Disseminated nocardiosis is defined as lesions containing Nocardia found at more than one body location2. The most common underlying is pulmonary disease3 and 50% of all cases of pulmonary nocardiosis involve an extra pulmonary site1. Disseminated disease usually occurs in immunocompromised patients10 and the most common predisposing factors (coinfections) was started to trimeta in infection is organ transplantation and diabetes11. The most common cutaneous manifestations in disseminated nocardiosis are pustules, abscesses, and nodules, which are frequently ulcerated6 and common sites for these manifestations are the trunk and proximal extremities6. Our patient has underlying Diabetes Mellitus and she presented with multiple disseminated subcutaneous nodule with pneumonia symptoms but there was no evidence of truth. The reason for her to be admitted in hospital is that she was ill and not able to give adequate sputum specimen and it may occur as a result of the dissemination from the lung. However, we did not manage to culture Nocardia sp from her sputum as she was ill and not able to give adequate sputum specimen and in review of this case was reported by Jorge et al in a case of cutaneous infections of nontraumatic origin caused by Nocardia asteroides in a hospitalized patient with chronic pulmonary disease resulting from inhalation of spores11. Primary pulmonary nocardiosis is usually an acute or subacute disease, but the symptoms can also be chronic, resembling a chronic nature, without clinical evidence of disease12. However, dissemination from a pulmonary focus may occur, even in the absence respiratory symptoms, causing metastatic lesion anywhere in the body including the skin. Clinical signs to look for are: they did report the principal method for diagnosis of nocardial infection6. Staining with modified acid-fast stains, and especially Gram stain is important to provide rapid presumptive diagnosis while awaiting the results of the culture. In the clinical specimen, Nocardia are seen macroscopically as beaded, Gram-positive, thin, branching filamentous organisms, usually on a background of purulence with many polymorphonuclear leukocytes. Gram staining is the most sensitive method for visualizing and recognizing Nocardia species in clinical specimens. Nocardiosis is often misdiagnosed because of its rarity and nonspecific clinical picture6. In this case diagnosis was made following the isolation of a Nocardia species in a culture. In addition to that, radiology findings suggestive infective cause secondary to Nocardiosis.”}

**References**


**Discussion**

Disseminated infection had to be suspected when an immunocompromised patient presents with nonspecific pulmonary complaints accompanied by skin pustules, nodules, or abscesses. It is important to establish early diagnosis for better outcome. Increasing awareness of the possibility of nocardiosis and the performance of specific investigations are required to prevent the misdiagnosis of this rare condition.

**Fig 1**

Fig 1: Crusted ulcers on left forearm.

**Fig 2**

Fig 2: Erythematous nodule with pustules on left upper arm.

**Fig 3**

Fig 3: Crusted ulcer on right leg.

**Fig 4**

Fig 4: Erythematous Nodules and pustules and abscesses on right knee

**Fig 5**

Lesions resolving after 2 weeks of initiating TMP/SMZ (Fig 5) and completely healed after 6 weeks of treatment (Fig 6).

**Fig 6**

**Poster No: 3**

**DISSEMINATED SUBCUTANEOUS NOCARDIOSIS WITH PULMONARY INVOLVEMENT: A CASE REPORT AND LITERATURE REVIEW**

Selva Rani S, Tang JJ

Department of Dermatology, Hospital Raja Permaisuri Bainun.

**CASE REPORT**

**Introduction**

Cutaneous nocardiosis is a rare infectious disease that can present as either primary cutaneous infections or as disseminated disease6. Nocardiosis is caused by an aerobic, gram positive, inconstantly acid-fast species of the family Actinomycetaceae. They are found in dust, soil, sand, decaying vegetation and stagnant water6. Hence, we report a case of disseminated subcutaneous nocardiosis with pulmonary involvement and a review of the literature.

**Case report**

A 70 years old Chinese lady with underlying Diabetes Mellitus, Hypertension and Stroke, presented with multiple subcutaneous nodules, pustules and abscess with ulceration which was scattered over the body and limbs for 3 weeks prior to admission. It was associated with fever, loss of appetite, nausea, vomiting and shortness of breath. There was no history of contact with TB and no recent history of trauma. She was treated by GP with three courses of oral antibiotic but there was no improvement with the skin lesions. Two months prior to presentation, she had stroke with right hemiparesis and since then she is dependent in the activity of daily living. She is married with 6 children. She is ex rubber tapper and retired for 4 years. Physical examination revealed multiple scattered erythematous nodules over the back, abdomen, upper and lower limbs. Some of the nodules ruptured with pus discharge forming ulcers which is covered by crust. Respiratory examination revealed bibasal crepitations and all other systemic examination were normal.

Skin biopsy was performed on the subcutaneous nodule which showed lobular panculitis with inflammatory cells infiltration and few epithelioid granulomas but special stain for bacteria, fungus and mycobacterium were all negative. Culture from her blood, pus from the nodule and skin biopsy were positive for Nocardia sp. Chest X-ray revealed bilateral interstitial and air space opacities which is likely to represent infective changes secondary to nocardiosis. Sputum for Acid Fast Bacilli and bacterial culture were negative.

A diagnosis of disseminated subcutaneous nocardiosis with pulmonary involvement was made based on findings. She was initially started on IV Tazocin but there was no improvement in terms of skin lesions and respiratory symptoms. Upon establishing the diagnosis of disseminated nocardiosis, she was started on trimethoprim (160mg) and sulphamethoxazole (800mg) (TMP/SMZ) oral tablets twice daily and IV Tazocin was withheld. After 2 weeks of treatment with TMP/SMZ, her respiratory symptoms improved and the skin lesions markedly reduced (Fig 5). By six weeks of treatment, almost all skin lesions healed (Fig 6). The patients was planned to complete six months of treatment.