Nocardia asteroides Pericarditis

The article entitled "*Nocardia asteroides* Pericarditis: Report of a Case and Review of the Literature," by Poland and associates in the June 1990 issue of the *Proceedings* (pages 819 to 824), made interesting reading. Reports of at least two other cases of *N. asteroides* pericarditis have been described in patients with the acquired immunodeficiency syndrome (AIDS),[1] and these cases were not mentioned in the article. In both of these cases, the diagnosis was established by a pericardial fluid culture positive for *N. asteroides*. Both patients were treated with trimethoprim-sulfamethoxazole. These cases are especially noteworthy because *N. asteroides* infection in general is uncommon in patients with AIDS.

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In the June 1990 issue of the *Proceedings* (pages 819 to 824), Poland and colleagues contributed a valuable article on *Nocardia* pericarditis, including a critical review of the literature. In a discussion of surgical treatment options for purulent pericarditis, they included "creation of a pericardial window." Such an approach would be contraindicated, if the correct definition of pericardial "window" is applied. Unfortunately, the authors join a wide company of others who have mistakenly used this label.

A pericardial window is a surgical opening between the left pleura and the pericardium, which is rarely used because of the availability of adequate treatment for malignant pericardial effusions.[1,2] I feel certain that the authors would not wish to contaminate the left pleural cavity with infectious pericardial contents.

It is difficult to understand how the widespread misperception of this term arose. Catheter drainage to the outside, even with a large pericardial hole and a large tube, is not a "window." In any other cavity or hollow organ, it would simply be called "drainage." Unfortunately, physicians often adopt fancy verbiage when plain terminology will do.[3] In this case, it is hardly a terminologic quibble—it is the description of a procedure different from that intended. These remarks are made to clarify an otherwise excellent presentation.

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2. Spodick DH: Pericardial windows are suboptimal. Am J Cardiol 51:607, 1983
3. Spodick DH: Cardiolocution (editorial). Am J Cardiol 48:973-974, 1981

The authors reply

We appreciate the thoughtful letters of Drs. Joshi and Spodick. Dr. Joshi is correct in pointing out two additional cases of *Nocardia asteroides* pericarditis in patients infected with the human immunodeficiency virus (HIV). The addition of these two cases further strengthens our conclusions regarding management of this disease. Neither patient in that series underwent pericardiectomy, and both subsequently died of complications of *Nocardia* infection (Holtz HA: Personal communication). Of note, the Centers for Disease Control does not routinely code the diagnosis of nocardiosis in patients with HIV infection, and the HIV Division is unaware of any association between HIV infection and nocardiosis (Selik R: Personal communication).

Dr. Spodick appropriately condemns the use of the term "pericardial window" in describing treatment options for purulent pericarditis, and we heartily agree. As we emphasized in our review, only patients who underwent pericardiectomy and received appropriate antibiotics for nocardiosis survived. We hope that our article will serve to encourage physicians to deal aggressively with this otherwise lethal disease.

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