

## Polyserositis: A Rare Presentation

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To the Editor,

Melioidosis or Whitmore's disease is an infectious saprophytic disease caused by *Burkholderia pseudomallei*. The disease is most prevalent in South East Asia and Northern Australia. Thailand has the maximum reported cases.<sup>1</sup> In India, it is more prevalent in the South Western coast; however, there are no data on its prevalence and most of the cases go unrecognized.<sup>2</sup> The disease is transmitted via exposure of broken skin to contaminated soil, particularly wet paddy fields. Other mode of transmission is via aerosols. Important risk factors for the disease are occupational exposure, i.e., agriculturist, type 2 diabetes mellitus, immune deficiency state, and renal disorder.<sup>3</sup>

This is a case of a 42-year-old diabetic male from south India who is an agriculturist by occupation, presented with history of fever and body ache of 10 days' duration and retrosternal chest pain and breathlessness of 5 days' duration. Breathlessness was associated with cough with scanty whitish expectoration. The patient also complained of left-sided pleuritic type of chest pain. Over the next few days, the patient developed pedal edema. However, there was no other significant history. On examination, there was tachycardia, tachypnea, and bilateral pitting pedal edema. Respiratory system examination showed features of bilateral pleural effusion. Cardiovascular examination showed muffled heart sound and abdomen examination showed evidence of ascites. On investigation, there was leucocytosis. Serology for ANA and other connective tissue markers were negative. Chest X-ray confirmed bilateral pleural effusion. Echocardiography revealed pericardial effusion. Ultrasound of the abdomen showed hepatosplenomegaly and moderate ascites. Pleural fluid and pericardial fluid analysis showed features of exudative effusion and culture grew *Burkholderia pseudomallei*; however, blood culture was negative.

Chest pain was relieved by creating a pericardial window into the pleural space. Pleural fluid was drained with an intercostal drainage. The patient was started on intravenous ceftazidime and oral co-trimoxazole which he received for 15 days and then put on oral antibiotics. The patient was afebrile in 10 days and there was

improvement in symptoms and also in the clinical findings. He was discharged after a month of stay in the hospital on doxycycline and co-trimoxazole for another 20 weeks and advised follow-up.

The usual features on presentations are localized skin nodules at the point of entry of the bacilli, acute pulmonary infection in the form of breathlessness, pneumonia or pleural effusion.<sup>3</sup> They may also present with features of sepsis due to bacteremia as the extreme form which has high mortality rate. Other nonspecific features like joint pain, lymphadenitis, pain abdomen may be the presenting symptoms.

This patient presented with fever and body ache, and on investigation, he was found to have polyserositis (pleural effusion, ascites, pericardial effusion). There are hardly any reported cases of melioidosis presenting as polyserositis. Hence, melioidosis should be considered as one of the differential diagnosis of polyserositis particularly since the patient is a farmer and he is a diabetic. Also, since the relapse rate and mortality is high with this disease,<sup>4</sup> there is a need for early diagnosis and treatment particularly in India where it is underdiagnosed.

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## References

1. Limmathurotsakul D, Wongratanacheewin S, Teerawattanasook N, Wongsuvan G, Chaisuksant S, Chetchotisakd P, et al. Increasing incidence of human melioidosis in Northeast Thailand. *Am J Trop Med Hyg* 2010 Jun;82(6):1113-1117.
2. Vidyalakshmi K, Shrikala B, Bharathi B, Suchitra U. Melioidosis: an underdiagnosed entity in western coastal India: a clinico-microbiological analysis. *Indian J Med Microbiol* 2007 Jul;25(3):245-248.
3. Raja NS, Ahmed MZ, Singh NN. Melioidosis: an emerging infectious disease. *J Postgrad Med* 2005 Apr-Jun;51(2):140-145.
4. White NJ. Melioidosis. *Lancet* 2003 May;361(9370):1715-1722.