Dengue Panic Syndrome: Lesson to be Learnt

Sir,

DENGUE is a relatively new illness in India. Whenever there is an epidemic of dengue there is a state of panic amongst the general population, media as well as doctors. Guidelines are available, one from WHO 2009 and the other from NICD but they are found to be insufficient to deal with the problem and need some modifications which are in accordance with our health infrastructure.

In the year 2010 we faced an epidemic of dengue in S.N.Medical College, Agra. About 130 patients were admitted from September to November 2010. Out of these 130 patients only 3 patients later developed DSS and mortality was <1% as is the case in any experienced centre.

For the diagnosis of dengue, commercial as well as ELISA based kits are available which detect dengue IgM, which appear on the 5th day of illness. NICD accepts only ELISA based kits as diagnostic method of choice but by the 5th day of illness many of the dengue patients are already afebrile, so use of ELISA based kit causes unnecessary delay in diagnosis. The need of the hour is a rapid antigen detection kit for diagnosis which can detect the patient on first day of illness with high sensitivity and specificity. The WHO 2009 guidelines suggests that rapid antigen detection test can be used as a screening method during the outbreak.

During the dengue epidemic most common myth among public is regarding Platelet count which normally falls by 3rd-8th day of illness. Bleeding in dengue is multifactorial and prothrombotic platelet transfusion in non bleeding dengue patients has no benefit. But in reality, most physicians treating dengue give repeated platelet transfusion even in stable patients and all irrelevant costly drugs like Immunoglobulin, Danazol and steroids are used to raise platelet counts due to Rouleax formation.

Most important challenge to the physician treating dengue is to decide which patients may pass into DSS. As per WHO 2009 guidelines patients with an increasing hematocrit with decrease in P count are most susceptible to sudden catastrophic bleeding. Usually baseline hematocrits are not available and interpretation in the light of patients clinical condition, hydration state and underlying anemia is difficult. Guided fluid replacement therapy in DSS with repeated hematocrit measurement is difficult as most hospitals have inadequate infrastructure for repeated hematocrit measurement. Thus we need a better marker to identify which patients of dengue fever may land up into DSS.

Decreased platelet count not only creates a dread amongst patients but also a doctor panic syndrome. The doctors also start chasing platelet count and all irrelevant costly drugs like Immunoglobulin, Danazol and Steroids are used to raise platelet count. This actually worsens the clinical outcome. Due to the rapid urbanization more and more cities are facing the problem of water logging and thus the repeated epidemic of dengue in India during the monsoon period. WHO 2009 and NICD guidelines are not followed by doctors in India and so what is called for are more practical guidelines for Indian conditions.

References


Encephalopathy in Critically Ill Patients

Sir,

We have read with great interest the article titled “Encephalopathy in Critically Ill patients” by Chandra SR et al.1 In our experience severe sepsis is a common cause of admission to ICU and its incidence is probably growing in recent years. Encephalopathy is also a common problem in ICU.2 Therefore we are surprised to note that not a single patient of severe sepsis has been reported by them. Amongst infections they saw only a single case of Pneumonia and Leptospirosis each in their series of 100 patients. Encephalopathy may be multi-factorial due to infection, electrolyte imbalances, adverse effects of drugs (the notorious poly-pharmacy in such patients), role of cytokines, free radicals etc and finally the role of disease itself. Sepsis-Associated Encephalopathy (SAE) is the most common type of encephalopathy that is seen within a medical ICU.3 Possibly there is a selection bias in their patients as the study has been conducted in tertiary hospitals and specialised centres and may not be representative of true picture on ground.

References


Reply from Author

SIR,

Thank you for sending the comments for clarification. Kindly note that our patients were critically ill due to cardiac and neurological problems and not from general Medical ICU. The patient with leptospirosis presented with neurological complication and the patient with pneumonia was admitted with suspicion of CNS infection. We agree that this has contributed to the selection bias rightly pointed out by Prof. Sharma, Prof. Sharma Sagar and Prof. Ram.