E.g., Rotavirus, Norovirus, Adenovirus. Bacteria: E.g., E. coli, Salmonella, Shigella, Campylobacter, Vibrio cholerae, Clostridium difficile. Parasites: E.g., Giardia lamblia, Entamoeba histolytica, Cryptosporidium.

2. Food Poisoning / Toxins: Ingestion of food contaminated with bacterial toxins (e.g., from Staphylococcus aureus, Bacillus cereus) or certain chemical toxins can cause acute diarrhea and vomiting.

3. Medications: Many drugs can cause diarrhea as a side effect. Antibiotics: Can disrupt normal gut flora, leading to diarrhea or C. difficile infection. Laxatives (overuse). Antacids containing magnesium. Some chemotherapy drugs, metformin, colchicine.

4. Food Intolerances and Malabsorption Syndromes: Lactose Intolerance: Inability to digest lactose (milk sugar) due to lactase enzyme deficiency. Fructose Malabsorption or Sorbitol/Mannitol Intolerance (artificial sweeteners). Celiac Disease: Immune reaction to gluten, damaging small intestine lining. Pancreatic Insufficiency: (e.g., in cystic fibrosis, chronic pancreatitis) leading to fat malabsorption (steatorrhea).

5. Inflammatory Bowel Disease (IBD): Chronic inflammatory conditions of the digestive tract. Crohn's Disease. Ulcerative Colitis.

6. Irritable Bowel Syndrome (IBS): A common functional disorder affecting the large intestine, can present with diarrhea-predominant IBS (IBS-D), constipation-predominant, or mixed. Often related to stress and diet.

7. Other Medical Conditions: E.g., Hyperthyroidism, carcinoid syndrome, some endocrine tumors, diverticulitis, short bowel syndrome.

8. Stress and Anxiety: Can sometimes trigger acute episodes of diarrhea in some individuals.

1. Assessment: History: Onset, duration, frequency, consistency of stools (watery, bloody, mucoid), associated symptoms (vomiting, fever, abdominal pain), recent food/water intake, travel history, medication use, sick contacts. Physical Examination: Assess hydration status (vital signs, skin turgor, mucous membranes, sunken eyes, capillary refill, urine output), abdominal tenderness, signs of systemic illness. Stool Examination (if indicated): For microscopy (ova, cysts, parasites, WBCs), culture and sensitivity (if bacterial infection suspected, bloody diarrhea, or prolonged illness), C. difficile toxin assay. Blood tests (if severe or prolonged): FBC, electrolytes, renal function.

2. Rehydration Therapy (Cornerstone of Management): Oral Rehydration Solution (ORS): Preferred for mild to moderate dehydration. Give frequently in small amounts. Teach caregiver how to prepare and give ORS. Intravenous (IV) Fluids: For severe dehydration, persistent vomiting, or shock. Use isotonic solutions like Ringer's Lactate or Normal Saline, according to WHO plans or physician orders. Monitor closely.

3. Nutritional Management: Continued Feeding: Do NOT stop feeding during diarrhea, especially for children. Continue breastfeeding infants frequently. For older children and adults, offer easily digestible, nutritious foods as tolerated (e.g., cereals, rice, bananas, yogurt, cooked vegetables, lean meats). Avoid sugary drinks or very fatty/spicy foods initially. The BRAT diet (Bananas, Rice, Applesauce, Toast) is an older concept and may not provide adequate nutrition; a more varied diet is usually better.

4. Zinc Supplementation (for children WHO recommends 10-20mg of zinc daily for 10-14 days for children with diarrhea to reduce duration and severity, and prevent future episodes.

5. Antibiotics (Only if Indicated for Specific Infections): Routine use of antibiotics for acute watery diarrhea is NOT recommended as most are viral. Antibiotics are indicated for: Dysentery (bloody diarrhea, e.g., Shigella - use ciprofloxacin, azithromycin). Confirmed Cholera (e.g., doxycycline, azithromycin). Severe traveler's diarrhea, some parasitic infections (e.g., metronidazole for Giardia, amoebiasis). Immunocompromised patients with bacterial diarrhea.

6. Symptomatic Relief (Use with Caution): Antidiarrheal Agents (e.g., Loperamide): Generally NOT recommended, especially in children or if bloody diarrhea/fever, as they can prolong infection by slowing gut motility. May be used cautiously in adults with non-infectious watery diarrhea after ruling out infection. Antiemetics (for vomiting): May be used if vomiting is severe and hindering oral rehydration, but rehydration is the priority.

7. Monitoring: Frequency of stools, consistency, presence of blood/mucus. Hydration status. Vital signs. Urine output. Response to treatment.

8. Health Education and Prevention: Handwashing with soap (WASH principles - Water, Sanitation, Hygiene). Safe food preparation and storage. Use of safe drinking water. Proper sanitation and human waste disposal. Promote breastfeeding. Rotavirus vaccination for infants. When to return if symptoms worsen or don't improve.

Discharge: When dehydration is corrected, patient is tolerating oral fluids and food, stool frequency has decreased, no fever or severe symptoms, and caregiver understands home care and follow-up.

1. Dehydration: Most common and potentially life-threatening complication, due to excessive loss of water and electrolytes. Can range from mild to severe.

2. Electrolyte Imbalances: Loss of electrolytes like sodium (hyponatremia or hypernatremia if improper rehydration), potassium (hypokalemia - can cause muscle weakness, arrhythmias), bicarbonate (metabolic acidosis).

3. Malnutrition / Weight Loss: Especially with chronic or recurrent diarrhea due to poor absorption of nutrients, reduced intake, and increased metabolic demands. Can lead to growth faltering in children.

4. Hypovolemic Shock: If severe dehydration is not corrected, it can lead to insufficient circulating blood volume, shock, and organ failure.

5. Acute Kidney Injury (Renal Failure): Can result from severe dehydration and hypoperfusion of the kidneys.

6. Spread of Infection (if infectious cause): To other individuals through fecal-oral route if hygiene is poor.

7. Hemolytic Uremic Syndrome (HUS): A serious complication primarily associated with E. coli O157:H7 infection, characterized by hemolytic anemia, thrombocytopenia, and acute kidney injury.

8. Persistent Diarrhea: Diarrhea lasting 14 days or longer, often associated with malnutrition and increased risk of mortality.

9. Post-Infectious Irritable Bowel Syndrome (PI-IBS): Some individuals develop IBS symptoms after an episode of acute infectious gastroenteritis.

10. Skin Irritation / Perianal Dermatitis: Frequent loose stools can irritate the skin around the anus.

11. Bacteremia / Sepsis (rare with common gastroenteritis, but possible with invasive bacteria).

Question 4

SEBEI SCHOOL OF NURSING AND MIDWIFERY - NO.77

- Outline the clinical features of typhoid fever.

- Describe the management of a patient admitted to your ward with typhoid fever for first 24 hrs.

- List 5 complications of typhoid fever.

ANSWER: Examination Script

First Week (Early Stage): Stepwise Rising Fever: Temperature gradually increases each day, often higher in the evenings, and may reach 39-40 degC (102-104 degF). Headache: Often generalized and persistent. Malaise / Fatigue / Weakness: General feeling of being unwell and tired. Anorexia (Loss of Appetite). Dry Cough (Non-productive). Constipation (more common in adults initially) or sometimes Diarrhea (more common in children, often greenish "pea soup" stools). Abdominal Discomfort or Pain (often vague). Relative Bradycardia (Faget's sign): Pulse rate may be slower than expected for the degree of fever (not always present).

Second Week (Established Illness): Sustained High Fever: Fever remains high. Abdominal Distension and Tenderness: Often more pronounced. Rose Spots: Faint, salmon-pink, maculopapular rash, typically 2-4mm in diameter, appearing in crops on the trunk (chest, abdomen, back). Blanch on pressure. Present in about 30% of cases, more common in fair-skinned individuals, and transient. Splenomegaly (Enlarged Spleen): Palpable in some patients. Hepatomegaly (Enlarged Liver): May occur. Diarrhea (may become more prominent now) or continued constipation. Mental State Changes ("Typhoid State"): Apathy, confusion, delirium, or even coma in severe cases (typhoid encephalopathy). Muttering delirium.

Third Week (If Untreated or Complications Develop): Continued high fever, increasing weakness and prostration. Risk of serious complications (see below) such as intestinal hemorrhage or perforation is highest during this week. Weight loss becomes more significant.

Fourth Week (Convalescence / Recovery - if survives without complications): Fever gradually subsides, symptoms improve. However, relapse can occur. Some individuals become chronic carriers.

1. Initial Assessment and Confirmation of Diagnosis: History: Onset of symptoms, travel history to endemic areas, exposure to contaminated food/water, immunization status. Physical Examination: Vital signs (temperature, pulse, BP, respirations), look for rose spots, abdominal tenderness, hepato-splenomegaly, assess hydration and mental status. Laboratory Investigations: Blood Culture: Gold standard for diagnosis, especially in the first week. Stool and Urine Cultures: May become positive later in the illness. Widal Test (Serology): Detects antibodies against S. Typhi. Less reliable for acute diagnosis as it takes time for antibodies to develop and can have false positives/negatives. Often done, but interpretation needs care. Full Blood Count (FBC): May show anemia, leukopenia (low WBC count) or normal WBC, sometimes thrombocytopenia. Liver Function Tests (LFTs): May show mild elevation of liver enzymes.

2. Initiate Appropriate Antibiotic Therapy Promptly: Once typhoid fever is suspected or confirmed. Choice depends on local antibiotic susceptibility patterns due to increasing drug resistance. Commonly Used Antibiotics: Fluoroquinolones (e.g., Ciprofloxacin, Ofloxacin) - resistance is increasing. Cephalosporins (Third-generation, e.g., Ceftriaxone IV/IM, Cefixime oral) - often used for severe cases or suspected resistant strains. Azithromycin (oral) - increasingly used, especially where fluoroquinolone resistance is high. Older drugs like Chloramphenicol, Amoxicillin, Co-trimoxazole are less used due to resistance. Administer first dose as soon as possible after collecting cultures (if feasible without major delay).

3. Supportive Care: Hydration: Encourage oral fluids. If severe vomiting, dehydration, or unable to take orally, provide IV fluid therapy (e.g., Normal Saline, Dextrose solutions). Monitor fluid balance. Nutrition: Provide a soft, easily digestible, nutritious diet (high calorie, high protein) as tolerated. Small, frequent meals if anorexic. Fever Control: Administer antipyretics (e.g., paracetamol) as prescribed. Tepid sponging if fever is very high. Rest: Encourage bed rest during the acute febrile phase to conserve energy.

4. Monitoring: Vital Signs: Temperature, pulse, BP, respirations regularly (e.g., 4-hourly or more often if unstable). Hydration Status and Fluid Balance. Observe for signs of complications (see below), especially abdominal pain/tenderness, rectal bleeding, changes in mental status. Monitor response to antibiotics (fever should start to defervesce within 2-3 days of effective treatment).

5. Infection Prevention and Control (Enteric Precautions): Strict Hand Hygiene: For staff, patient, and visitors. Safe Disposal of Feces and Urine: Use of latrines. Disinfect contaminated items. Patient should not handle food for others until cleared. Health education on personal hygiene.

6. Symptomatic Relief: Manage headache, abdominal discomfort as needed.

7. Patient and Family Education: Explain the illness, treatment, importance of completing antibiotics, hygiene measures, and potential complications.

1. Intestinal Hemorrhage (Bleeding): Ulceration of Peyer's patches (lymphoid tissue) in the small intestine (ileum) can erode into blood vessels, causing significant GI bleeding, manifesting as melena (black, tarry stools) or sometimes hematochezia (fresh blood). Can lead to shock.

2. Intestinal Perforation: The ulceration can erode completely through the intestinal wall, leading to a hole (perforation). This allows intestinal contents to leak into the abdominal cavity, causing peritonitis. Characterized by sudden, severe abdominal pain, rigidity, and signs of shock. A surgical emergency.

3. Typhoid Encephalopathy / Toxic Confusional State: Neurological complications ranging from apathy, confusion, and delirium ("typhoid state," muttering delirium) to seizures, coma, or focal neurological deficits.

4. Myocarditis (Inflammation of the Heart Muscle): Can cause arrhythmias, heart failure, or ECG changes.

5. Cholecystitis (Inflammation of the Gallbladder): Acute or chronic inflammation of the gallbladder. The gallbladder can also be a site for chronic carriage of S. Typhi.

6. Pneumonia (Typhoid Pneumonia): Lung involvement can occur.

7. Osteomyelitis (Bone Infection) or Septic Arthritis (Joint Infection): Rare, but S. Typhi can spread to bones or joints.

8. Hepatitis (Inflammation of the Liver): Mild liver inflammation with elevated liver enzymes is common.

9. Relapse: Symptoms can recur after initial improvement, usually milder than the primary illness, especially if treatment was inadequate.

10. Chronic Carrier State: A small percentage of infected individuals (about 1-5%) become chronic carriers, continuing to shed S. Typhi in their feces or urine for a year or longer after recovery, even without symptoms, and can transmit the infection to others. The gallbladder is often the site of carriage.

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Clinical Section / Focus | Key Features & Exam Points | Nursing Management & Rationale

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