A RARE PRESENTATION OF MELIODOTIC SEPTIC ARTHRITIS OF ANKLE

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INTRODUCTION:

Meliodosis is an endemic disease with high rate of mortality in tropical countries.[1,2] The causative agent is Burkholderia pseudomallei, a gram-negative bacillus. Patients with diabetes mellitus have increased risk of developing meliodosis.[2] It has a wide spectrum of clinical manifestations ranging from visceral to cutaneous abscess, however septic arthritis is an unusual presentation.[1,2]

CASE REPORT:

A 61-year-old lady with underlying diabetes mellitus and iron deficiency anemia presented with complain of fever, left ankle swelling and painful weight bearing for 1 week. She denied trauma or wound prior to this occurrence. Her left ankle was swollen, warm, tender with painful range of motion. Blood investigations noted Hemoglobin 8.6 g/dl, Leucocyte 14.4x 10^3/u with neutrophilic predominance. Ankle radiograph showed no abnormality (Figure 1). Regional ultrasound revealed iso to hypoechoic collection with echogenic foci inferior to lateral malleolus. This area was marked over skin (Figure 2). She was started on intravenous Unasyn 3g TDS. Intraoperatively incision and drainage over the marked area noted pus tracking to ankle joint, hence arthrotomy washout done. Blood, intraoperative tissue and swab cultures grew Burkholderia pseudomallei. The following 1 week she remained febrile with persistent ankle pain and underwent arthrotomy washout twice with change of antibiotic. She was started on intravenous Ceftazidime 2g tds for 4 weeks and oral Cotrimoxazole (5tabs/day) for 20 weeks. Ultrasound abdomen screening for intraabdominal abscess was unremarkable. She has been clinically afebrile with no ankle tenderness since then.

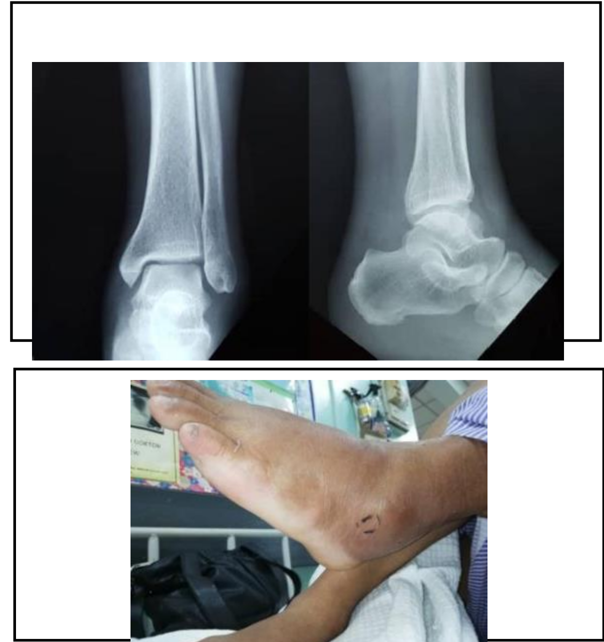

Figure 1
Figure 2

CONCLUSION:

This case highlights an uncommon manifestation of meliodosis. Early detection and appropriate antibiotic coupled with surgical drainage play a pivotal role in precluding dissemination. The gold standard in achieving diagnosis is pathogen identification by culture[1,2]. Following this, recommended treatment is intravenous Ceftazidime 2g TDS for 2-4 weeks followed by maintenance with oral Cotrimoxazole (trimethoprim-8mg/kg/day and sulfamethoxazole-40mg/kg/day) for 12-20 weeks for eradication and relapse prevention.[1]

REFERENCES:

1. Rajadhyaksha A, et al. Disseminated meliodosis presenting as septic arthritis. J Assoc Physicians India. 2012;60:44-45.
2. Raja NS. Meliodotic septic arthritis:a case report and literature review. J Microbiol Immunol Infect. 2007;40:178-182.