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Clinical Images

Classical eschar in scrub typhus

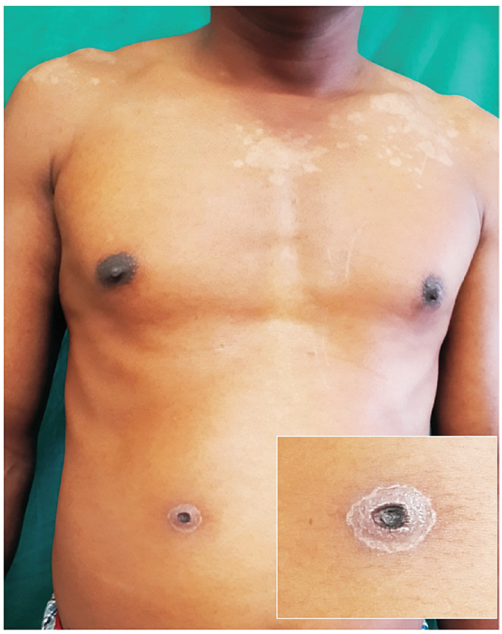

Fig. Clinical photograph showing an erythematous papule (measuring 10×5 mm) on the right upper quadrant of the abdomen capped by a well-defined blackish scab (Eschar; see inset) and surrounded by a collar of desquamation; hypopigmented macules of *Tinea versicolor* are also seen over the chest and shoulders.

A 35-year-old man, a stone driller by occupation, presented to the outpatient clinic of the department of Medicine, Jawaharlal Institute of Postgraduate Medical Education and Research (Puducherry, India) in December 2013 with a history of fever, body aches, and headache since last 15 days. He reported no localizing symptoms. There was no icterus or lymphadenopathy. An eschar was noted on the upper abdomen (Figure). A faint blanching erythema was also apparent on the trunk and proximal limbs. Liver and spleen were palpable two cm below the costal margins. Except for a mild leucocytosis (11,910 WBCs per µl), his blood counts, renal and liver function tests were normal. An immunochromatographic test was positive for antibodies to *Orientia tsutsugamushi*. He was treated with oral doxycycline 100 mg twice a day for seven days, and the fever subsided on day 3.

Scrub typhus is an underappreciated cause of acute febrile illness in many parts of India[1,2]. It is caused by the rickettsial pathogen *O. tsutsugamushi*, which is transmitted by the bite of larval trombiculid mites inhabiting scrub vegetation. Often, it results in life-threatening complications such as acute respiratory distress syndrome, hepato-renal dysfunction, and meningoencephalitis[3]. The eschar represents the site of inoculation, where initial multiplication occurs before widespread dissemination. An eschar is typically painless and non-pruritic, and hence its presence is not reported by patients[4]. A diligent search for eschar is often rewarding. It clinches a diagnosis of scrub typhus, enabling early initiation of treatment.

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