

Letter in Response to “Melioidosis in a Tertiary Care Center from South India: A 5-year Experience

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Dear Editor,

We read with interest the article entitled “Melioidosis in a tertiary care center from south India: A 5-year experience” by Ganeshan et al.¹ Our tertiary care teaching and referral center in Eastern India has diagnosed more than one hundred and fifty cases over 7 years and our coordinated team effort of microbiologists and clinicians brought Odisha as an endemic zone in the national map of melioidosis.² *Burkholderia pseudomallei* was isolated from 31% of cases of community-acquired sepsis (unpublished data) and 24.8% of localized pyogenic infections.³

We intend to add a few points based on our experience. Firstly, melioidosis should be ruled out in all patients presenting with community-acquired sepsis, deep organ abscesses, and cervical lymphadenopathy in all the coastal states of India in whom the pre-test probability is high in terms of associated risk factors like uncontrolled type II diabetes mellitus. Farmers though constitute a high-risk group, outdoor occupational exposure as a predominant risk factor for melioidosis seems to be blurring in recent times, and people across occupations seem to be vulnerable to melioidosis.² Secondly, though culture is still regarded as the diagnostic gold standard, has a maximum sensitivity of 60%.² Additional tests, such as antigen detection using lateral flow immunoassay (LFI), format that detects the *B. pseudomallei* capsular polysaccharide antigen directly from various clinical samples have shown promise, but availability remains an issue. Hence microbiology laboratories should expand their technological armamentarium for improved diagnosis.² Thirdly, the disk diffusion breakpoints by EUCAST were published recently, which may easily be incorporated by diagnostic microbiology laboratories in their routine practice.⁴ We presume the authors determined antimicrobial susceptibility using EUCAST breakpoints. There have been recent recommendations about increasing the duration of the intensive phase of treatment beyond two weeks which is a key driver for bringing down the mortality to less than 10%.⁵

Overall, as pointed out by the authors, awareness of the disease is the key to early diagnosis and successful management. In an issue of *Lancet Planetary Health*, Chai et al. issued a commentary titled “Earth, wind, rain and melioidosis”.⁶ *Burkholderia pseudomallei* was always there in the environment, only now clinicians and microbiologists have started recognizing it and the disease burden we are witnessing is the tip of the iceberg. Customized diagnostic algorithms for high-risk patients in critical conditions, and incorporation of melioidosis into clinical differentials will require strong collaboration between clinicians and microbiologists. It will

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also take years to attract the attention of the policymakers about this fatal, yet treatable disease.

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