A 60-year-old African man, without any significant medical history or immunodeficiency, was admitted to the hospital with a one-week history of fever, jaundice, and abdominal pain. On admission, he was febrile (temperature 40 °C) and tachypneic. Physical examination revealed crepitant rales in the lung bases, abdominal sensibility, with a maximum of pain, and a vascular souffle in the left flank quadrant. Laboratory studies showed a white blood cell count of 23.6 x 10⁹ cells/l, increased C-reactive protein (190 mg/l), and cholestasis with hyperbilirubinemia (114 μmol/l). Abdominal ultrasonographic examination and magnetic resonance imaging (MRI)–angiography showed a saccular aneurysm in the left common iliac artery, measuring 55 mm in transversal diameter (Figure 1). The diagnosis of mycotic aneurysm was strongly suspected. Resection of the aneurysm with implementation of an aorto-iliac allograft was realized within 24 h. Blood and arterial cultures grew an unusual Gram-negative bacillus, *Burkholderia pseudomallei* (Figure 2), the cause of vascular, lung and liver melioidosis in our case. The patient's clinical course was favorable under parenteral antimicrobial therapy (imipenem and ciprofloxacin) for 5 weeks, followed by oral antibiotic therapy (trimethoprim–sulfamethoxazole) for 5 months. At the last review, 6 months after stopping antibiotics, there was no clinical, biological, or radiological evidence of relapse.

Mycotic aneurysms of the arterial system are rare and the usual etiological agents implicated are *Staphylococcus aureus* and nontyphoidal *Salmonella* species. Melioidosis is an infectious disease caused by *Burkholderia pseudomallei*, which is endemic in Southeast Asia and northern Australia, and has also been reported from non-endemic areas of the world. *B. pseudomallei* is an important pathogen in humans and in a wide variety of animal species.¹ In France, the bacillus was first isolated in 1975 from a Przewalski horse; the origin of the contagion was determined to be horses imported from Iran, an area where the disease has been recognized in these animals since 1943.²,³ The most common clinical presentation of melioidosis is pneumonia, followed by skin, visceral, and genitourinary system abscesses. Melioidosis presenting as mycotic aneurysm has only rarely been reported and is associated with high morbidity and mortality.⁴ In the absence of a
severe purulent infection, repair using prosthetic grafts is recommended; conversely, in the presence of a severe purulent infection, an extra-anatomical bypass is generally required.\textsuperscript{5,6} Alongside the surgical management of mycotic aneurysm, the treatment of choice is ceftazidime or imipenem, maintained until clinical improvement, followed by oral treatment (trimethoprim–sulfamethoxazole) for at least 3–6 months.\textsuperscript{6,7} Authors following this therapeutic method did not note any relapse in the infection during 1–2 years of surveillance; however, patients should be followed closely for the rest of their lives in order to ensure an optimal survival rate.\textsuperscript{6,8,9} \textbf{Conflict of interest:} No conflict of interest to declare.

\textbf{References}


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