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Typhoid fever and paratyphoid fever are bacterial diseases that have an insidious onset characterized by fever, headache, constipation or diarrhea, ailments, chills and myalgia, with several clinical features that reliably distinguish them from various other infectious diseases. Diarrhea can occur, and vomiting is usually not severe. On the trunk may be a transient macular rash of pink spots. Confusion, delirium and bowel perforation can occur in severe cases, usually after 2 to 3 weeks of illness. The incubation period of typhoid fever is usually 6 to 30 days, and 1 to 10 days for paratyphoid fever. Diagnosis of blood culture is the basis of diagnosis. Bone marrow cultures have a sensitivity of 80% in some studies and may remain positive despite antibiotic therapy. Cultures of stool and urine are positive less frequently. Several crops are usually needed to identify the pathogen. Serological tests, such as the widal test, are not recommended due to the high rate of false positives. Treatment of typhoid fever and paratyphoid fever is treated with antibiotics. Resistance to antimicrobials in typhoid increases. Most typhoid and paratyphoid infections diagnosed in the United States are caused by strains not susceptible to fluoroquinolone. Therefore, do not use fluoroquinolones for empirical treatment in anticipation of susceptibility results. Patients who have traveled to Pakistan should be treated with azithromycin for simple suspected typhoid and carbapenemoma for severe or complex illness. Treatment can be adjusted when culture and sensitivity results are available. The U.S. Ethnological Agent estimates that 5,700 Typhi salmonella infections occur in people in the United States each year; an estimated 620 of them were hospitalized. The CDC has not made an assessment for South Carolina. The Global Group estimates that there are 11 to 21 million typhoid cases and 200,000 deaths worldwide each year. It is estimated that five million cases of parathoid fever occur worldwide each year. Diagnosed cases In the United States, about 350 patients are diagnosed with typhoid fever and 90 patients are diagnosed with parathyroid fever annually. Most diseases are in people who report recent trips to countries where diseases are common, such as India, Bangladesh and Pakistan. These cases do not take into account people who do not seek medical care, who are not tested for either the disease, or whose illness is not reported by the CDC. Sequelae Without therapy, the disease can last 3 to 4 weeks and mortality range from 12% to 30%. Resoff occurs in up to 10% of untreated patients about 1-3 weeks after recovery from the initial and often milder than the original disease. Chronic media condition in which stool or urine crops for Typhi salmonella remain positive more than one year, occurs in up to 5% of infected people. Transmission of typhoid fever and parathyroid fever is usually transmitted through the consumption of drinking water or food contaminated with faeces of people who have typhoid or paratyphoid fever or people who are chronic carriers of responsible bacteria. Risk groups are very low in the United States, higher among international travelers, and highest among people living in places with poor sanitation and hygiene. Most patients with typhoid fever and paratyphoid fever in the United States report international travel 30 days before illness; most of these patients went to South Asia (e.g. India, Bangladesh, Pakistan). The CDC has been monitoring typhoid fever since 1975 and paratyphoid fever since 2008. About 350 culture-confirmed cases of typhoid fever and 90 culture-confirmed cases of paratyphoid fever were reported annually in the CDC's National Typhoid Surveillance System and Paratyphoid Fever (NTPFS) during 2008-2015. These cases do not take into account people who do not seek medical care, who are not tested for either the disease, or whose illness is not reported by the CDC. The CDC tracks changes in antibiotic resistance in salmonella causing typhoid fever and parathid fever through the National Antimicrobial Resistance Monitoring System (NARMS). Trends in typhoid cases in the United States declined slightly from 2008 to 2015. Since 2016, reported cases have increased slightly. Problems reducing susceptibility to fluoroquinolones (e.g. ciprofloxacin) and the emergence of multidrug resistance have complicated the treatment of infections, especially those acquired in South Asia. There have been reports of sporadic ceftriaxone-resistant salmonella-resistant typhi infections and at least one documented outbreak. An outbreak of widespread drug-resistant typhoid continues in Pakistan. Published 1 August 2014 Last updated 22 December 2017 - Last updated: November - 2015 : 63 Edition : API recommendations Rajesh Upadhyay1, Milind Y Nadkar2, A Muruganathan3, Mangesh Tiwaskar4, Deepak Amarpurkar5, NH Banka6, Ketan K Mehta7, BS Sathyaprakash8 Expert Group/Director and Head, Department of Gastroenterology and Hepatology, Max Super-Specialty Hospital, New Delhi/Professor, Department of Medicine, Seth G.S. Medical College , Mumbai, Maharashtra/Adjunct Professor, Tamil Nadu Dr. MGR Medical University, Chennai, Tamil, Mumbai, Maharashtra/Consultant Gastroenterologist, Bombay Hospital and Medical Research Center and Breaking Candy Hospital, Mumbai, Maharashtra/Hif Hepato-Gastroenterologist, Bombay Hospital Medical Institute Medical Institute Mumbai, Maharashtra/Consulting Physician, Asian Heart institute and Health Care Mumbai, Maharashtra/Professor Gastroenterology, MS Ramaiah Medical College, Bengaluru, Karanataka Enteric Fever is a condition that takes its toll even now in India, where its prevalence does not seem to decrease despite the presence of antibiotics and vaccines on the market. With the advent of antibiotic-resistant strains of pathogens, the management of the disease is becoming increasingly difficult. In addition, there are no standard guidelines specific in India to treat this scourge. In order to bridge this gap in need and for primary care physicians, a first-of-its-kind Enteric Conclave has been held. The meeting was a highly innovative initiative that facilitated a frank exchange of views between gastroenterologists, consultant physicians and general practitioners who came together under a common roof to discuss epidemiology, diagnosis and typhoid use. While gastroenterologists usually get to see only complex forms of the disease, and consultant physicians mostly deal with cases that are serious, most cases in India are cared for by primary care physicians. Thus, experts almost do not see 15% of such cases, while it is the primary care physician who treats typhoid fever at the grassroots level. Many of these doctors are forced to manage their patients in the absence of diagnostic facilities such as blood culture and serological tests. Despite advances in medicine in developing countries, combating a disease such as typhoid may seem like a herculean task. During this focused panel discussion, various important issues related to this serious public health problem in India were discussed. Practical models from all over the country were compared, and best clinical practices were identified. Epidemiological problems of enteric fever in the Indian scenario term enteric fever (EF) include typhoid fever and parathyroid fever. Typhoid fever is caused by a gram-negative organism, Salmonella enterica serovar Typhi (Salmonella typhi), while parathyroid fever is caused by any of the three subspecies of the Salmonella enterica, namely S. paratyphi A, S. schottmuelleri (also called S. paratyphi B) and S. hirsch. Type A is the most common pathogen worldwide, while type B predominates in Europe. Type C is rare and is only found in the Far East. The overall ratio of the disease caused by S. typhi to S. paratyphi is about 10 to 1.1 A panel of experts who participated in the meeting prefers to use the term enteric fever instead of typhoid fever as the former covers both typhoid fever and paratyphoid fever. U enteric fever tends to cause constipation. Therefore, the presence of diarrhoea should instead raise suspicion of a co-infection. Long-term Long-Term Proton pump inhibitors (PPIs) increases the incidence of EF because less or no acid in the stomach facilitates the passage of bacteria without breaking down stomach acid.2 Definitions3 Confirmed dietary fever: Fever ≥38 degrees Celsius for at least three days, with laboratory-confirmed positive culture (blood, bone marrow, gut fluid) C typhi. Probable enteric fever: fever ≥38 degrees Celsius for at least three days, with positive serodiagnosis or antigen detection test, but without S. typhi isolation. Chronic carrier condition: S. typhi secretion in stool or urine (or recurring positive bile or duodenal culture) for more than one year after the onset of acute intestinal fever; Sometimes, S. typhi can be isolated without any history of enteric fever. Pollution and transmission People are the only natural host and reservoir. The infection is transmitted by eating or water contaminated with faeces. Contaminated water, as well as raw fruits and vegetables fertilized with sewage, were the sources of outbreaks. The highest incidence occurs where the water supply serving large populations is contaminated with faeces. Cold foods such as ice cream are recognized as a significant risk factor for transmission of enteric fever.3 The global prevalence of enteric fever World sees about 22 million new cases of typhoid occur each year. Young children in under-resourced poor areas account for the highest number of cases and mortality rates (215,000 deaths per year). Most of these deaths are due to S. typhi infection. The country of South-East Asia, especially children and young adults, bears the brunt of the disease. Other areas of proliferation include Africa and South America. Outbreaks have been reported in the Philippines, Fiji, Fiji and the Philippines. There is evidence that enteric fever is often embodied, so the actual figures may be even higher than the above.4 The prevalence of enteric fever in India In disease-endemic areas, the annual incidence of enteric fever is about 1%. The peak of the incidence is observed in children aged 5-15 years; but in regions where the disease is highly endemic, as in India, children under the age of 5 may have the highest rates of infection.5 In 2008, Ochiai et al conducted a prospective population survey in five Asian countries deemed endemic to enterive, using standardized surveillance techniques as well as standardized clinical and microbiological methods to give an update assessment of the burden of enteria in Asia India. As the study was selected by Calcutta. Results in India showed in figures 1, 2 and 3.6, the results showed a high incidence of enteric fever in India, with the incidence of pre-school children (aged 25) of the same magnitude as among school-age children (ages 5-15). High High The burden in pre-school children underscores the importance of vaccines and birth systems in this age group, as well as older and adolescents.6 Fifty-seven percent of isolates were found to be resistant to nalydixic acid, 1.6% to ciprofloxacin, and 7% were multipragosic (resistant to chloramphenic, ampicillin and cotrimyzolu). Resistance to nalydixic acid is an indirect marker of fluoroquinolone resistance; Indicating high resistance to fluoroquinolone.6 Since fluoroquinolones are the empirical therapy of choice in enteric fever, increasing antibiotic resistance may require the replacement of low-cost antibiotics with new, expensive agents that may be unavailable and unavailable to many poor patients. It also highlights the need to monitor resistance models and to consider vaccines as disease control tools.6 A prospective study conducted at the Indian Tertiary Hospital found that the prevalence of multiple drug resistance (to chloramphenicol, ampicillin and co-trimoxazole) in organisms causing enteric fever nearly doubled between 1999 and 2005 (figure 4). While 80% of patients were infected with S. typhi, paratyphium A was a pathogen in 9% of cases. The remaining 11% of patients were infected by other groups S. enterica and E. salmonella, typhimurium, and paratyphi C and sentenberg.8 Social and economic effects of intestinal fever are also high, because patients with acute disease and complications may need to be hospitalized. This leads to the loss of working days and therefore income.3 In the study Ochiai et al.6 2% of Indian patients with enteric fever need hospitalization. The study analyzed the tendency of antibody titers to O and H antigens S. typhi for ten years (1998-2002 and 2007-2011) in Indian patients of different age groups who were diagnosed with enteric fever. This study showed that overall seropositiveness rates during the 10-year study period increased significantly, as shown in Figure 5.9 of the carrier's position when entering the human body, Salmonella typhi crosses the intestinal epithelial layer and is carried by macrophages to the liver, pancreas and spleen. From the liver organisms can be spilled into the gallbladder, where, being resistant to bile, they can remain for long periods of time and lead to either an active infection (cholecystitis) or chronic infection (carrier condition).10 About 3 of 5 of infected people become carriers, especially with gallbladder abnormalities such as gallstones. These people are often impromptu and can remain in this state for many years with little or no detrimental effect. However, they continue to bacteria for long periods of time, thus forming a potential source of infection10 especially in cooking conditions. The story of Typhoid Mary, a cook at the beginning of the beginning New York's century that infected approximately 50 people (three fatally), highlights the role of asymptomatic carriers in maintaining the cycle of human-to-human spread.11 chronic carrier condition is the most important risk factor for hepatobiliary carcinoma, as bile-carrying with gallstones have been shown to carry an 8.47 times higher risk of gallbladder cancer.10 It is for these reasons that the eradication of transportation is of paramount importance. Factors influencing epidemiology12.13 Age Incidence of enteric fever in endemic areas tend to be low in the first few years of life, peaking among school-age children and young adults and then falling in middle age. Older people are relatively resilient, probably due to frequent increased immunity. Season in endemic areas peaks of transmission occur in dry weather or early rains. This is because warm and humid conditions favor the growth of the body. Also in the summer, people are more likely to drink water outside their homes, which may be quality. In the rainy season, water can be contaminated. Food habits Food cooked outside the home, such as ice cream or flavored ice drinks from street vendors; Drinking contaminated water; and eating vegetables and salads grown with human waste as fertilizer are the main risks. Other close contact or relative with the recent enteric fever Poor socioeconomic status High population density Poor personal hygiene Lack of sanitation Lack of safe water supply Low toilet use living near open body water Recent consumption of antimicrobials Transmission of enteric fever is also explained by flies, laboratory failures, non-sterile tools, and intercourse. MDR Enteric Fever was first reported in 1972 with chloramphenic-resistant S. typhi, and since then chloramphenicol or a lot of drug-resistant catori fever (MDREF) has been reported during outbreaks from many parts of the world. MDREF is most common in schoolchildren, but can also affect younger children. MDREF is more commonly associated with hepatomegaly and splenomegaly. Resistance to ceftriaxone and cefixim has been seen in many studies, as well as resistance to quinolones, which indicates that salmonella rapidly develops resistance to quinolones and therefore existing quinolones, such as sparfloxacin, levofloxacin, gatifloxacin and moxifloxacin, should be used very rationally (1). According to prospective surveillance conducted in the urban slums of Delhi, the direct and indirect costs per episode of the culture-confirmed blood of enteric fever amounted to 3,597 MGR outdoors. In the case of hospitalization, this cost increased (18,131 MKR). Almost similar observations have been made in other studies from other parts of the parts Country. Costs have increased several times due to increased hospitalization and growing resistance to affordable antibiotics. These costs also add to the annual loss of income for affected individuals and their families.15 Diagnostic approach to enteric fever isolation S. typhi from blood, bone marrow, or specific anatomical lesions is the only definitive way of diagnosing enteric fever.3 The presence of characteristic clinical symptoms or demonstrating a specific antibody response induces the disease, but not definitive. The clinical features of the panelists were the view that good clinical history and physical examination are very important for diagnosing enteric fever. In fact, the presence of fever with hepatosplenomegaly should make you think of this condition as one of differential diagnoses. Participants were fully agreed on this and felt that cineri fever could be diagnosed clinically with symptoms such as severe fever, headache, toxemia, abdominal pain (early in children), nausea, dry and covered tongue, relative bradycardia (the most important clinical trait), and pink spots that are rare in clinical practice. First, the liver becomes palpable. The spleen usually becomes palpable only a week later.2 Typical Presentation16 7-14 days after taking S. typhi First Week Fever Exhibits step-ladder pattern - i.e., the temperature rises during each day and drops by the next morning. Peaks and troughs gradually rise over time (Figure 6). gastrointestinal manifestations of diffuse abdominal pain and tenderness; Sometimes, fierce colic pain in the upper right quadrant. Monocytic infiltration into Peyer's patches, causing inflammation and narrowing of the bowel lumen, leading to constipation. Other symptoms of Dry Cough Dull Frontal Headache Delirium Stupor Malaise The second week Progressing above the signs and symptoms of plateau fever at 39-40 degrees Celsius Rose salmon color spots, blanching, maculopula on the chest, abdomen and back, may not be visible in dark-skinned individuals 1-4 cm wide, less than 5 in quantity, present in 25% They patients decide within 2-5 days. Represent bacterial embolisms of the dermis abdominal distension Soft splenomegaly Relative bradycardia - the temperature height is not accompanied by a physiological increase in the pulse rate of the Dicrotic pulse - double stroke. The second beat weaker than in the first third week of fever persists Increase in toxemy anorexia Weight Loss Conjunctivitis Thready Pulse Tachypnea Crackles over the lungs of The Severe Abdominal Stretching Sometimes, Folly, Green-Yellow, Liquid Diarrhea (Pea-Soup Diarrhea) Tifoid condition - characterized by apathy, confusion, psychosis due to severe toxemia, myocarditis or intestinal hemorrhage Fourth Fourth Gradual improvement of fever, mental state, and abdominal distension within a few days of untreated patients may suffer from intestinal and neurological complications of weight loss and debilitating weakness (may last for several months) Asymptomatic carrier condition in some patients who may transmit bacteria indefinitely Atypical presentation16 In some patients, intestinal fever may not be present in the typical manner described above. The presentation of the disease depends on the reaction of the host, geographic region, racial factors and infecting the bacterial strain. Fever: The characteristic pattern of stepladder fever is observed only in 12% of cases, and fever has a steady insidious onset. GI Symptoms: Diarrhea, not Constipation, is common in young children with AIDS and one-third of immunocompetent adults with intestinal fever Other atypical manifestations: Only Fever Severe headaches mimicking meningitis Acute Lobar pneumonia Arthralgias urinary symptoms Severe jaundice Neurological symptoms in some patients, especially in India and Africa, such as delirium, Symptoms of Parkinson's or Guillain-Barre Syndrome that a very toxic species of patient with low counts should cause suspicion of enteria fever or viral infection. Increasing the number usually means sepsis or perforation, with eosinopenia is an important finding. Monocytosis is also a common find. The presence of eosinopenia and thrombocytopenia strongly leads to enteric fever.2 Hematological tests17.18 Full blood test of hemoglobin: Honey anemia Total leukocytes (TLC): Low to normal Eosinopenia platelets: Low to normal liver function test: Mildly abnormal serum transaminase levels 2 to 3 times the upper limit of normal clinical jaundice is a rarity Significant hepatic dysfunction of rare crop cultures culture culture : The specificity of blood culture is 100%. For a good harvest, you need to collect at least 25-30 ml of blood. The more blood volume, the better the yield. The ideal time to do a culture of blood is when the patient has chills (rather than when fever spikes as is commonly believed). Blood for culture should be taken before giving the first dose of antibiotics. However, in clinical practice, antibiotic therapy is initiated on the basis of diagnosis, and blood culture is recommended. It is always best to do a test for sensitivity to antibiotics along with the culture, as it will help to choose the most suitable antibiotic. Culture should be repeated after an hour and then after 24 hours. A unified culture should not be encouraged. (Participants, on the other hand, showed that they rarely did a culture of blood in the primary health care facility, as it expensive for patients. They usually depended on the results of the Widal test and the full blood cell which shows eosinopenia and relative lymphocytosis). The positivity of blood culture is this: 1st week 90% 2nd week 75% 3rd week 60% 4th week 25% Blood culture positivity decreases due to the introduction of antibiotics; however, the blood culture will continue to test if persistent cases. A lot of the time, contaminants like coagulase-negative staphylococcus in blood culture can cause a false-negative report. Therefore, culture must be done with due care. The culture of the clot is also done.2 The cost of blood culture in India ranges from '600 to '800. Culture involves grafting a sample (blood, bone marrow or stool) into a broth of enrichment, and when there is growth, making subcultures on a solid agar. Biochemical testing is carried out to identify the resulting colonies. This is once again confirmed by the slide of agglutination with the appropriate antisera.19 Direct blood culture followed by microbiological identification remains the gold standard in the diagnosis of enteric fever.20 Blood culture shows the body's growth in 80% to 100% of patients.17 especially those With a history of fever within 7-10 days.3 However, patients who have started antibiotics may not show any growth.17 The range of sensitivity of blood culture is estimated to be between 40% and 80%. Sensitivity may be low in endemic areas with high antibiotic use, making it difficult to assess true specificity.18 The inability to isolate organisms may be due to delay in diagnosis, laboratory media limitations, widespread and irrational use of antibiotics, and low cultural blood, especially in children.21 The likelihood of recovery is directly proportional to the volume of blood; Therefore, it is important to have sufficient blood volume taken for culture.20 Due to higher levels of bacteriology in children compared to adults, at least 10-15 ml of blood of schoolchildren and adults, and 2-4 ml from toddlers and preschoolers should be taken to achieve optimal isolation rates.3 Restrictions in use Less sensitive to diagnosis of infection among children compared to adults2 Positive in only 40-60% Usually at the beginning of the disease18 Dear and requires specialized insitutions and staff20 S. typhi and S. paratyphi A is not always iconic, even if good microbiological remedies are available.20 bone marrow culture: The culture of bone marrow aspirate is the gold standard for diagnosing enteric fever.3 and can give positive results even if the patient has started antibiotics.23 This is of particular importance in patients who have been treated previously have a long history of illness and have had a negative blood culture with the recommended blood volume.3 This test has 55-67% and specificity of 30%.18 The level of positivity can be further increased to up to 100% if the FAN culture environment is used and growth monitoring is used in automated culture systems.23 Speaking of bone marrow culture, participants said the study is never conducted at the primary health care level. Even otherwise, it should be avoided, given that it is expensive as well as painful. Experts said that, unlike blood culture, bone marrow culture remains positive even after the introduction of antibiotics. Thus, it is more suitable for hospitalized and very sick patients.2 Restrictions in use Although most sensitive, it is an invasive procedure, and cannot be performed outside of specialized settings20 has limited clinical value, especially in outpatient management18 The pattern of difficult to obtain stool culture: Stool culture can help in identifying carriers of typhoid. The chair should be collected from acute patients in a plastic container sterile wide-mouthed and should be treated within two hours of collection. The larger the number of stools collected, the more likely it will be to get a positive result. Rectal tampons can be obtained instead of stool samples, but they are less successful in insulation.3 Chair culture in India costs about '350 to '450. All panelists agreed on the need to make re-chair crops to detect carriers, since they tended to shed bacteria sporadically. Chefs in particular should get their chair culture done to exclude the carrier state, as they can infect large numbers of people with cooking.2 Restrictions in the use of sporadic body shedding in the stool potentially jeopardizes stool cultivation approach20 becomes positive only after the first week of infection and has a much more sensitivity than blood culture (30% vs. 40-90%)18 Low sensitivity in developing countries18 is not commonly used for the culture of the 18th : The culture of urine, according to experts, is usually not done. The positivity of urine culture increases in carriers with urinary tract obstruction.2 The urine culture for enteric fever has a variable sensitivity range of 0-58%.18 In India, the cost of urine culture varies from '350 to '450. Culture of pink spots: Punch-biopsy spiked spots can be learned to give a sensitivity of 63% and can be positive even in patients who reviewed serum culture.16 antibiotics.16: To conduct serum culture, 1-3 billion blood is grafted into the tube without anticoagulant. When the convalescent phase begins after about 5 days, a second sample is collected. After blood clotting, the serum is separated and checked immediately or stored for a week without affecting the antibodies titre.3 Duodenal aspirate culture: Sharing experiences in Duodenal aspirate culture, panelists explained that this study may have good sensitivity because bile is directly included in the duodenal nora. However, they added that The test is not practical and represents more academic interest. The culture of duodenal aspirate in chefs can help detect carriers among them. Other materials that may be cultural include bile, secretion of rose stains, purgay from suprapurative lesions, and CSF or sputum if the patient has complications. In the autopsy, the culture of the liver, spleen, gallbladder and mesentery lymph nodes is also positive.2 In the study24 of 36 patients with bacteriologically proven enteric fever, the culture of the duodenum (derived from string capsules) was as sensitive in diagnosis as bone culture and more effective than blood culture and stools. The sensitivity of the culture of duodenal matter was not affected by the duration of the disease or antibiotic therapy. Even on the seventh day of antibiotic treatment, the culture of duodenal content was positive in eight out of 17 patients, while stool culture was positive in only two of the same patients. Aside from good sensitivity, the culture of duodenal content is simple, economical and can be performed with minimal convenience.24 However, this method is not widely performed due to poor tolerance to string devices, especially on the part of children.25 According to a comparative study25 different methods of bone marrow culture culture remain the most effective method of restoring S. typhi. Chair cultures seem to be more effective in children than in adults, while duod culture offers few benefits in young (2 to 6 year olds) children. Molecular Diagnosis of Polymerase Chain Reaction (PCR): PCR is a promising test that is as sensitive as blood culture, but less specific.18 It has been found to be at zgt;90% sensitive and relatively easy to work with. In addition, it can amplify DNA from dead or irrefutable bacteria, providing additional benefit sensitivity. However, this seems to have limited potential for diagnosing enteric fever. In the absence of any proven PCR tests, the proprietary systems that are currently in use are open to different interpretations and do not meet strict quality control standards for worldwide recognition.20 PCR is quite expensive, costing from '3800 to '4000 in India. Experts considered that PCR may not meet the criteria of the gold standard for diagnosing enteric fever in terms of sensitivity and specificity, as it does not cover all antigens of the disease. Only antigens 14, 15 and 18 are selected by one PCR test. In addition, this test is not available in remote and peripheral areas. Participants also echoed the same sentiments as they added that PCR is unlikely to Used to diagnose enteric fever in India.2 Nest polymerase chain reaction: Nest polymerase chain reaction is more sensitive than PCR and uses H1-D primer to strengthen specific S. typhi genes in patients' blood.18 It includes two



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