the list of emerging bacterial zoonotic agents in wild rodents that could be pathogenic for humans. Further studies are warranted to evaluate the prevalence of this bacterium in rodents in other countries and to demonstrate that rodents may be a source of transmission of this bacterium to humans, especially immunocompromised patients.

Acknowledgments

We thank Annick Bernard and Linda Hadjadj for technical assistance.

This study was supported by the French National Research Agency; CERoPath (Community Ecology of Rodents and their Pathogens in Southeast Asia Project ANR 07 BDIV 012); Infectiopôle Sud; Center for Excellence on Agricultural Biotechnology; the Science and Technology Postgraduate Education and Research Development Office; the Office of Higher Education Commission, Ministry of Education (AG-BIO/PERDO-CHE); and the Center of Advanced Studies for Agriculture and Food, Institute for Advanced Studies, Kasetsart University.

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DOI: http://dx.doi.org/10.3201/eid1903.120987

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Melioidosis and Hairy Cell Leukemia in 2 Travelers Returning from Thailand

To the Editor: Patients with underlying medical conditions travel more than ever (I), and such travelers may be exposed to uncommon infections (2). We report 2 cases of melioidosis and hairy cell leukemia in travelers returning from Thailand.

Case-patient 1 was a 48-year-old man hospitalized in Paris with fever, asthenia, chills, and pancytopenia after returning from a 1-week visit to Thailand where he had been in flooded regions (Koh Samui and Koh Samet). Clinical examination showed a temperature of 40°C and mucocutaneous pallor. Laboratory tests showed a hemoglobin level of 7.9 g/dL, a platelet count of 33 × 10^10/L, a leukocyte count of 1.3 × 10^9 cells/L, a polymorphonuclear cell count of 0.77 × 10^9 cells/L, a monocyte count of 0, and a C-reactive protein level of 158 mg/L. Results of tests for HIV, dengue, and malaria were negative.

Presumptive antimicrobial drug treatment with piperacillin/tazobactam (12 g/1.5 g/d) was initiated at admission. A blood smear showed 10% hairy cells, and a bone marrow biopsy confirmed a diagnosis of hairy cell leukemia and interstitial infiltration of CD20-positive, monoclonal antibody DBA44-positive, and tartrate-resistant acid phosphatase-positive cells.

Because of persistent unexplained fever, full-body computed tomography (CT) was performed and showed multiple liver, spleen, and lung abscesses (Figure, panels A and B). Culture of a CT scan–guided liver abscess puncture specimen was positive for *Bukholderia pseudomallei* after 12 days of antimicrobial drug treatment. Treatment was changed to cefzadime (120 mg/kg/d) trimethoprim/sulfamethoxazole.
(TMP/SMX) (10/50 mg/kg/d) and oral doxycycline (200 mg/d) for 3 weeks. The outcome was good.

Oral treatment with TMP/SMX and doxycycline (200 mg/d) was continued for 20 weeks. Treatment for hairy cell leukemia with cladribine was initiated after 10 weeks of antimicrobial drug treatment. Two years later, the patient showed complete remission of hairy cell leukemia and melioidosis.

Case-patient 2 was a 64-year-old man hospitalized in Paris for persistent fever 16 days after his return from Thailand. Two months earlier in Thailand, he had received treatment for hepatosplenic melioidosis with ceftazidime (120 mg/kg/d), TMP/SMX (10/50 mg/kg/d), and doxycycline (200 mg/d) for 15 days, and then oral amoxicillin/clavulanic acid (3 g/d) for 3 months. At admission, he had fever, chills, abdominal pain, and cough. Clinical examination showed a temperature of 40°C and left lung crackles. Chest and abdomen CT images showed a focus of lung consolidations (Figure, panels C and D), left pleural effusion, pericarditis, and spleen abscesses. Laboratory tests showed a leukocyte count of 1.05 × 10^9 cells/L, a monocyte count of 0.04 × 10^9 cells/L, a hemoglobin level of 7.9 g/dL, a platelet count of 62 × 10^9/L, and a serum ferritin level of 8,530 IU/L. Blood cultures were positive for B. pseudomallei. The strain was sensitive to amoxicillin/clavulanic acid. Bone marrow aspiration and biopsy showed hemophagocytosis and interstitial infiltration of CD20-positive, monoclonal antibody DBA.44-positive, CD 103-positive, CD25-positive, CD11c-positive, and CD123-positive cells, leading to a diagnosis of hairy cell leukemia. The patient was given a 2-week course of intravenous TMP/SMX (50 mg/10 mg/kg/d), oral doxycycline (4 mg/kg/d), and intravenous ceftazidime (120 mg/kg/d), followed by a 6-month course of oral TMP/SMX (10 mg/50 mg/kg/d) and doxycycline (200 mg/d). The condition of the patient improved and pancytopenia resolved. Thus, he did not require any treatment for hairy cell leukemia. No relapse of melioidosis occurred.

Melioidosis is endemic to the Pacific region and Southeast Asia (3,4). Most cases reported in other regions are imported (5). In Thailand, where both patients had traveled, the number of cases increased from 11.5/100,000 inhabitants in 1997 to 21.3/100,000 in 2006 (6). The 2 main routes of transmission are transcutaneous and aerosols. Natural disasters, such as flooding, are a risk factor for melioidosis, as for case-patient 1.

This disease has an overall mortality rate of 50%. The clinical spectrum ranges from acute septicemia (mortality rate 80%) to the subacute form. B. pseudomallei is difficult to detect by culture of biologic samples, and serologic analysis or PCR for this bacteria are not routinely available. Therefore, a diagnosis of melioidosis can be easily missed.

Melioidosis occurs mainly in patients with underlying diseases such as diabetes (37%–60% of cases), chronic alcoholism (12%–39%), thalassemia, and chronic nephropathy, and in persons receiving long-term corticosteroid treatment (7). Reports of patients with melioidosis and hematologic malignancies or solid cancers are scarce (4,5,7). Hairy cell leukemia could now be included in this group of diseases.

Hairy cell leukemia is a rare chronic B-cell lymphoproliferative disorder characterized by pancytopenia; splenomegaly; and infiltration of the bone marrow, spleen, and liver by malignant B cells that have hair-like cytoplasmic projections (8,9). The incidence of hairy cell leukemia is
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Acknowledgment

We thank Laurent Meyer for reviewing the manuscript.

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