Medical Memoranda

Typhoid Fever in Hong Kong Junk Family

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The epidemiology of enteric fever in Hong Kong is not fully understood. The disease is endemic but cases are scattered, so that neither water supply nor bulk foodstuffs can be the main vehicles of infection. The following account of 11 cases occurring in a family group of 23 people illustrates the local clinical variations of typhoid, which, it is suggested, are a factor in the endemicity.

HISTORY

The community consists of the mother and father and five unmarried offspring, and two married sons and their wives and 12 children (Fig. 1). The adults live and work on a junk and the younger children who go to school live on a sampan, which is permanently at anchor. The dimensions of these two vessels are 36 by 13½ ft. (11 by 4 m.) and 14 by 5 ft. (4 by 1½ m.). The overcrowding on board makes it a matter of conjecture whether everybody sleeps lying flat.

A striking feature of the epidemic was the variation in the clinical severity and course of the disease. Two patients were seriously ill on admission, and the condition of one child became critical from acute haemolytic anaemia while in hospital. Two of the children had no symptoms at all, though they ran a continuous pyrexia around 102° F. (38° C.); none of the others was seriously inconvenienced, though they too were febrile for varying periods. Rose spots were seen in only three patients. Glucose-6-phosphate dehydrogenase (G-6-PD) deficiency was detected in one family unit, the inheritance being through the mother (see Fig. 1). There were no deaths. The anaemia developed in a boy of 1½ years with G-6-PD deficiency treated with chloramphenicol. The only other complication attributable to typhoid fever was an acute psychosis, which occurred in a boy of 16 years admitted on the fifth day of the disease. There was nothing atypical in his illness, which responded well to chloramphenicol, but during convalescence, about five weeks after the onset of the disease, he became mentally disturbed and an episode of schizophrenic type occurred with agitation, hallucinations, and vague ideas of persecution. He was transferred to the mental hospital, where he recovered after seven weeks’ treatment. There was no family or personal history of mental illness.

COMMENT

The frequency of mild forms of typhoid, especially in young children, is a recognized feature of the disease in Hong Kong (Forrest et al., 1967). This may well be a factor in maintaining the endemic situation. Ambulant cases such as those reported here can spread the disease widely.

The advantages of treating these mild cases with chloramphenicol must be weighed against the dangers of its use, particularly in a family in which G-6-PD deficiency is present. A haemolytic episode occurred in one small boy (with the deficiency) to whom the drug was given, whereas four patients recovered without chloramphenicol. A deficiency of G-6-PD is common in Hong Kong and was found in over 5% of southern Chinese males (Chan et al., 1964), but whether chloramphenicol promotes haemolysis in such individuals is still uncertain (Hersko and Vardy, 1967). Haemolytic anaemia, a recognized complication of typhoid in Hong Kong (McFadzean and Choa, 1953), is often associated with G-6-PD deficiency or haemoglobinopathy; and in some cases, despite detailed investigation, the cause of the haemolysis may not be found (McFadzean and Chan, 1969). The association with G-6-PD deficiency is also not invariably—for instance,
only one of the three cases with the deficiency developed 
anemia in the course of the typhoid.

Psychosis is another recognized complication of typhoid 
which appeared in these cases, but it usually occurs in the 
acute febrile stage, and indeed may be the presenting symptom. 
The late onset of psychosis in typhoid is, however, well known 
to local psychiatrists (Singer, personal communication).

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Health Services, for permission to publish this paper. We gladly 
acknowledge our debt to Miss Lettie Ho, health visitor, and Mr. 
Tsui, head clerk, Sai Ying Pun Hospital.

Fluctuating Hemiparesis in a Young Man


Hemiparesis in early adult life is not common. A fluctuating 
hemiparesis is distinctly uncommon. The following case is 
therefore thought worth reporting.

CASE REPORT

The patient was a right-handed 26-year-old married man who 
worked as a chicken hatchery foreman. He and two sisters all had 
congenital nystagmus. In 1956 he became unconscious from a fall 
on the right parietal region. In 1961 he fell again, bruising his 
face, and in 1964 he fell once more, injuring the right side of his 
face.

His present illness began on 29 June 1968 when his left foot 
began to slap as he walked, and within a few minutes the left leg 
became weak. Two days later weakness of the left arm was noted. 
There was no disturbance of consciousness, vision, or speech. In 
August he was admitted to hospital elsewhere. Examination at that 
time besides the congenital nystagmus revealed a left hemiparesis, 
pronounced in the lower limb with ankle clonus and extensor plantar 
response, but slight in the upper limb. There were signs of mild 
side (Cushing, 1927), but a fluctuating hemiparesis from this cause appears to be 
unrecorded.

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REFERENCE