A 34 year old male who is a known case of type 2 diabetes on regular medication presented with history of mass on the left side of the neck for two weeks. Initially the patient complained of fever associated with chills in the first week which subsided following a five day antibiotic regime with Amoxicillin and clavulanic acid combination. The fever was superseded with a tender gradually progressive swelling measuring about 3x2 cm on the left side of the neck. On examination the patient had a soft to firm fluctuant tender mobile swelling in the left level IV region of the neck with local rise of temperature. Blood investigations showed an elevated ESR and increased random blood sugar levels. An ultrasonography of the neck suggested multiple echoic lesions measuring 33X16X20 mm with small necrotic central areas. The impression of cervical lymphadenitis was suggested with fine needle aspiration cytology (FNAC) advised for correlation. The FNAC report was suggestive of supportive lymphadenitis. The patient underwent incision and drainage. The culture sensitivity of the pus was suggestive of burkholderia pseudomallei sensitive to ceftazidime. The patient responded well to the treatment.
Discussion

Melioidosis is predominantly seen in diabetics and immunosuppressed patients. A population-based survey conducted in Udupi Karnataka India by Vandana KE et al. to assess the serological evidence of exposure to B. pseudomallei in 711 adults aged 18 to 65 years illustrated that 29% of the study sample were seropositive. Another study conducted by Kang G et al in Vellur, Tamilnadu India near agricultural land reported a seropositivity of 10.2%. The results of these studies are comparable to areas considered endemic, such as Vietnam (6.4-31.8%) and Thailand (21-47%) and Australia. The presentation of Melioidosis with head and neck manifestations are rare. A clinical study conducted over a period of 6 years from 2005-2010 by K.Vidyalakshmi et al in India isolated a total of 14 out of the 95 cases with head and neck manifestations. These included 6 cases of cervical lymphadenopathies, 2 cases of parotid abscess and 6 dental abscess following manipulation. The rate of head and neck infections in South East Asia is higher with 40% of children evaluated for supportive parotid abscess being diagnosed with Melioidosis. Cervical lymphadenopathy is rare in Melioidosis. The clinical features mirror that of granulomatous diseases which could lead to the misdiagnosis of tuberculosis in endemic areas. The isolation of Burkholderia pseudomallei is difficult unless the pathologist carries a high level of suspicion. Delayed specific treatment could lead to further complications. Fifty percent of patients who developed septic shock following Melioidosis in a study conducted by B.J. Currie et al died.

The treatment protocol for Melioidosis includes an intensive 2 weeks of intravenous therapy with a sensitive antibiotic most commonly ceftazidime (30-50 mg/kg IV q8hr; not to exceed 6 g/day) as a study conducted by White NJ et al observed. This should followed by a 3 month eradication therapy with oral combination of Trimethoprim and sulfamethoxazole. Due to a poor understanding of the nature of the disease recurrence rates following an apparent cure are high in studies conducted in endemic areas with 16% of cases showing recurrence in Thailand and 6% in northern Australia. Conclusion

Burkholderia pseudomallei are bacterial infection poorly diagnosed or neglected due to a lack of awareness in India. With an incidence rate as high in India as endemic zones Melioidosis should be considered as a growing endemic in the region.

References