

Yersinia

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Yersinia enterocolitica is a Gram-negative rod that can infect the terminal ileum, appendix, ascending colon and mesenteric lymph nodes, and can cause a granulomatous inflammatory process that may mimic CD. *Yersinia* typically causes a fever and gastroenteritis, but may persist and cause a terminal ileitis, which, on occasion, may perforate. The diagnosis - may be made on stool culture, but is more often confirmed serologically . If discovered at laparotomy , the terminal ileum and mesenteric nodes will look thickened and inflamed and a lymph node biopsy can be taken for diagnostic purposes. The disease is normally self-limiting, but responds to treatment with co-trimoxazole or chloramphenicol antibiotics. *Salmonella* are a family of Gram-negative rods that can cause a range of enteric infections. *Salmonella* gastroenteritis is typically caused by *Salmonella enteritidis* from poultry and is most often a self-limiting illness comprising headache, fever and watery diarrhoea. When severe, antibiotics and hospitalisation and intravenous fluids may be needed. The diagnosis is based on stool culture. *Shigella* and enteropathogenic strains of *richia coli* may cause similar diarrhoeal illnesses. Typhoid fever is caused by *Salmonella enterica* and presents with fever and abdominal pain after an incubation period of 10–20 days. Over the next week, the patient can develop distension, diarrhoea, splenomegaly and characteristic ‘rose spots’ on the abdomen caused by a vasculitis. Typhoid is a systemic infection and diagnosis of typhoid is confirmed by culture of blood or stool. Treatment is by antibiotics, usually chloramphenicol. A number of surgical complications can result, including paralytic ileus, intestinal haemorrhage, free ileal perforation and cholecystitis. Invasion of the systemic circulation, which is a characteristic feature of salmonellosis, may cause severe Gram-negative sepsis, resulting in septic shock. Some patients develop metastatic sepsis, including septic arthritis and osteomyelitis, meningitis, encephalitis, disseminated intravascular coagulation and pancreatitis. Perforation of a typhoid ulcer characteristically occurs during the third week of the illness, although it is sometimes the first clinical sign of the disease. The ulcer is parallel to the long axis of the gut and is usually situated in the distal ileum. Perforation requires surgery to wash out and close the ulcer and intestinal resection is usually avoided. In unstable patients, notably with evidence of septic shock, the bowel should be exteriorised and the perforation closed after recovery . Paratyphoid infection (with *Salmonella Paratyphi A*) resembles typhoid fever and is treated in a similar manner (see Chapter 6).

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