ment. The development of cholestatic jaundice in patients receiving danazol is likely to be rare but a higher index of suspicion is warranted in view of increasing indications of its use.

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Giant-cell arteritis of the ovarian arteries with associated temporal arteritis

Sir,

We report a case of giant-cell arteritis (GCA) involving the ovary and later presenting with temporal arteritis.

A 76 year old female gave a 4 month history of fever, asthenia and weight loss. On physical examination a pelvic mass was felt. Ultrasound examination showed a large left ovarian cyst and a cystoadenoma was found at surgery. The patient was discharged and experienced an uncomplicated postoperative course except for daily fever. She was readmitted 2 months after discharge because of high fever and malaise. She had no headache, visual loss, myalgic nor arthralgic complaints. On examination, there were decreased pulses in the right temporal artery. Laboratory tests revealed anaemia and ESR 115 mm/hour. Biopsy of the right temporal artery was consistent with temporal arteritis. The surgical sample of the previous oophorectomy was reviewed and the characteristic changes of GCA were found in the arteries of the ovary hilum (Figure 1). She was treated with prednisolone with rapid general improvement, disappearance of fever and lowering of ESR.

Since Polasky *et al.*¹ described a case of GCA involving the cervix and corpus of the uterus, 25 cases of GCA of the female genital tract have been reported.² Isolated GCA of the uterine cervix not associated with temporal arteritis has also been described and related to previous gynaecological surgery.³ A unifying element of the

Figure 1 Giant-cell arteritis with epithelioid granulomas of the ovarian hilar arteries (arrows).

reported cases is presentation for surgery with symptoms unrelated to giant-cell arteritis, as well as postmenopausal age. Only one patient presented with areas of infarction and necrosis at the wall of a papillary serous cystadenoma.⁴ Uterine prolapse seems to be a common physical finding but benign ovarian tumours (serous and mucinous cystadenomas, bilateral fibroma, rete ovarii cyst) and carcinoma of the cervix have also been recorded.⁵ Polymyalgia rheumatica was present in only six of the previous cases. In only a few previous cases a temporal artery biopsy was performed following the finding of GCA of the reproductive tract, and in those instances, as in the case reported here, temporal arteritis was found.

When CGA of the reproductive tract is found, coexisting temporal arteritis should be suspected. Temporal artery biopsy and appropriate therapy may prevent the serious manifestations of the arteritis.

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Nocardia brasiliensis meningitis

Sir,

A 23 year old female agricultural worker presented with progressive visual loss of 6 months duration and intermittent mild headache of 2 months. On examination there was a marked reduction in visual acuity in both eyes with a 2/60 vision. Ophthalmoscopy showed changes consistent with a primary optic atrophy. There were no meningeal signs or other significant findings on systemic examination. Routine screening tests were normal and VDRL was negative. A lumbar puncture was done which showed a normal cerebrospinal fluid (CSF).

A provisional diagnosis of a demyelinating disorder was made and prednisolone was started at a dose of 40 mg per day. Six days later she developed a high grade fever with severe headache and vomiting. There were no meningeal signs and the sensorium was not clouded. A repeat lumbar puncture showed a cell count of 2,000/mm³ consisting of predominantly lymphocytes and a moderately low CSF sugar. The possibility of a viral meningitis was considered and the steroids were tapered off. However, 2 days later she developed meningeal signs and we opted to use a combination of intravenous penicillin, chloramphenicol and gentamicin though bacterial cultures remained sterile. Within 48 hours of starting these drugs there was considerable improvement in her clinical signs but in another 5 days they all recurred. At this stage computed tomography head scan was done which was normal. A repeat lumbar puncture continued to show a significant lymphocytic pleocytosis with moderately low sugar values.

In view of the atypical presentation a fungal culture was done from the last CSF sample. From this, a pure growth of *Nocardia brasiliensis* was obtained after 2 weeks of incubation on Sabouraud's dextrose agar. This was identified by the standard methods.¹ The sulphonamides group of drugs are more frequently used in treatment of nocardiosis. Hence we chose to use a high dose co-trimoxazole infusion in a dose of 20 mg/kg of trimethoprim. She improved in 48 hours and this improvement persisted. We were able to change over after a week to an oral regime of the drug at the same high dose.

Nocardia brasiliensis is widespread in soil samples.² Infections present predominantly as cutaneous or sub-cutaneous infections as mycetoma and lymphocutaneous diseases.³ Systemic and disseminated forms of infection have been sporadically reported.^{3–5} Pulmonary involvement is the commonest systemic manifestation. Involvement of the central nervous system mainly as a meningitis has to the best of our knowledge not been previously reported. This case also emphasizes the usefulness of a high dose of co-trimoxazole therapy for *N. brasiliensis* infections.

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