

Review of a Case Series on Expanded Dengue Syndrome and Review of Literature

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Madam,

First, I would like to congratulate the authors on writing a much-needed case series, with five patients, on different presentations of expanded dengue syndrome (EDS)—which is a term developed by the World Health Organization to include all cases that do not fall in either dengue shock syndrome or dengue hemorrhagic fever. Each of the five patients with or without other coinfections had atypical presentation of dengue fever with the involvement of various organ systems.

While the first and second patients had concurrent infection with falciparum malaria and vivax malaria, respectively; the third patient had coinfection with scrub typhus; the fourth patient was diagnosed with long-segment myelitis of the brainstem; and the last patient in this series had a rare presentation consistent with postdengue hemophagocytic lymphohistocytosis (secondary HLH). It is known that there is no direct correlation between the severity of dengue and the type of organ involvement, and even without the classical features of dengue, serious complications can arise.

In conclusion, the authors have rightly pointed out that it is of utmost importance to have a high index of suspicion and be well-informed of the different presentations and coinfections associated with EDS.

Of the various organ involvement documented in EDS, the most commonly found gastroenterological manifestation is asymptomatic transaminitis while gastrointestinal bleeding is rarely observed.

Of renal involvement, the authors have correctly mentioned that acute kidney injury (AKI) may be due to immunological cause or direct injury from the dengue virus, while other manifestations, like hemolytic uremic syndrome, proteinuria, or nephrotic syndrome, are rarely encountered.

Of central nervous system involvement—which is found to be involved only in 1 to 5% of the cases infected with dengue—dengue encephalitis and acute transverse myelitis have been documented.

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Of the cardiovascular manifestations, arrhythmia with sinus bradycardia has been most often documented. Other arrhythmias described in dengue are sinoatrial nodal block, atrioventricular nodal block, complete heart block, paroxysmal supraventricular tachycardia, and atrial fibrillation, which are rightly among other types of cardiological involvement found.

Bone marrow and hematological involvement in the form of splenomegaly or disseminated intravascular coagulopathy or lymphadenopathy have been documented. Hemophagocytic lymphohistocytosis, which was well-documented by the authors in the fifth patient in this series, is a rare complication.

Pulmonary manifestations in the form of acute respiratory distress syndrome or pulmonary hemorrhage have been commonly encountered as have been documented in the first and the second patients.

Other system involvements in the form of acute parotitis, visual disturbances, fatigue, hallucinations, and psychosis have been rightly mentioned by the authors.

Overall, the authors have done a great job by documenting the various presentations of EDS encountered by them. This will help clinicians to diagnose and treat such patients with greater efficiency.