中文題目：以 beta-lactam/beta-lactamase inhibitor 及 TMP/SMX 成功治療類鼻疽肺炎

英文題目：Pulmonary melioidosis successfully treated with beta-lactam/beta-lactamase inhibitor and TMP/SMX

作　　者：廖威盛[1] 謝孟娟[2,4] 徐慧君[2,4] 閻俊如[2,4] 王惠菁[2,4] 林蔚如[1,3] 蔡明儒[1,2,5]

服務單位：高雄醫學大學附設中和紀念醫院 [1]內科部 [2]胸腔內科 [3]感染內科 [4]護理部
高雄醫學大學醫學院 [5]醫學研究所

Case Presentation

A 51-year-old man with an unremarkable medical history had worked in Vietnam for several months. He presented to the hospital in Vietnam with fever, chills, mild dyspnea, and poor appetite for days. He soon returned to Taiwan and visited the ED of our hospital. The chest radiograph showed consolidation in the left lung, mimicking a lung mass. The laboratory test showed severe leukocytosis (30500/mcL) and high C-reactive protein (CRP) level (375.63 mg/L). Computed tomography (CT) of the chest showed pneumonia in the left lung and right lower lung and lymphadenopathy in the pericarinal region and left upper mediastinum, while superimposed malignancy could not be excluded. After four days of empirical antibiotic treatment with moxifloxacin, he was admitted to the chest ward and the antibiotic was changed to ampicillin/sulbactam as the preliminary report of blood culture showed growth of Gram-negative bacilli. He remained having intermittent high fever, but was doing quite well without dyspnea after admission. Although the blood culture yielded *Burkholderia pseudomallei*, ampicillin/sulbactam was kept and oral trimethoprim/sulfamethoxazole (TMP/SMX) was added because of interval improvement in the chest radiograph, leukocytosis and CRP level. His fever subsided few days later. Gallium-67 citrate whole body scan revealed markedly increased radioactivity in upper mediastinum, bilateral lung hila and heterogeneously increased radioactivity in bilateral lung fields. After two weeks of intravenous ampicillin/sulbactam treatment, he was discharged home with oral TMP/SMX and amoxicillin/clavulanate. The oral antibiotics were kept for four months. The serial follow-up chest radiographs showed gradual resolution of the pneumonia.

Discussion

Melioidosis is a clinically diverse disease caused by *Burkholderia pseudomallei*, a facultative intracellular gram negative bacterium. All cases of melioidosis should be treated with an initial intensive therapy (at least two weeks of intravenous therapy) followed by eradication therapy orally for a minimum of three months. The antibiotics preferred for initial intensive therapy were ceftazidime, imipenem, or meropenem, while TMP/SMX was suggest for eradication therapy. In our case, due to the clinical stability and improving course under ampicillin/sulbactam, the antibiotic regimen was not changed to ceftazidime or carbapenem. TMP/SMX was added for improving treatment effect to the intracellular pathogen. The patient had an uneventful recovery after five months of antibiotic treatment. In summary, this case demonstrated that pulmonary melioidosis could be successfully treated with beta-lactam/beta-lactamase inhibitor and TMP/SMX, especially in clinically stable patients.