

Case Report: Melioidosis - poor compliance resulting in a relapse

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Introduction

Melioidosis is an emerging infection in Sri Lanka, acquired by inoculation or inhalation of soil and water containing *Burkholderiapseudomallei*. The disease may be acute, chronic, localized or disseminated.

Case report

A 55 year old male with poorly controlled diabetes mellitus presented with fever for 5 days and left sided abdominal pain in January 2017. Two years previously, just after returning from Malaysia, he developed recurrent episodes of a neck abscess. His CRP was 192 mg/L. Ultrasound abdomen revealed splenomegaly with multiple focal lesions. Blood culture grew *B. pseudomallei* with a positive antibody titre of >1280. He was treated with IV ceftazidime and oral cotrimoxazole for two weeks and discharged on oral cotrimoxazole for ten more weeks.

Five months later he presented with fever, left sided abdominal pain and difficulty in breathing for 5 days and admitted discontinuation of the eradication phase cotrimoxazole after 4 weeks. The white cell count was 21.47 x 10⁹/L and CRP was 185 mg/dl. Ultrasound abdomen showed a small subphrenic collection with splenic abscesses. On the CT scan, there were empyema of the left lung, a subphrenic collection and multiple abscesses in the spleen, liver and kidneys. Aspirated pus grew *B. pseudomallei* after 4 attempts and prolonged incubation of the sample. The melioidosis antibody titre was >10240. On admission, he was started with IV ceftazidime, oral doxycycline and cotrimoxazole in high doses. The patient improved clinically and was discharged after counselling on completing the eradication phase of treatment.

Discussion and Conclusion

Recurrent melioidosis may be caused by relapse or reinfection. Inadequate intravenous antibiotics, multifocal infection, bacteraemia, disseminated melioidosis during the primary episode and inadequate duration and poor compliance of eradication therapy are associated with recurrences. The second episode is a probable relapse which was not confirmed due to unavailability of genotyping facilities. Knowledge on the nature of the disease with its propensity to relapse, prompt aspiration of abscesses and repeated attempts at culture were important in confirming the relapse in this case. It is the responsibility of the clinicians to counsel the patient on discharge about the importance of compliance with the eradication treatment to prevent life threatening relapses.

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