澳大利亚 John Murtagh 全科病案研究（七）
——48 岁的农民发烧、寒战、黄疸

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【关键词】 传染性疾病；诊断；治疗

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1 病例简介

XC 先生 3 d 前突然出现发烧、寒战、乏力，腿部肌肉特别使小腿肌肉疼痛。同时头痛、眼睛痛且对光线敏感，鼻出
血、身上有红疹、腹部不适。他说以前从来没有这种情况，身体一直很健康，而且没有吃过任何药。XC 先生病后一直是农民，
大多数时间是种稻子、养猪和家禽（鸡和鸭）。最近几个星期下雨较多，农田低洼的地方遭水淹，他不得不日日夜夜工
作，因而感到精疲力尽。

体检结果显示：病人寒战，两眼结膜充血发红，黄疸。对
病人的皮肤检查结果显示，腿部有伤口，胸部有散在的斑点和
轻度的斑丘疹。

生命体征：脉搏 112 次/min，律齐。体温 40℃，呼吸 16
次/min，血压 90/65 mm Hg（1 mm Hg = 0.133 kPa）。腹部检
查显示肝区柔软，无肝大，无腹水，无潜血结肿大。病人呈现
轻度的颈项偏直。

查体检查尿液呈深色，提示尿胆红素阳性，尿胆素原原
性，并有血尿。

2 需要考虑的问题

可能的诊断是什么？
可能的鉴别诊断是什么？
对这个病人应该考虑到哪些严重威胁生命的疾病？

3 病案讨论

发热并突然出现黄疸的最常见原因是甲型肝炎。不过，该
病人表现出的病毒性肝炎症状并不典型。主要的鉴别诊断是其
他传染性肝炎和上行性胆管炎。

严重威胁生命的疾病应该考虑到败血症、黄疸性出血性肝
脏病、重症肝炎（包括可能的肝癌）以及上行性胆管炎。

不过病人的农民职业以及在洪灾地区接触猪和其他家禽的
背景，提示有黄疸型肝炎病的可能。病原体往往存在病人宿

物（通常为老鼠）的尿液中，病人通常是因为接触了被污染
的水而感染的。病原体很可能是通过病人腹部的伤口进入其
体内，因为他曾经在洪灾的洪水里面工作。

XC 先生的临床表现是典型的钩端螺旋体病，是经过有传
染性的老鼠携带的黄疸出血性钩端螺旋体所引起的。

4 诊断

上面的诊断是临床上的初步诊断。在实验室条件容许的情
况下，可以进一步做实验室检查。

- 钩端螺旋体抗体效价增高
- 血和尿的 PCR（聚合酶链反应）阳性
- 在暗视野显微镜下观察，血液中发现螺旋体（这个操
作难度很大）

肝功能检查结果应该可以发现胆红素和转氨酶增高。常规
血检可以发现白细胞明显增多，还有可能血小板减少。

5 治疗

钩端螺旋体病在老年人病死率较高。建议的治疗方法是静
脉滴注青霉素 G，120 ~ 150 万 U，4 次/d。有些罕见的病例在开始使用青霉素的几个小时内，可能发生吉
海反应（Jarisch – Herxheimer reaction，主要表现为症状加剧，特别是发热）。应该观察病人的肝功能和肾功能，并监测可能
出现的脑膜炎。

6 特别提示

近年来，钩端螺旋体病常发生在炎热或亚热带的东南亚
国家，并与农田的洪水灾害直接相关。非黄疸型的病例比较
常见，而且其严重程度低于不常见的黄疸型病例（黄疸出
血性钩端螺旋体病，Weil 病）。这是一种与职业有关的疾病，还
可以称为污染热或非典热、沼泽热或沼泽热、大钩端螺旋体病
热、肝炎热、污水热或猪病热。

译者注：钩端螺旋体病在我国简称为“钩体病”。此类有
“打黄热”或“黄疸病”的记载。属天然疫源性疾病传染病。
根据卫生部疾病控制中心，据中国疾病预防与控制中心报道，全
国发病率高达 10 ~ 100 万以上的特大流行约 10 次，主要发生在
洪涝灾害之年。

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A 48 YEAR OLD FARMER WITH FEVER, CHILLS AND JAUNDICE

John Murtagh

Case history Mr X C presents with a three day history of the sudden onset of fever, chills (rigors), weakness and aching muscles of the legs especially the calf muscles. He also complains of headache, sore eyes with light sensitivity, epistaxis, a rash and abdominal discomfort.

He stated that he had not experienced anything like it in past and had been in good health most of his life. He does not take any medication.

He said that he had been a farmer most of his adult life producing rice together with pigs and poultry (chickens and ducks). He described how there had been an excessive amount of rain in recent weeks and that there had been flooding on the lower parts of the farm causing him to work day and night. He had been feeling tired and run down.

Examination revealed a very sick looking man who was shivering and with the red eyes of conjunctivitis and the yellow discoloration of jaundice. Inspection of his skin revealed cuts and abrasions on his leg and scattered petechiae on his chest with a mild maculopapular rash.

Vital signs: pulse 112 and regular, temperature 40 °C, respiration 16/min, BP 90/65

Abdominal examination revealed a tender liver and no hepatomegaly, splenomegaly or lymphadenopathy. He had mild neck stiffness.

Dipstick testing of the urine which was a dark colour revealed positive bilirubin and urobilinogen and blood.

Questions to ask?

What is the probability diagnosis?

What are possible differential diagnoses?

What serious life threatening conditions must be considered in this patient?

Discussion

The most common cause of a febrile illness with jaundice of sudden onset is hepatitis A. However the presentation in this patient is atypical of viral hepatitis. Differential diagnoses include other infective forms of hepatitis and ascending cholangitis.

Serious life threatening conditions that should be considered are septicemia, icteric leptospirosis (Weil’s disease), severe pneumonia including the possibility of avian influenza and ascending cholangitis.

However the association with a farmer working in a flooded area with pigs and other farmyard animals does point to the possibility of leptospirosis. The organisms are typically transmitted to humans from contact with contamination of infected urine from the reservoir animal usually via rats. The organisms appeared to have entered the host through superficial skin wounds on his legs as he waded through contaminated water.

The clinical presentation of Mr X C is typical of icterohaemorrhagic fever caused by Leptospira icterohaemorrhagia from infected rats

Confirmation of diagnosis

The diagnosis is a clinical one initially. The appropriate laboratory investigations include (depending on laboratory resources)

- Raised antibodies to leptospirosis
- Positive PCR tests of blood and urine
- Demonstration of the spirochete organisms on dark field microscopy of blood (very difficult to perform)

Liver function tests should show elevated bilirubin and transaminases.

A routine full blood examination should show marked leucocytosis and possibly reduced platelets

Treatment

Icterohaemorrhagic fever has a high mortality rate in the older person. The recommended treatment is with intravenous benzyl penicillin (penicillin G) 1.2 to 1.5 million units four times daily. In rare cases a Jarisch – Herxheimer reaction (aggravation of symptoms especially fever) can develop within hours of starting penicillin. Patient need to be monitored for hepatic and renal function and for the possibility of meningitis

Special notes

Leptospirosis has been reported commonly in tropical to subtropical south – east Asian countries in recent years in association with flooding of farmland. The non-icteric form is more common and less serious than the uncommon icteric form (Weil’s disease). As an occupational disease it also is referred to as Mud fever Swamp fever Canicola fever Canecutters fever Sewer worker’s fever

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