Such cases might be accompanied by bacteraemia and the diagnosis is entirely dependent on the EBUS aspirated material.

Because of the low sensitivity of culture (60%), the use of non-culture methods with high sensitivity is desirable.[3] We use an active melioidosis detect-lateral flow assay (InBios International, Seattle, WA, USA) as an adjunct test to culture at our centre. This test has been shown to have optimal sensitivity and specificity, and has the potential to be used as a point-of-care test for early diagnosis of melioidosis in resource-constrained settings.[4] A study[5] on a lateral flow recombinase polymerase amplification assay showed that it was a good alternative to the traditional PCR-based test.

The ability of clinicians to notice subtle signs of melioidosis and quickly communicate their clinical suspicion of the disease to microbiologists is the key to rapid diagnosis. Clinicians' suspicion helps judicious use of specific media, automated culture, and identification in a resource constrained country.

In addition to raising awareness among clinicians and microbiologists about this disease and considering melioidosis as a neglected tropical disease,[1] we feel it is important to create country-specific melioidosis registries. These registries would contribute not only to improved patient care by providing readily accessible information and better understanding of the disease transmission but also be used for clinical research and prevention of this emerging disease.

We declare no competing interests.

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We read with interest Emma Birnie and colleagues' Article about the global burden of melioidosis in 2015.[1] However, they did not mention the burden of the disease in the Caribbean islands, where cases have been reported although it is not a major endemic region.[2]

Martinique is a 1000 km² island in the French West Indies (ie, Martinique, Guadeloupe, Saint-Martin, Saint-Barthélémy), with 390 000 inhabitants. We have treated 14 patients with melioidosis in our hospital since 1993, including six who died from their disease. The mean age of those patients was 66 years (SD 13)—older than most patients with the disease in South and Central America[1]—and 13 (93%) were men. Neither excessive exposure to soil and water nor occupational exposure were reported. Four patients previously had type 2 diabetes, one previously had chronic kidney disease, five previously had excessive alcohol consumption, and six had cancer, which are usually not known to be risk factors.[3] The infections occurred mainly during the rainy season (11 of 14) and the incidence was approximately two times higher in years with excessive rainfall (nine of 14).

Burkholderia pseudomallei was isolated from the blood in 12 patients, from a joint or bone in two, from urine in one, and via bronchoalveolar washing in one. Four patients had a pulmonary form, two had a urinary infection, and three had soft-tissue abscesses.

For the eight patients who recovered, the mean duration of antibiotic therapy was 3·1 months (SD 3·8), with longer durations for musculoskeletal infections. Initial empiric antibiotic treatment was effective against *B pseudomallei* in only three of 14 patients, with *B pseudomallei* usually being resistant to antibiotics for community-acquired infections. Mortality was 43%, and of those who died, five had concurrent neoplasia.

All cases were diagnosed from cultures—the gold standard. Our hospital's bacteriological laboratory received all samples from the emergency units on our island, and we are the only reference centre for infectious diseases in Martinique.

Martinique is a touristic destination, thus melioidosis should be considered in people returning from the island. One additional case, a young traveller who developed fatal melioidosis after returning from Martinique in 2010, was reported by Gétaz and colleagues.[4]

Thus, although the Caribbean region is not a major endemic region, there is a melioidosis burden in West Indies.

We declare no competing interests.

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