Case Report

Reversible hearing impairment: delayed complication of murine typhus or adverse reaction to azithromycin?

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Delayed and reversible hearing loss occurred in a 55-year-old male patient with murine typhus infection. The patient had the initial symptoms of headache, fever and chills, followed by the occurrence of bilateral hearing loss on day 9 from fever onset. Murine typhus was diagnosed with a high IgM titre by indirect immunofluorescence assay. After treatment with azithromycin and prednisolone, the fever and other symptoms subsided gradually and bilateral hearing loss improved 3 weeks later. Though an adverse reaction to azithromycin could not be ruled out, delayed onset of hearing loss was more likely a complication of murine typhus, mainly because the hearing loss did not occur during the azithromycin usage period. Although hearing loss due to murine typhus is rare, clinicians should be alert to the existence of such a delayed complication.

Introduction

Murine typhus, caused by Rickettsia typhi, has various clinical manifestations. Fever and headache are the most common clinical presentations. Other symptoms and signs include rash, arthralgia, hepatomegaly, abdominal pain, cough, diarrhoea and confusion (Bernabeu-Wittel et al., 1999; Dumler et al., 1991; Fergie et al., 2000; Gikas et al., 2002; Hernandez Cabrera et al., 2004; Silpapojakul et al., 1993; Whiteford et al., 2001). Among the rare neurological complications, central nervous system abnormality is the most commonly described presentation (Masalha et al., 1998; Silpapojakul et al., 1991; Vallejo-Maroto et al., 2002). Peripheral nerve involvement has only been reported in a limited number of case reports (Tsiachris et al., 2008; Vander et al., 2003). Here we present a case of reversible bilateral hearing loss associated with murine typhus.

Case report

A healthy 55-year-old male presented to our emergency department on 20 December 2005 with a 4-day history of headache, fever and chills. He did not complain of any obvious upper airway symptoms such as cough, rhinorhoea or sore throat. He was alert and his neck was not rigid. There was no skin rash. The remaining physical examination was unremarkable. Chest radiography revealed infiltration over the left lower lobe. Laboratory tests revealed a white blood cell count of 5600 mm$^{-1}$ (normal range, 4000–10 000 mm$^{-1}$), an elevated C-reactive protein level of 78.3 mg l$^{-1}$ (normal, <5 mg l$^{-1}$), an elevated aspartate aminotransferase (AST) level of 103 U l$^{-1}$ (normal range, 10–35 U l$^{-1}$) and an elevated alanine aminotransferase (ALT) level of 76 U l$^{-1}$ (normal range, 10–40 U l$^{-1}$). He received oral medications including cephradine (250 mg q.i.d. per os), acetaminophen (500 mg t.i.d. per os) and azithromycin (500 mg q.d. per os) for 3 days, then he was discharged.

Five days later, this patient visited our emergency department again due to sudden bilateral hearing loss. His body temperature was 38.1°C. No obvious ear/nose/throat abnormality was noted after detailed examination by a specialist. Brain computed tomography revealed no space-occupying lesion. Laboratory tests revealed a mildly elevated white blood count (9950 mm$^{-1}$), elevated C-reactive protein level of 78.3 mg l$^{-1}$ (normal, <5 mg l$^{-1}$), and an elevated ALT level of 76 U l$^{-1}$ (normal range, 10–40 U l$^{-1}$).
protein level (82.7 μg ml⁻¹) and elevated aminotransferases (AST, 150 U l⁻¹; and ALT, 208 U l⁻¹).

He was admitted to the neurological intensive care unit with suspected meningitis with acoustic nerve involvement. Cerebrospinal fluid studies revealed that the cell count was 2 cells μl⁻¹ (lymphocyte/monocyte: 0/2), glucose was 44 mg dl⁻¹ (normal range 40–80 mg dl⁻¹) and protein was 77 mg dl⁻¹ (normal range 15–45 mg dl⁻¹). Aerobic and anaerobic cultures of the cerebrospinal fluid yielded no pathogen. Both India ink and cryptococcus antigen results were negative. The results of Venereal Disease Research Laboratory (VDRL) testing for syphilis, virus isolation and varicella-zoster virus IgM were all negative.

Rickettsial disease was suspected due to impaired liver function tests and fever episodes. Indirect immunofluorescence assays for scrub typhus and Q fever were negative. An indirect immunofluorescence assay (R. typhi IFA slide kit; PanBio) performed at the Taiwan Center for Disease Control laboratory revealed positive IgM and IgG (both >1:640) against R. typhi on the 14th day after his fever onset. Positivity of murine typhus infection is determined by a fourfold increase of IgG in paired serum samples or any IgM more than 1:80.

Empiric antimicrobial agents acyclovir (750 mg q.8 h), ceftriaxone (1 g q.12 h) and vancomycin (1 g q.12 h) were prescribed at admission. Prednisolone 30 mg per os b.i.d. was also prescribed for the hearing impairment. The dose of prednisolone was tapered over 10 days. The fever subsided 2 days later and he expressed subjectively slight improvement of bilateral hearing ability.

Magnetic resonance imaging examination of the brain on day 3 of admission revealed no intracranial lesions. The result of his pure tone audiometric test was bilateral hearing impairment of total frequency. This patient was discharged on 5 January 2006. His hearing ability recovered with residual bilateral high-frequency hearing loss, which was measured by a pure tone audiometric test 11 days after discharge (Fig. 1) and at a 1-year follow-up visit.

**Discussion**

Neurological complications of rickettsial diseases occur in 2–5% of patients (Marrie & Raoult, 1992). Nervous system complications may develop in the early phase of the disease (Archibald & Sexton, 1995; Masalha et al., 1998; Vallejo-Maroto et al., 2002). Among the rare peripheral nerve complications of rickettsial diseases, facial paralysis in murine typhus infection and Guillain–Barré syndrome associated with scrub typhus have been reported (Lee et al., 2007, 2009; Vander et al., 2003). Hearing impairments can manifest as unilateral or bilateral hearing loss in many rickettsial diseases (Table 1). Hearing impairment in Rocky Mountain spotted fever has been known for decades to be a long-term sequela (>1 year) (Archibald & Sexton, 1995; Steinfeld et al., 1988) or a transient deficit (Dolan et al., 1986). However, hearing impairment as a manifestation of murine typhus was only reported in 2008, where a murine typhus patient had sudden bilateral hearing loss 3 weeks after the onset of his symptoms (Tsiachris et al., 2008). Here we report a murine typhus patient who developed sudden hearing loss 9 days after fever onset. Both hearing impairment events presented as a delayed complication.

Tetracycline-based antibiotics, including doxycycline, are the first choice for treatment for rickettsial diseases. A study from Thailand reported that a 3-day course of azithromycin (500 mg q.d.) was as effective as a 7-day course of doxycycline (100 mg q.12 h) for rickettsial diseases (Phimda et al., 2007). The fact that our patient became afebrile with azithromycin also reveals its effectiveness. Hearing loss has been noted as an adverse effect of azithromycin since 1994 (Wallace et al., 1994). When the adverse effect of azithromycin is associated with prolonged treatment duration for Mycobacterium lung diseases or people living with human immunodeficiency virus, it is usually reversible (Lo et al., 1999; Tseng et al., 1997; Wallace et al., 1994). In other instances, hearing impairment related to a short course of azithromycin usage was mostly irreversible in healthy patients (Mick & Westerberg, 2007; Ress & Gross, 2000), with the exception of one case (Mamikoglu & Mamikoglu, 2001). Although our patient had received a short course of azithromycin treatment, we assume that this hearing impairment event was related to
Table 1. Clinical characteristics of cases of rickettsial disease-related hearing loss reported in the English literature

A case with deafness, urinary incontinence and peripheral neuropathy was reported without detailed description of the related duration and management of deafness (Archibald & Sexton, 1995).

<table>
<thead>
<tr>
<th>Disease</th>
<th>Unilateral or bilateral</th>
<th>Day of onset of fever</th>
<th>Antimicrobial agent</th>
<th>Steroid</th>
<th>Recovery, duration of hearing loss</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murine typhus</td>
<td>Bilateral</td>
<td>5</td>
<td>Azithromycin, 500 mg q.d. for 3 days</td>
<td>Prednisone 30 mg q.d. tapered over 10 days</td>
<td>Yes, 22 days</td>
<td>This case</td>
</tr>
<tr>
<td>Rocky Mountain spotted fever</td>
<td>Bilateral</td>
<td>21</td>
<td>Doxycycline, 200 mg q.d. for 21 days</td>
<td>Nil</td>
<td>Yes, 14 days</td>
<td>Tsiachris et al. (2008)</td>
</tr>
<tr>
<td></td>
<td>Bilateral</td>
<td>Same day</td>
<td>Chloramphenical, cefoperazone</td>
<td>Nil</td>
<td>Yes, 50 days</td>
<td>Steinfeld et al. (1988)</td>
</tr>
<tr>
<td>Mediterranean spotted fever</td>
<td>Unilateral</td>
<td>18</td>
<td>Doxycycline, 200 mg q.d. for 10 days</td>
<td>Nil</td>
<td>Yes, 14 days</td>
<td>Dolan et al. (1986)</td>
</tr>
<tr>
<td>African tick-bite fever</td>
<td>Unilateral</td>
<td>&gt;63</td>
<td>Initially no anti-rickettsial treatment; doxycycline* after hearing loss developed</td>
<td>Prednisone 37.5 mg daily, followed by four courses of intravenous methyl prednisolone 1 g q.o.d. for 6 days.</td>
<td>Yes, 90 days No recovery</td>
<td>Tsiachris et al. (2008)</td>
</tr>
<tr>
<td>Scrub typhus</td>
<td>Bilateral</td>
<td>17</td>
<td>Cefriaxone 1 g q.12 h for 7 days, doxycycline 200 mg q.d. for 7 days</td>
<td>Nil</td>
<td>Yes, 24 days</td>
<td>Mahajan &amp; Bakshi (2007)</td>
</tr>
<tr>
<td></td>
<td>Bilateral</td>
<td>7</td>
<td>Doxycycline 200 mg q.d. for 7 days</td>
<td>Nil</td>
<td>Yes, 22 days</td>
<td>Premaratna et al. (2006)</td>
</tr>
<tr>
<td></td>
<td>Bilateral</td>
<td>14</td>
<td>Chloramphenicol and doxycycline*</td>
<td>Nil</td>
<td>Yes, rapid recovery, 6 months, confirmed by audiometry</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bilateral (two cases)</td>
<td>10, 9</td>
<td>Tetracycline*</td>
<td>Nil</td>
<td>Yes, rapid recovery, objective recovery in 2 weeks–3 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bilateral (three cases)</td>
<td>11, 12, 10</td>
<td>Doxycycline*</td>
<td>Nil</td>
<td>Yes, rapidly improved</td>
<td>Premaratna et al. (2006)</td>
</tr>
</tbody>
</table>

*Data on the duration of antimicrobial therapy are not available.
murine typhus because; (1) the hearing loss developed 4 days after stopping azithromycin treatment, not during the period of azithromycin usage; and (2) the hearing deficit was reversible in an otherwise healthy patient after receiving a short course of azithromycin.

A study on spotted fever group rickettsiae revealed the involvement of *Rickettsia* in endothelial cells, increasing microvascular permeability (Walker, 2007) and progressing to a vasculitis which affected the vasa vasorum of the cochlea or the vasa nervosum of the cochlear nerve. The above was proposed on the occurrence of a hearing impairment (Tsiachris *et al.*, 2008). In animal model studies, cortisone was found to have no effect on the development of immunity and on the resistance to challenge with murine typhus (Downs & Whitmire, 1957). Early administration of doxycycline and corticosteroids is not beneficial for hearing impairment. Appropriate diagnosis and empirical antibiotics are necessary, whereas corticosteroid treatment would be helpful for clinicians to recognize that murine typhus could manifest as fever associated with subsequent nervous system impairment.

To our knowledge, this is the first report of hearing impairment associated with murine typhus in Asia. It would be helpful for clinicians to recognize that murine typhus could manifest as fever associated with subsequent hearing impairment. Appropriate diagnosis and empirical antibiotics are necessary, whereas corticosteroid treatment is still controversial, for managing the hearing impairment complication related to murine typhus.

**References**


