References

1. Polasky, N., Polasky, S., Magenheimer, H. & Abrams, N.R. Giant cell arteritis. Review and report of a case. *JAMA* 1965, **191**: 341–343.
2. Nehra, P.C., Ramus, D.M. & Peterson, J. Giant-cell arteritis of the uterus with associated temporal arteritis: a case report. *Obstet Gynecol* 1990, **76**: 935–938.
3. Padwell, A. Isolated arteritis of the uterine cervix. Three cases report. *Br J Obstet Gynaecol* 1986, **93**: 1176–1180.
4. Birch, P.J. A gynaecological complication of polymyalgia rheumatica/giant cell arteritis. *Br J Obstet Gynaecol* 1989, **96**: 1356–1358.
5. Sonnenblick, M., Nesher, G. & Rosin, A. Nonclassical organ involvement in the temporal arteritis. *Semin Arthritis Rheum* 1989, **19**: 183–190.

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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References

1. Rippon, J.W. Nocardiosis. In: *Medical Mycology, the Pathogenic Fungi and the Pathogenic Actinomycetes*, 2nd ed. W.B. Saunders Co., Philadelphia, 1982, pp. 51–67.
2. Callen, J.P. & Kingman, J. Disseminated cutaneous *Nocardia brasiliensis* infection. *Paediat Dermatol* 1984, **2**: 49–51.
3. Smego, R.A. & Gallis, H.A. The clinical spectrum of *Nocardia brasiliensis* infection in the United States. *Rev Infect Dis* 1984, **6**: 164–180.
4. Karassik, S.L., Subramanyam, L., Green, R.E. & Brook, J. Disseminated *Nocardia brasiliensis* infection. *Arch Dermatol* 1976, **112**: 370–372.
5. Schmid, A., Traupe, H., Todt, H.C. & Trittma, C. Intracerebral *Nocardia brasiliensis* infection. *Neurosurg Rev* 1987, **10**: 315–319.