

# Chronic Osteomyelitis due to *Burkholderia pseudomallei*

Sir,

Bone infections due to *Burkholderia pseudomallei* is uncommon with only a few reports in the literature<sup>1</sup>. This report documents a case of chronic osteomyelitis caused by *B. pseudomallei*.

A 38-year-old Indian male, a known diabetic, was admitted to the orthopaedic unit of Hospital Universiti Sains Malaysia with complaints of fever and painful swelling in the right foot. The swelling developed following injury to the foot, while bathing in a river. On admission he was started on intravenous cloxacillin 500 mg 6 hourly. A clinical diagnosis of abscess foot was made and an incision and drainage (I and D) was performed. Gentamicin was added to his antibiotic regimen when his local condition did not improve and the infection was extending to above ankle. Pus from incision and drainage grew *B. pseudomallei* and patient was started on intravenous ceftazidime. However infection was not controlled and patient developed septicemia. To control the ascending infection, below knee open amputation was performed following which the infection was controlled and patient improved with good wound healing. The patient was covered with ceftazidime for two weeks and secondary wound closure was done. The patient was discharged well and was maintained on co-trimoxazole for four weeks.

One year later, the patient returned with complaints of pain and swelling of the left leg of one month duration. Clinical examination revealed a small tender swelling over the upper part of the tibia. X-ray revealed a small lytic lesion in the tibia. Needle aspiration was done and the aspirate grew *B. pseudomallei* on culture. The patient was started on ceftazidime 1 gm for two weeks and the lesion was cured. On discharge the patient was maintained on co-trimoxazole for one month.

The patient returned after eight months with complaints of painful swelling on the left tibia. Aspirated material was sterile on culture. The patient was started on ceftazidime 1 gm/bd for two weeks. On discharge he was maintained on oral co-trimoxazole for three months. The patient is on regular follow-up for two years with no recurrence of the infection.

We conclude that in abscesses in immunocompromised patients, resulting from injury sustained outdoors and not responding to conventional antimicrobials, the possibility of *B. pseudomallei* infection should be considered. In such situations early institution of appropriate antibiotics will prove to be a life saving measure. A prolonged maintenance therapy with oral antibiotics is essential to prevent recrudescence of the infection<sup>2</sup>.

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