OSTEOMYELITIS IN SACROILIAC AND SEPSIS BY *BURKHOLDERIA PSEUDOMALLEI*: MELIOIDOSIS IN PATIENT WITH SYSTEMIC LUPUS ERYTHEMATOSUS – CASE REPORT

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BACKGROUND

Melioidosis is an emerging infectious disease in Brazil caused by exposure to water or soil contaminated by the bacteria *Burkholderia pseudomallei*. Its clinical presentation is diverse, ranging from uncomplicated soft tissue infections to severe pneumonia and sepsis. Musculoskeletal involvement (4 to 12%) is often associated with systemic manifestations, mainly affecting lower limbs.

CASE REPORT

Male patient, 22 years old, diagnosed with systemic lupus erythematosus one month before admission (criteria: homogeneous nuclear ANA pattern 1:640, positive anti-dsDNA, thrombocytopenia, hypocomplementaemia, alopecia, polyarthritis, serositis, nephritis), using hydroxychloroquine 400 mg/day and methotrexate 15 mg/week, was admitted to this service due to renal activity and arthritis. After nine days of hospitalization, he evolved with fever associated with persistent pain in the right gluteal region and limited walking. Blood cultures showed growth of *B. pseudomallei*, which led to the investigation of a pulmonary focus with chest computed tomography (CT), despite the absence of respiratory complaints. Computed tomography showed multiple pulmonary nodules and micronodules, with sparse central excavation foci in both lung fields, bilateral pleural effusion and minimal laminar pericardial effusion. Magnetic resonance imaging (MRI) with gadolinium of sacroiliac showed areas of cortical irregularity and bone edema, associated with fluid collection in peripheral post-contrast enhancement, compatible with osteomyelitis on the right side. The diagnosis of melioidosis was established and the treatment chosen was meropenem and sulfamethoxazole-trimetoprim (SMX-TMP), being transferred to the ICU with sepsis. The use of intravenous SMX-TMP was maintained for 21 days, showing sepsis resolution and gluteal pain reduction. After hospital discharge, the patient continued using oral SMX-TMP for 12 months. In the outpatient follow-up, he presented clinical and radiological resolution of the condition, with right sacroiliac MRI showing only chronic lesions, with signs of fat in the subchondral region on the articular surface, subchondral cystic areas, without bone edema or areas of anomalous enhancement.

CONCLUSION

Melioidosis is a disease that mainly affects immunosuppressed patients, including those with autoimmune rheumatic diseases. Diagnosis is based on clinical and laboratory findings, and microbiological confirmation in culture is essential. *B. pseudomallei* should be considered one of the etiological agents of bone and joint infections due to its increased incidence in Brazil, with high rate of morbidity and mortality when not early diagnosed and treated.

KEYWORDS

Melioidosis, *Burkholderia pseudomallei*, Systemic lupus erythematosus, Osteomyelitis.