LETTER TO THE EDITOR

MULTIPLE VISCERAL ABSCESS IN A CASE OF MELIOIDOSIS

Sir,

Melioidosis is an infection caused by *Burkholderia pseudomallei*, an important human pathogen in tropical areas, but rarely thought of and investigated in India, where sporadic cases are reported. We report an unusual case of melioidosis with multiple abscesses in the liver and spleen in a diabetic elderly man from India with no travel history who presented with prolonged fever. Diagnosis of melioidosis was from the blood and pus culture.

A 51-year old diabetic man from Orissa presented with a history of low-grade fever, progressive left-lower-quadrant abdominal pain for 3 months. Abdominal examination revealed non-tender hepatosplenomegaly. Hematological and biochemical indices, apart from a hematocrit of 23.9%, erythrocyte sedimentation rate of 80 mm, alkaline phosphatase of 226 U/L (50-136) were within normal range. The chest radiograph was normal. Computerized tomography (CT) of the abdomen showed the presence of multiple hypo dense lesions in the liver and spleen [Figures 1 and 2]. The patient was initially put on ceftriaxone and metronidazole. The pus from the liver abscess was aspirated under ultrasound guidance and was cultured. Two days after incubation, scanty growths of gram-negative non-lactose fermenter colonies were isolated, identified as *B. pseudomallei*. Two samples of blood culture were also positive. The medical treatment was switched to ceftazidime (2 g q 8h). The patient’s clinical condition did not improve and the patient succumbed to his illness on the seventh day after admission.

Figure 1: CT scan of abdomen showing mild hepatomegaly with few small abscesses in both lobes.

Figure 2: CT scan of the abdomen showing splenomegaly with multiple splenic abscesses and a septated perisplenic fluid collection.
In India, the endemicity of melioidosis is not reported. The incubation period is not clearly known as the organism can be transmitted during contact with *B. pseudomallei* contaminated soil or water through exposure of abraded skin, inhalation and possible ingestion. The incubation period among travelers varies depending on the route of exposure varying from 1-5 days in localized form to 10-14 days in pulmonary form.\(^1\)

Most of the patients have underlying predisposing conditions, such as diabetes mellitus as in our patient.\(^2\) The clinical manifestations of melioidosis vary from abscess to fulminant sepsis and classified into 4 groups: (i) disseminated septicemic melioidosis, defined as positive blood culture and more than one organ involved (ii) non-disseminated septicemic melioidosis is defined as positive blood culture and only one foci or no apparent focus of infection (iii) localized melioidosis, as only single focus of infection and (iv) negative blood culture and multifocal localized, defined as multiorgan involvement but negative blood culture.\(^3,4\) Septicemia is the most common presentation. Many reports of melioidosis with abscess in unusual sites such as neck area, adrenal gland and prostate gland had published from India.\(^5\) The diagnosis of melioidosis in this patient was from the recovery of the organism in pus and blood culture. Serologic diagnosis is unreliable. Cefazidime is the drug of choice in systemic melioidosis. Doxycycline can be used in localized infections in combination with cotrimoxazole. For severe and/or septicemic disease, initiate parenteral therapy with cefazidime and co trimaxozole for 2 weeks followed by oral therapy for 6 months. Recently G-CSF has been tried in the management of septicemic form of melioidosis in Australia and has been approved for the management of severe septicemic melioidosis. Our patient had a disseminated septicemic disease, which was responsible for the mortality.

This case report demonstrates that health professionals should think of the possibility of melioidosis, an emerging infection in India as a cause of septicemia in a selected sub group of population presenting with multiple abscesses because of its high mortality in spite of treatment. We surmise that melioidosis is under diagnosed and underreported in India and we alert clinicians, microbiologists and public health professionals to the possibility of melioidosis being far more common than previously recognized.\(^6,7\)

**REFERENCES**