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CASE REPORT

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Nocardia brasiliensis primary pulmonary nocardiosis with subcutaneous involv

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Abstract

This is a report of an unusual case of *Nocardia brasiliensis* causing primary pulmonary nocardiosis with disseminated subcutaneous lesions in an immunocompetent patient. This case highlights the importance of considering nocardiosis as a differential diagnosis in patients with pulmonary and cutaneous lesions and the need for vigorous management for complete cure

Case Report

A 26-year-old previously healthy lady from a farming background developed cough and dyspnoea followed one month later by swelling of the right hand and draining sinus in the right axilla. She had multiple surgical drainages of the swellings at a district hospital but without clinical cure. She presented to the medicine outpatient department one year after the symptoms started with complaints of increasing dyspnoea and new painful swellings over the dorsum of the right hand [Figure 1], right supraclavicular region and the left deltoid region. There was no history of fever, trauma, and thorn prick. She had no known exposure to patients with pulmonary tuberculosis. On examination, she was afebrile, slightly anaemic, breathing comfortably on room air. Local examination of her arms revealed grossly swollen right hand with healed scars from previous incisions. Discharging sinus with serosanguinous discharge with no visible granules was present at the right axilla. Fluctuant, tender swellings were present at the right supraclavicular and left deltoid regions. Chest radiographs revealed diffuse opacity of the entire left lung and upper lobe apical opacity of the right lung [Figure 2]. Other organ systems were not involved.

A provisional diagnosis of nocardiosis and soft tissue tumour was made and trimethoprim-sulfamethoxazole was started. Meanwhile pus and tissue from the swellings and sputum were sent for microbiological investigations. Gram stain revealed polymorphonuclear leukocytes and Gram-positive bacilli in chains and fine branching filaments with tendency to fragment into coccoid and bacillary forms. Branching acid-fast bacilli were seen in modified acid-fast staining [Figure 1]. Since the findings were characteristic of nocardiosis, trimethoprim-sulfamethoxazole was continued. The patient also underwent drainage and debridement of the abscess. She showed marked improvement in the next two weeks of treatment. The microorganism involved was later confirmed to be *Nocardia brasiliensis* by culture and conventional biochemical tests.