adopted. This policy may avoid protracted starvation, facilitate earlier surgery and could minimize complications of prolonged hospitalization.

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Primary Cutaneous Nocardiosis: An Emerging Pathogen Associated with a Peripheral Intravenous Catheter

The Editor

Sir,

Nocardiosis is an infection caused by members of the genus Nocardia, an aerobic actinomycetaceae. These are saprophytic bacteria which are important components of soil and water. Nocardia have worldwide distribution and are not thought to be commensals of the skin (1, 2). About 10% of infections of the skin and subcutaneous abscesses result from direct inoculation of Nocardia from the soil. Subcutaneous nocardiosis resulting from haematogenous spread occurs in 25% of cases (3). Appropriate management of nocardial infections is critical, particularly in immunocompromised patients in whom mortality rates may be as high as 29% (1, 4). This report describes the development of primary cutaneous nocardiosis at the insertion site of a peripheral intravenous catheter in a patient with ulcerative colitis.

An asthenic 44-year old man with a six-year history of ulcerative colitis was admitted to the University Hospital of the West Indies (UHWI) as a result of exacerbation of his condition. On admission, a peripheral polyurethane intravenous (IV) catheter was inserted into his left forearm for the intravenous administration of fluids, hydrocortisone (600 mg per day), amoxycillin-clavulinic acid (3 mg/day), oral prednisone (40g/day) and mesalazine (3.6g/day). This catheter was removed and a new polyurethane intravenous catheter was inserted in the patient's right forearm on day three. This intravenous site remained functional for seven days, after which the catheter was removed following the development of an erythematous area of induration (1x1cm) at the insertion site. The patient was at this time afebrile with haemoglobin (Hb) of 8.8g/dL and white blood cell count of 12.8 x 10^9 /L.

Amoxycillin-clavulinic acid was discontinued and cloxacillin (2g/d) commenced. The area of induration on the right forearm progressed to become a painful fluctuant mass, measuring 4 x 4 cm over the next eight days. Incision of the mass resulted in the drainage of 10cc of creamy yellow pus and *Nocardia spp* was confirmed using standard microbiological investigations (2, 3). Blood and sputum cultures were negative. Oral trimethoprim-sulfamethoxazole was added to the treatment regime for a period of two weeks with complete resolution of the abscess. Follow-up blood cultures remained negative.

Peripheral intravenous catheters although commonplace in the hospital environment are associated with an increased risk of direct inoculation of organisms into the skin which may result in disseminated infection and death (5–7). The point of origin of the forearm abscess in this patient correlated precisely with the site at which the intravenous catheter was inserted. Nocardia is an unusual pathogen associated with the use of intravenous catheter infections. Early detection and appropriate management is necessary in the prevention of possible severe and fatal complications (1, 4).

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