



Whitmore Disease- A Great Mimicker

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Abstract

Melioidosis is infectious disease caused by Gram negative bacterium Burkholderia pseudomallei. The disease was first discovered by Alfred Whitmore in 1912 in Myanmar. Hence it is also called WHITMORE DISEASE. It is restricted to South east Asia and Australia, occasional cases seen in India and China. It is found in water and soil. It causes wide spectrum of disease ranging from asymptomatic infection to abscess, pneumonia, disseminated disease. Signs and symptoms mimic Tuberculosis so it is called a MIMICKER.

Keywords: *Melioidosis, whitmore disease, disseminated disease, mimicker, tuberculosis.*

Introduction

Melioidosis is an infectious disease caused by Burkholderia pseudomallei which is a Gram negative bacterium. The disease was first discovered by Alfred Whitmore in 1912. Hence called Whitmore disease. It is found in soil and water. It is spread through direct contact with soil mainly through skin abrasions. and surface waters. Humans and animals believed to acquire infection by inhalation of contaminated dust or ingestion of contaminated water. It causes wide spectrum of disease ranging from asymptomatic infection to abscess, pneumonia, disseminated infection. Signs and symptoms mimic tuberculosis. The presence of nonspecific signs and symptoms caused it to be named the GREAT MIMICKER. People with diabetes are at risk.

Case Report

A 36 year female diabetic presented with fever high grade associated with chills and rigors, evening rise of temperature since 25 days. Productive cough with pleuritic chest pain since 25 days, history of decreased appetite and easy fatigability present. She had swelling of left ankle 10 days after the onset of fever associated with intense pain. On examination pallor, mild hepatosplenomegaly present. Right side bronchial breathing present. CBP showed progressive decline in total count and platelets Hb 10.6 to 8.6, total count 2960 to 2200, platelets 1.4 lakhs to 1 lakh. Liver function tests SGPT 102u/l SGOT 242u/l ALP 197u/l Serum bilirubin 1mg/dl. Chest x-ray showed non homogenous opacity in right lung lower zone. Ultrasound abdomen showed ill defined space occupying lesion in liver. CT abdomen showed liver abscess. Peripheral smear showed pancytopenia (dimorphic picture relative lymphocytosis, thrombocytopenia)and secondary

HHH hemophagocytic lymphohistiocytosis. Patient kept on empirical antibiotics but no response. Xpert MTB is negative viral screen, fever profile and H1N1 negative. On gram staining gram negative rod with safety pin appearance is noted. On blood culture after 48 hrs of inoculation wrinkled colonies with earthy odour noted *B. pseudomallei* isolated. Patient kept on ceftazidime inj 2g iv tid showed good response symptomatically improved.

Discussion

A 36 yr diabetic female who presented with fever with chills and rigors productive cough with pleuritic chest pain with evening rise of temperature, decreased appetite and septic arthritis left ankle with consolidation of right lower lobe of lung and liver abscess with blood culture positive for burkholderia pseudomallei suggesting disseminated melioidosis. The treatment of choice is inj iv ceftazidime 2g 8th hrly for 2 weeks followed by 4 wks of TMP SMX.

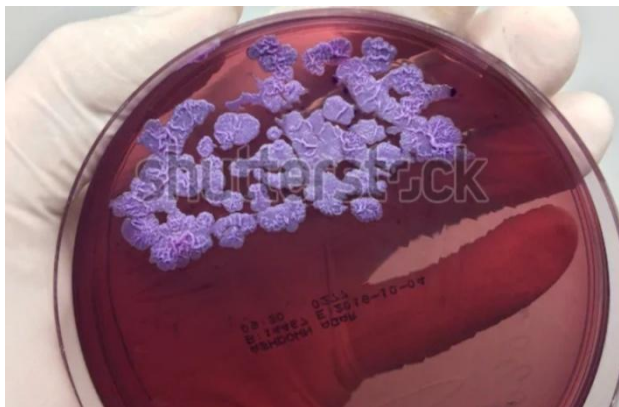


Figure:1- Blood Agar showing wrinkled colonies



Figure: 2 Chest X-ray- Consolidation Rt lower lobe

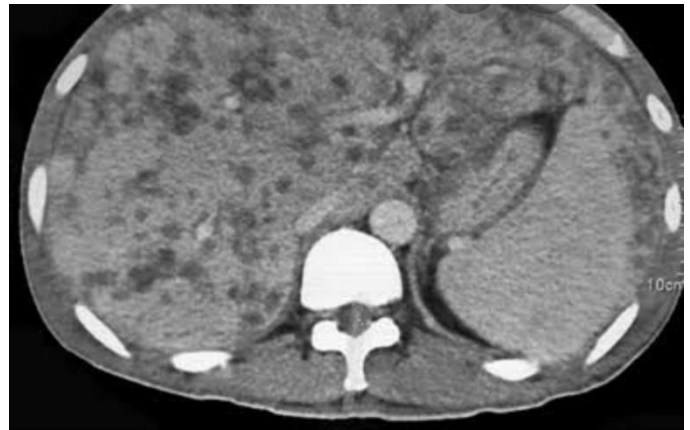


Figure: 3 CT Abdomen showing Hepatic Abscess

Conclusion

This is a rare case of disseminated melioidosis which presented with symptoms and signs similar to tuberculosis in diabetic female.

Clinical manifestations alone are not diagnostic and such a diagnosis requires high degree of suspicion prolonged treatment to avoid chronic debility and mortality.

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