

**Cas Clinique
n°2**

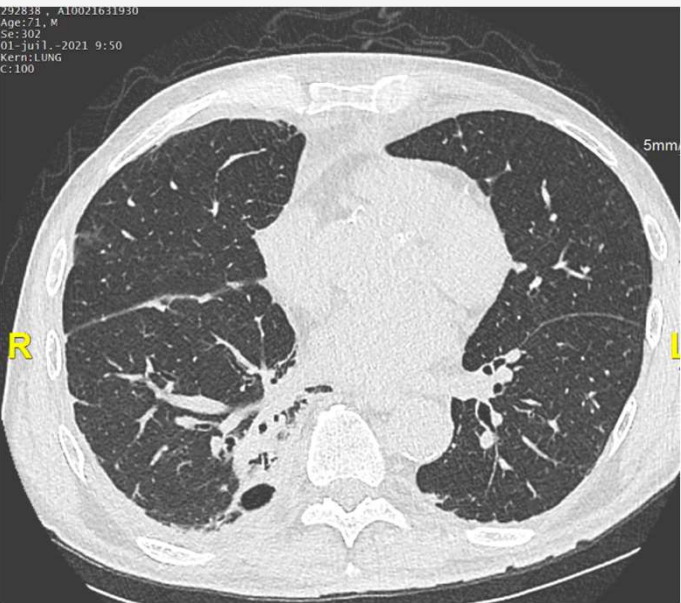
Homme de 71 ans, tabagique, greffé rénal, sous immuno-suppresseurs

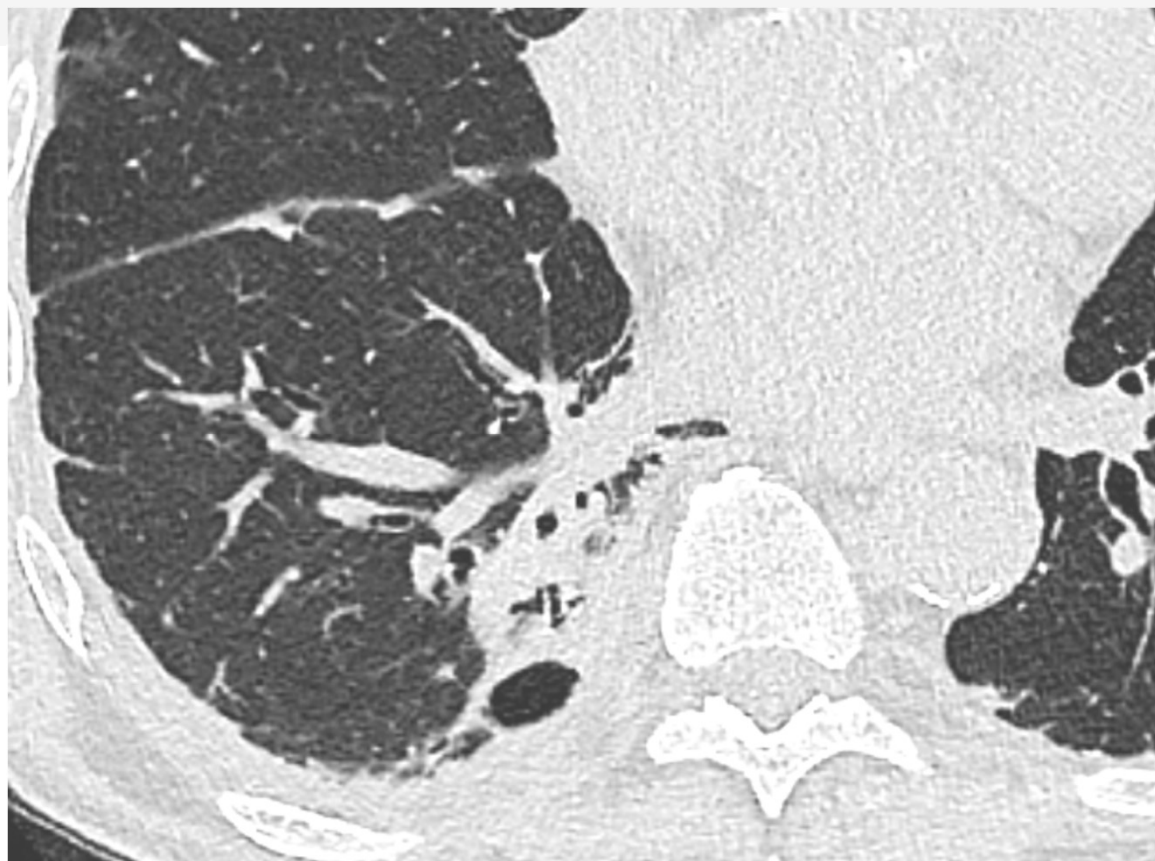
ACFA, exogénose, terrain débilité, habitat insalubre

Importante altération de l'état général, toux, crachats...

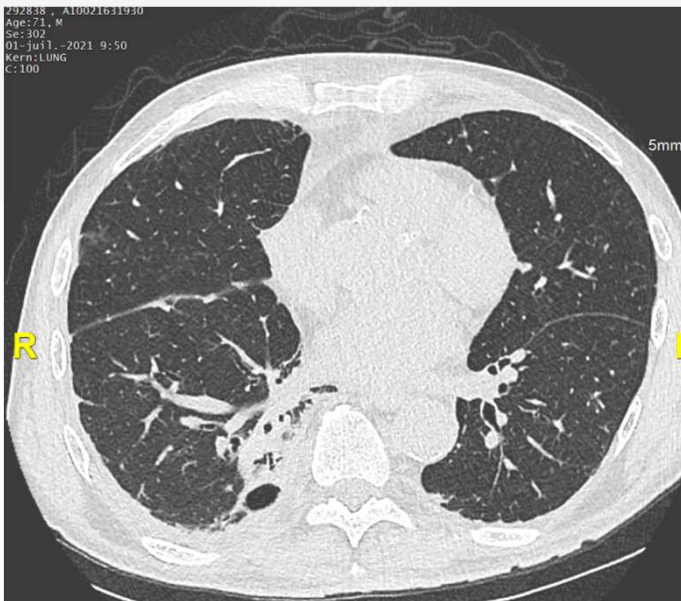
Dénutrition, asthénie, tuméfaction pariétale thoracique antérieure
érythémateuse fluctuante faisant craindre un processus néoplasique
Voussure de l'hypochondre droit

Biologie: syndrome inflammatoire majeur: CRP = 129



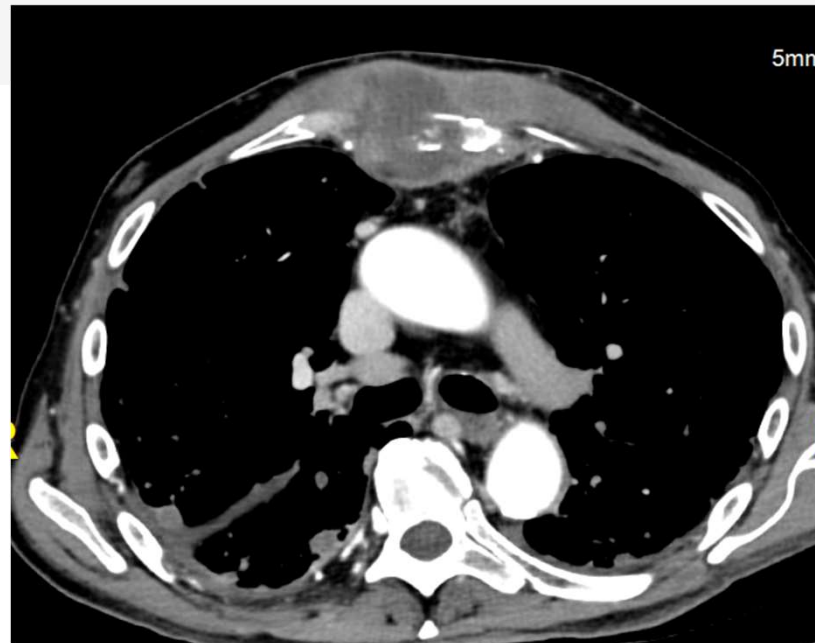


Que voyez vous ?

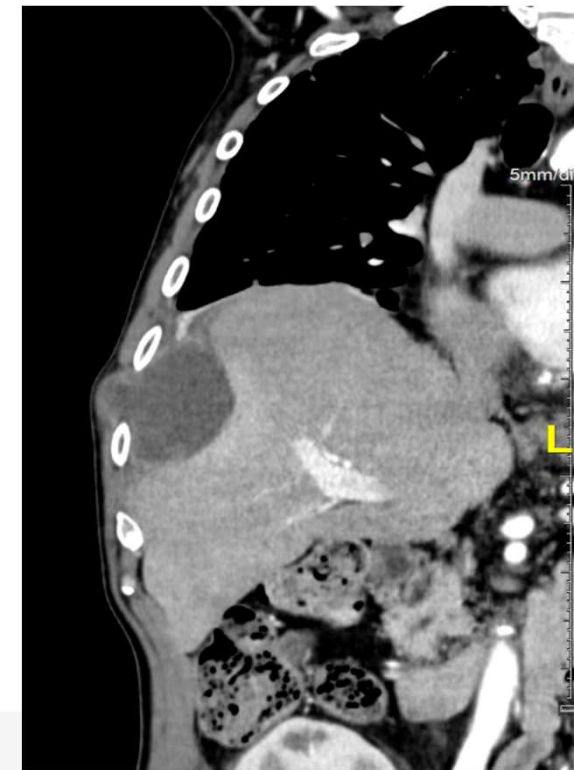


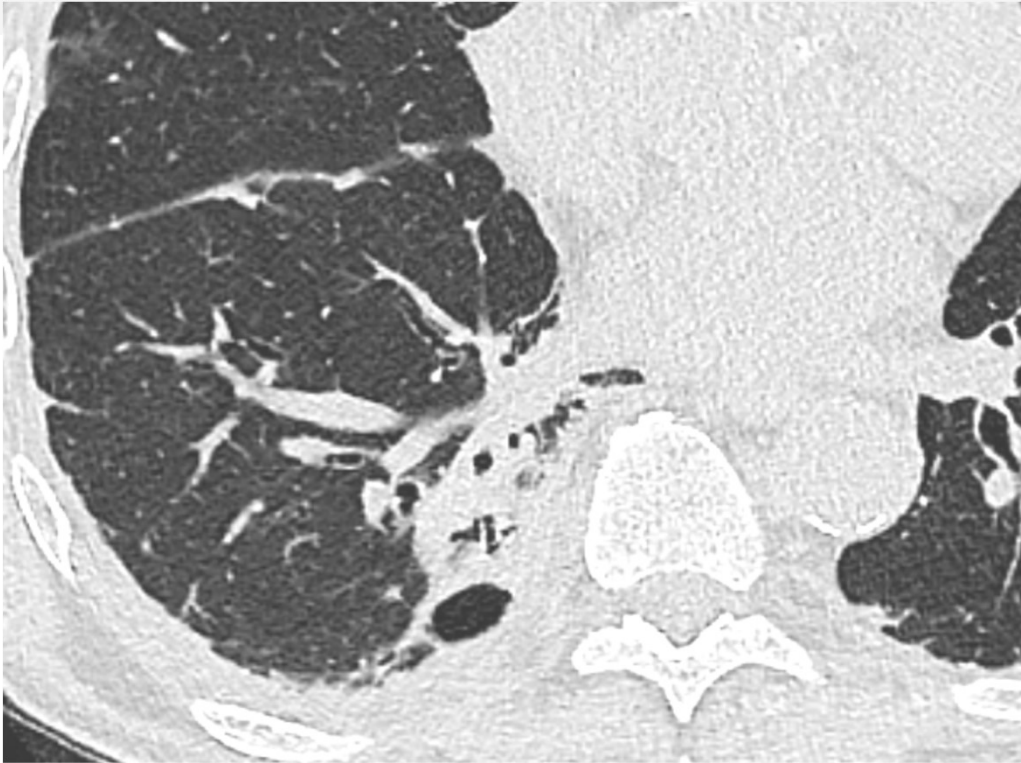
Syndr me cavitair  pleural
avec  paississ ment pari tal

Masse pari tale infiltrante du sternum
avec destruction osseuse



Empy me pleural avec infiltration et
voussure intercostale lat rale droite
(6  espace), scalloping sur le foie





Syndrome cavitare, condensation au contact de la gouttière costo-diaphragmatique droite



Micro-nodulation, scissure perlée, comblement du cul de sac pleural

Qu'en pensez vous, que faire ?

Le patient a une ponction biopsie pariétale sous scanner

La masse prélevée est largement nécrotique sans cellule tumorale ou suspecte

Les marqueurs tumoraux sont négatifs

Le taux très élevé de la CRP fait évoquer un processus infectieux / inflammatoire sous-jacent

L'analyse en examen direct et mise en culture du BK sont négatives

Le patient est mis sous antibiothérapie C3G – TIENAM / 6 semaines

Relais par Trimethoprim/Sulfamethoxazole .

Evolution clinique rapidement défavorable par poussées successives, inobservance du traitement.

Patient réhospitalisé en urgence pour pneumopathie hypoxémiante

- Choc septique

Hyperleucocytose + Polynucléose neutrophile, CRP*=359, PCT*=2.88.

- Parage chirurgical de l'abcès sternal

- Nouveau choc avec acidose métabolique et défaillance multi-viscérale léthale.

*CRP = C Reactiv Protein

*PCT = Procalcitonine

Quel est votre diagnostic ?

Pneumopathie à Nocardia

Diagnostic difficile car forme pseudo-tumorale thoracique

- Abscesses nécrosants invasifs
- Terrain immuno-déprimé
- Dissémination systémique
- Retard au diagnostic, Immuno -suppression, Inobservance du traitement expliquant la forme léthale

Evoquer le diagnostic devant: une condensation cavitaire avec abcès des tissus mous, empyème nécessitant (2^o -6^o espace intercostal), sans adénomégalie dans un contexte d'immuno-dépression

Rechercher des abcès cérébraux (IRM)

Nocardia : Infection opportuniste tellurique, antécédents d'ingestion d'eau ou de terre souillée

Empyème necessitans: Diagnostics infectieux:
Mycobacterium Tuberculosis, Actinomyces >> Nocardia,
Staphylocoque Aureus, Aspergillus

Diagnostics différentiels:
carcinome bronchique, mésothéliome, lymphome

Traitement :Trimethoprim/sulfamethoxazole + parage chirurgical
des abcès / collections

Messages

Evoquer le diagnostic devant un syndrome tumoral ou pseudo-tumoral invasif, sans adénomégalie, avec une CRP et une PCT très élevées

Devant un empyème pleural, penser à *Nocardia*
Rechercher des filaments à l'examen bactériologique

Formes résistantes au Trimethoprim/Sulfamethoxazole



Références



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Nature Public Health Emergency Collection

Public Health Emergency COVID-19 Initiative

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Infectious Lung Disease

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Abstract

Infectious diseases are one of the main causes of morbidity and mortality worldwide. With new pathogens continuously emerging, known infectious diseases reemerging, increasing microbial resistance to antimicrobial agents, global environmental change, ease of world travel, and an increasing immunosuppressed population, recognition of infectious diseases plays an ever-important role in surgical pathology. This becomes particularly significant in cases where infectious disease is not suspected clinically and the initial diagnostic workup fails to include samples for culture. As such, it is not uncommon that a lung biopsy becomes the only material available in the diagnostic process of an infectious disease. Once the infectious nature of the pathological process is established, careful search for the causative agent is advised. This can often be achieved by examination of the hematoxylin and eosin-stained sections alone as many organisms or their cytopathic effects are visible on routine staining. However, ancillary studies such as histochemical stains, immunohistochemistry, in situ hybridization, or molecular techniques may be needed to identify the organism in tissue sections or for further characterization, such as speciation.

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Keywords: M. leishmanii; Mycobacterium tuberculosis; Nocardia; Sarcoidosis

Empyema necessitatis revisited

Empyema necessitatis (EN) is a rare disease, with unknown incidence, which has received little attention from a dermatological point of view but it is essential to recognize it because of the possibility of causing mortality if not treated properly and in time. We report a 32-year-old woman, diagnosed with nervous anorexia, with an enlarging mass on the anterior right thoracic wall. Culture showed *Acinetobacter baumannii* as the main etiological agent of her empyema "necessitatis". She was successfully treated with amoxicillin with clavulanic acid. We found that 1) *M. tuberculosis* (35%) is still the most frequent agent, but *Acinetobacter* (25%) and *MRSA* (15%) are becoming more relevant; 2) the most frequent dermatological finding is a subcutaneous fluctuant mass on the chest wall; 3) new treatments have lowered mortality. Any enlarging and painful subcutaneous thoracic mass with fluctuation should be considered as an EN, responsive to antibiotics and the diagnostic approach must include a chest X-ray to rule out lung infection. Dermatologists should know about this infrequent entity in order to properly identify the potentially life-threatening process under these circumstances, achieving an early diagnosis and proper treatment.

Key words: empyema thoracis, thoracic mass, actinomyces, anorexia nervosa, localized nodulocystic therapy

Article accepted on 24/9/2019

Empyema necessitatis (EN) is defined as the collection of purulent material through subcutaneous tissue to form an abscess on the thoracic wall. It was first described in 1680 by Balthus [1] and subsequently by Leconte [2] in 1800. Common manifestations of EN are abscesses, the most important one is the presence of a subcutaneous mass on the chest wall. Thus, dermatologists should be aware of this disease because sometimes they are the first physician to attend these patients.

Case report

A 32-year-old woman went to her primary care physician with a one-month history of non-productive coughing and an enlarging painful mass on the anterior right thoracic wall. There were no symptoms of fever, dyspnea, thoracic pain or any other. She was diagnosed with nervous anorexia eight years ago and also had a previous chest history. The patient was sent to hospital with an abscess that X-ray showed a shadow on the right lung, along with isolated pleural effusion. Physical examination showed nodulocystic lesions with extended walls of size



Empyema necessitatis due to *Nocardia farcinica*

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Affiliations ► expand
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Abstract

An 84-year-old female with severe liver cirrhosis due to hepatitis C presented with a progressive bulging of the anterior chest wall for two weeks. On examination, 7 cm × 7 cm × 5 cm large subcutaneous mass was on the anterior chest wall and contrast-enhanced computed tomography of the chest demonstrated localized empyema with extension through the chest wall, into the anterior with rib destruction. Microscopic appearance of the abscess revealed filamentous branching rods, and eventually *Nocardia farcinica* was identified using Matrix-Assisted Laser Desorption/Ionization-Time of Flight. The patient was successfully treated with trimethoprim-sulfamethoxazole and subcutaneous debridement. In general, *Mycobacterium tuberculosis* and *Actinomyces* spp. are the most common causative pathogens of empyema necessitatis, and cases of *Nocardia* spp. are rarely seen. Clinicians should pay attention to the possibility of *Nocardia* empyema necessitatis in immunocompromised patients.

Keywords: Empyema necessitatis; Liver cirrhosis; *Nocardia farcinica*.

INTERNAL MEDICINE

CASE REPORT

Purulent Pericarditis and Cardiac Tamponade Caused by *Nocardia farcinica* in a Nephrotic Syndrome Patient

Rujipoo Sirijaput, Sorachai Nilwat, Orathai Tungtan and Wiwan Tungsutwita

Abstract

Nocardia is an uncommon infection that occurs primarily in immunocompromised patients. We herein report an extremely rare case of *Nocardia farcinica* (N. farcinica) pericarditis. A 35-year-old man with nephrotic syndrome that required chronic corticosteroid therapy presented with pleuritic chest pain and cardiac tamponade. Pericardiothorax revealed purulent pericardial effusion and a histological examination showed the characteristic branching filamentous bacteria identified as *N. farcinica*. Aggressive surgical drainage and a trimethoprim-sulfamethoxazole based regimen resulted in clinical improvement. To the best of our knowledge, this is the first reported case of *N. farcinica* pericarditis in Thailand.

Key words: *Nocardia* spp., pericarditis, purulent, cardiac tamponade, nephrotic syndrome

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