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FROM EYE DROOP TO AN EYE OPENER

Dr. Kamala Kant Bhoi*[1], Dr. Swati Tamaskar[2], Dr. Aum Bapat[3], Dr. Naresh Verma[3] and Dr. Dinesh Pardeshi[4]

[1]Assistant Professor, Department of Neurology, Shri Balaji Institute of Medical Science, Mowa, Raipur, C.G. 492001.
[2]Associate Professor, Department of Ophthalmology, Shri Balaji Institute of Medical Science, Mowa, Raipur, C.G. 492001.
[3]DNB Resident, Department of Medicine, Shri Balaji Institute of Medical Science, Mowa, Raipur, C.G. 492001.
[4]Assistant Professor, Department of Radiology, Shri Balaji Institute of Medical Science, Mowa, Raipur, C.G. 492001.

***Corresponding Author: Dr. Kamala Kant Bhoi**
Assistant Professor, Department of Neurology, Shri Balaji Institute of Medical Science, Mowa, Raipur, C.G. 492001.

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ABSTRACT
A 44-year-old diabetic female presented with high-grade fever, left eye ptosis, eyelid swelling, headache, fatigue, and myalgia. The diagnosis was confirmed by blood culture, revealing Burkholderia pseudomallei infection, a rare cause of Melioidosis. She improved with prompt antibiotic therapy.

KEYWORDS: Melioidosis, Burkholderia pseudomallei, Ptosis, Fever, Diabetes.

INTRODUCTION

A 44-year-old female admitted with high-grade fever, ptosis of the left eye, eye lid swelling, headache, fatigue, myalgia since eight days. Does it ring any bell: Tropical fever, Posterior communicating artery aneurysm, Meningitis or Myasthenia gravis? Well, let's see how a blood culture proved to be an eye opener.

CASE REPORT

A 44-year-old female, recently diagnosed diabetic, presented with the complaints of high-grade fever since eight days, ptosis of left eye with redness, swelling of eyelids, headache, vomiting, fatigue, and myalgia [Figure: 1 & 2]. No history of diplopia, insect bite, trauma, any skin rashes, neck rigidity, tingling sensations in any limbs, and previous such episodes.

Investigations

The investigations showed Hb - 11.9 gm/dL, Platelets - 2.07 lac/cmm, TLC – 7100/cmm, ESR - 90mm/1st hr, CRP >300, PCTQ - 1.71, normal routine urine analysis, FBS - 223mg/dL, Hba1c - 4.9, normal liver and renal function tests, normal routine fever profile, leptospira IgM – negative, peripheral smear - normal picture. Ultrasonography of abdomen showed hepatomegaly (16cm) and splenomegaly (14cm). 2D echocardiography revealed normal function. Contrast-enhanced MRI brain: no evidence of intracranial hemorrhage, mass effect, or midline shift [2, Figure;3,]. Contrast-enhanced MRI orbit: fusiform thickening of levator palpebrae superioris, superior oblique, and superior rectus, inflammation with myositis and mild cellulitis [Figure:4]. Blood culture Burkholderia species after 48 hrs of aerobic incubation.

Review of Literature

Melioidosis or Whitmore's disease is a tropical disease caused by the bacterium Burkholderia pseudomallei.[1] The disease is endemic in Southeast Asia and Northern Australia, and is often associated with exposure to contaminated water or soil.[2] The clinical presentation can vary widely, ranging from asymptomatic infection to severe sepsis and organ failure.[3] The disease can also present with localized infections, such as abscesses or cellulitis.[4] Diagnosis typically involves culture of the bacterium from clinical specimens, such as blood or tissue.[9] Molecular diagnostic techniques, such as PCR, can also be used to detect the presence of B. pseudomallei.[10] Treatment is by use of antibiotics, such as Ceftazidime or Meropenem and supportive care.[13] Early diagnosis and treatment are critical to preventing complications and improving outcomes.[14]

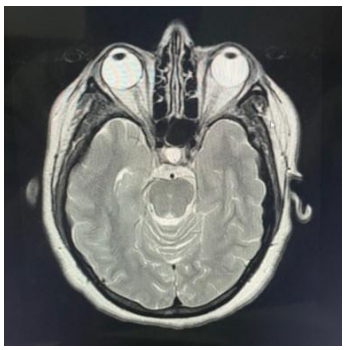

Figure 1: MRI brain.

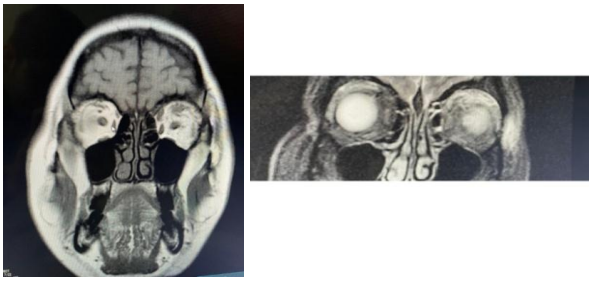

Figure 2: MRI brain with orbits.

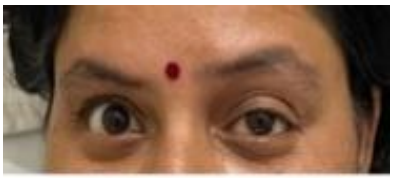

Figure 3: On admission.

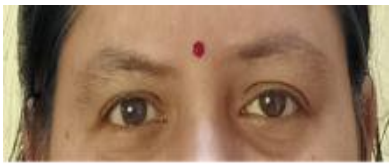

Figure 4: On discharge.

DISCUSSION

The diagnosis of Melioidosis in our patient was confirmed by blood culture, which revealed Burkholderia pseudomallei infection.[1] This highlights the importance of considering Melioidosis in the differential diagnosis of patients presenting with fever and orbit inflammation, particularly in endemic regions.[5] The clinical presentation of our patient, with high-grade fever, left eye ptosis, eyelid swelling, headache, fatigue, and myalgia, is consistent with previous reports.[6] The presence of hepatomegaly and splenomegaly in our patient is also consistent with previous report.[7] Early diagnosis and treatment are critical to preventing complications and improving outcomes.[8] In our patient, prompt treatment with antibiotics and supportive care led to a successful outcome.

CONCLUSION

Our case highlights the importance of early diagnosis and treatment of Melioidosis, a potentially life-threatening disease. Earliest antibiotic therapy and supportive care are crucial for improving outcomes.

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