Disseminated *Nocardia* in an Immunocompetent Host

Grant A. Wintheiser, MD; Elise R. Venable, MBBS; and Zelalem Temesgen, MD

A 44-year-old man with no medical comorbidities presented with recurrent inferior vena cava thrombosis and several months of fever, headache, and weight loss. Positron emission tomography—computed tomography was performed, which revealed a 1.5-cm fluorodeoxyglucose avid left lung mass and hypermetabolic soft tissue masses in bilateral inguinal regions (Figure 1). He underwent computed tomography—guided biopsy of the lung and left inguinal masses. Histopathology found clumps of filamentous branching bacilli, consistent with *Nocardia* (Supplemental Figure, available online at http://www.mayoclinicproceedings.org). Broad-range bacterial polymerase chain reaction (16s rRNA detection) returned positive for *Nocardia paucivorans*. Subsequent brain magnetic resonance imaging exhibited innumerable brain abscesses (Figure 2). Immunodeficiency work-up was performed and was unremarkable. He began therapy with intravenous trimethoprim-sulfamethoxazole, amikacin, and imipenem. Imipenem is required if there is central nervous system involvement. Treatment should be tailored based on susceptibilities, if available. After induction, patients may be transitioned to dual oral therapy with trimethoprim-sulfamethoxazole and either minocycline or amoxicillin-clavulanate. A total of 12 months of therapy is typical for immunocompromised patients and those with central nervous system involvement.4

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**FIGURE 1.** Fluorodeoxyglucose avid lung nodule (A) and inguinal masses (B) on positron emission tomography—computed tomography.
SUPPLEMENTAL ONLINE MATERIAL

Supplemental material can be found online at: http://www.mayoclinicproceedings.org. Supplemental material attached to journal articles has not been edited, and the authors take responsibility for the accuracy of all data.

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Correspondence: Address to Zelalem Temesgen, MD, Division of Infectious Diseases, Mayo Clinic Alix College of Medicine, Mayo Clinic, 200 First St SW, Marian Hall 5-528, Rochester, MN 55905 (temesgen.zelalem@mayo.edu).

ORCID
Grant A. Wintheiser: https://orcid.org/0000-0003-4492-6342; Zelalem Temesgen: https://orcid.org/0000-0001-9179-6697

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FIGURE 2. Abscesses with surrounding vasogenic edema on T2-weighted fluid-attenuated inversion recovery magnetic resonance imaging.