A 22 year male, farmer by occupation, was admitted with the history of fever and generalized bodyaches one week and jaundice of 5 days duration in August 2008. On examination patient was conscious and febrile. His blood pressure was 114/80 mm Hg, pulse rate 108/min and respiratory rate 30/min. He had icterus and axillary lymphadenopathy. He also had a punched out ulcer with blackened scab, the eschar, over forearm near wrist joint (Fig. 1). Chest X-ray showed bilateral haziness in lower lung fields. \(\text{pO}_2/\text{FiO}_2\) was < 200. His Weil-Felix test was positive with OXK \(\geq 320\). Biochemical investigations revealed deranged liver and renal function tests. Fever work up for malaria, leptospirosis and typhoid were negative. Patient was diagnosed as a case of scrub typhus with ARDS. He was managed with high flow oxygen, injectable azithromycin and supportive care. Patient responded well to treatment.

Another three patients also presented with similar complaints and had eschars at different sites. The second patient had eschar on medial aspect of left arm near elbow joint (Fig. 1), the third and fourth had eschar on dorsum of penis and medial aspect of mid-thigh respectively (Fig. 2). All had Weil-Felix OXK \(\geq 160\). They were treated with doxycycline.

Scrub typhus is a febrile illness widely endemic in Asia. It is caused by intracellular gram-negative bacteria, Orientia tsutsugamushi transmitted to humans, the accidental host by the bite of larval stage of infected trombiculid mites or chiggers. Scrub typhus has been reported from various regions of India especially the hilly regions of the Himalayas, Shimla, Assam, West Bengal and Tamil Nadu.\(^1,2\) Humans are infected accidentally, usually during rainy season.\(^1\) The site bitten by mite forms an eschar. Necrotic eschar at the inoculating site of the mite is pathognomic of scrub typhus.\(^1\) The eschar resembles skin burn of a cigarette butt. Clinical picture of scrub typhus is typically associated with fever, eschar, rash, myalgia, and lymphadenopathy. Although eschars have high diagnostic value, the lesions are painless and without any itching sensation in most cases, causing the infection to be undetected by most patients.\(^3\) The reported incidence of eschar in most studies\(^3\) varies from 46-85%. Irons et al reported that eschar is usually located in warm, damp areas where pressure from clothing occurs.\(^4\) Thus perineum, inguinal region, axilla, underneath the breasts are common areas. Our prime emphasis of these cases is that in three out of four typical eschar of scrub typhus was at uncommon sites. It is essential to look for eschar carefully on entire body in patients suspected of scrub typhus in areas known to have the disease in particular seasons, as prompt treatment is necessary to decrease mortality in this disease.

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REFERENCES