To The Editor—We note with interest the cases described by Apisarnthanarak et al. [1] detailing the radiological appearance of hepatic and splenic abscesses due to *Burkholderia pseudomallei*. We would like to report 2 differential diagnoses of multiloculated hepatosplenic abscesses; tuberculosis and liver abscess due to *Klebsiella* species.

A 46-year-old woman presented with a 2-month history of fever following recent prolonged residency in China and India. Physical examination was unremarkable, except for the fever, and investigations revealed the presence of a single abscess in the liver and a multiloculated abscess in the spleen (figure 1). Aspirates of the liver abscess were obtained; Gram staining did not demonstrate organisms, and results of bacterial cultures were negative, but subsequent results of culture for acid-fast bacilli were positive for *Mycobacterium tuberculosis*. The patient was treated successfully with standard antituberculous therapy.

A 48-year-old diabetic man presented with a 2-week history of fever. He had not traveled to any areas where melioidosis is considered to be endemic. Physical examination revealed fever and tender hepatomegaly, and imaging demonstrated a multiloculated liver abscess (figure 2). Blood cultures grew *Klebsiella pneumoniae*; aspiration of the abscess was attempted but was unsuccessful. The patient was successfully treated with intravenous ceftriaxone.

Focal hepatosplenic abscesses are an unusual manifestation of tuberculosis [2], but tuberculosis of other organs is an important differential diagnosis of melioidosis in countries where it is endemic.

**Figure 1.** Multiloculated splenic abscesses and liver abscess due to tuberculosis

**Figure 2.** Multiloculated liver abscess due to *Klebsiella pneumoniae*.
Is a Honeycomb Appearance on Computer Tomography Characteristic for *Burkholderia pseudomallei* Liver Abscess?

To the Editor—I read with interest the case reports by Apisarnthanarak et al. [1] in a recent issue of *Clinical Infectious Diseases*. The authors reported on the CT features of 3 patients with *Burkholderia pseudomallei* liver abscess and suggested that the “honeycomb” appearance was characteristic and that such features should prompt physicians to consider *B. pseudomallei* infection, particularly in patients from high-risk areas where *B. pseudomallei* is endemic. These findings may be useful in aiding early diagnosis. However, one wonders whether the honeycomb appearance described is actually just a part of a spectrum of liver abscess evolution from the initial solid to the later liquefied stages, regardless of the underlying organisms.

*B. pseudomallei* infection is common in certain tropical regions, particularly in Thailand and northern Australia [2], but the infection is being reported in many countries where it is not usually found. A recent review of 49 cases of liver abscess in my local region showed that *B. pseudomallei* accounted for 21.3% of cases, with infection due to *Klebsiella* species accounting for almost 50% [3]. There were no differences in age, number of abscesses, and chest radiography and CT scan findings of liver abscess between patients with the different etiologies. Both *Klebsiella* and *B. pseudomallei* abscesses (90% and 93.3%, respectively) were significantly associated with the presence of poorly controlled diabetes mellitus that was either previously known or newly diagnosed. All of our patients had *B. pseudomallei* isolated by blood or pus culture within a few days of initiating the culture. However, species identification required at least another 48 h. The sensitivity patterns are quite distinctive, with a universal intrinsic resistance to aminoglycoside.

Although the report by Apisarnthanarak et al. [1] showed possible characteristic features, these findings were based on only 3 patients. There are other clinical and initial laboratory findings that have been reported regarding the characteristics of *B. pseudomallei* liver abscess [4]. In my local region, we always consider *B. pseudomallei* as a possible etiology in all cases of liver abscess, particularly in patients with diabetes (previously known or newly diagnosed) or any other underlying immunocompromising conditions, such as malignancies and post-chemotherapy. The standard antibiotic regimen for sepsis at my institution consists of amoxicillin and clavulanic acid (with or without metronidazole), which provides coverage for infections caused by both *B. pseudomallei* and *Klebsiella* species. Third-generation cephalosporin is added if there is a high suspicion for *B. pseudomallei* infection. The presence of a honeycomb appearance on a CT scan may be helpful, but the absence of such findings should not detract the possibility of *B. pseudomallei* infection. Whether this CT finding is characteristic for *B. pseudomallei* liver abscess needs further evaluation using a larger sample size.

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References

2. Leelarasamee A, Bovornkitti S. Melioidosis: multiloculated liver abscess due to *Klebsiella pneumoniae*. Figure 2. Multiloculated liver abscess due to *Klebsiella pneumoniae*. 2006;42:264–5. Reprints or correspondence: Dr. Allen Cheng, c/- 3/68 Myers St., Geelong, VIC 3220, Australia (allen.cheng@menzies.edu.au).

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