Nocardia gypsoïdes corneal ulcer

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SUMMARY Nocardia gypsoïdes, a species characterised by its ability to produce calcium sulphate granules, has been isolated for the first time from a corneal ulcer. In vivo this pseudomycete also forms gypsum. Every effort should be made to identify Actinomycetales to species level. The names Leptothrix and Streptothrix should be abandoned.

Actinomycetales, because of their resemblance to mycotic agents and because they often cause diseases resembling mycotic infections, have in the past been referred to as fungi. However, there is no doubt that these agents are bacteria. They are now known as pseudomycetes.

Traditionally ophthalmologists have separated Streptothrix and Leptothrix from Actinomycetales as specific agents. Evidence, however, has shown these organisms to belong to the anaerobic genus Actinomyces and the aerobic genus Nocardia respectively, of the order of Actinomycetales.¹

Probably more than a single species of both Actinomyces and Nocardia cause a wide variety of ocular infections, and therefore much information is lost as to the relation of species of both genera to the type of ocular disease produced.

There have been few reports of nocardia infections of the cornea.²⁻⁶ Invariably the species isolated was Nocardia asteroides. We have isolated from a corneal ulcer Nocardia gypsoïdes,⁷ not known before to be associated with ocular disease.

Case report

The patient, a 65-year-old navvy, was first seen at the outpatient department of the Eye Clinic in September 1982. The disease in the left eye had started several weeks earlier; there was no history of trauma or foreign body. The patient complained of irritation and pain, tearing, and a moderate discharge from that eye. Several years earlier he had had pleurisy, for which he is checked yearly.

Examination revealed a visual acuity 20/20 in both eyes with correction. The right eye was normal on external examination. On the left side there was mild puckering of the eyelids due to photophobia. There was conjunctival hyperaemia, moderate pericorneal redness, and a mucopurulent discharge on that side. In the temporo-inferior quadrant, close to the limbus of the cornea, an ulcer with a diameter of 3 mm was observed. The edges of the ulcer were raised, and there was a 1 mm zone of infiltration round it. On the peripheral part of the ulcer, extending over the limbus and beyond in the adjoining conjunctiva, there was a heaped up, amorphous, crummy material in which hard white specks could be seen.

A mild flare and cells were present in the anterior chamber. Both lenses showed incipient cataracts, and

Fig. 1 Nocardia gypsoïdes ulcer after one week of treatment with chloramphenicol. Amorphous material on ulcer and limbus, partly covering the adjacent conjunctiva. Small white specks of gypsum are visible (arrow).

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on fundusoscopic examination mild arteriosclerotic changes of the vessels were noted.

Material from the ulcer transported in semisolid cysteine broth was cultured both anaerobically and aerobically on various bacteriological media.

The patient was treated with chloramphenicol eyedrops during the day and ointment for the night pending the determination of the causative agent’s sensitivity to antibiotics.

The mild toxic iritis was treated with scopolamine eyedrops.

The ulcer healed slowly under this regimen. One week after treatment was begun the edges of the ulcer had flattened a little and the grey infiltrated area around the ulcer had almost disappeared; the diameter of the ulcer had changed little, however (Fig. 1). Three and a half weeks after treatment the ulcer had closed. A little amorphous, crummy material was still visible on the conjunctiva, but after another week of treatment it had disappeared.

**Bacteriology**

Massive growth was obtained from the corneal swab on the aerobic culture media. Three days after inoculation small, dull, domed colonies with an off-white colour were visible. Smears revealed Gram-positive coccoid and bacillary forms and some filaments (Fig. 2). Five days after inoculation the colonies had a wrinkled brownish-grey aspect, and many hard white calcareous plaques, representing calcium sulphate, were visible in the colonies (Fig. 3). The organism was identified as *Nocardia gypsoïdes.* It was found to be sensitive to a variety of antibiotics such as penicillin, cloxacillin, lincomycin, gentamicin, cephalosporin, erythromycin, and chloramphenicol.

**Discussion**

Because nocardia are prokaryocytes and are sensitive to antibiotics they are classified as bacteria. In the past, organisms associated with chronic canalculusitis and mucopurulent discharge, showing coccoid, bacillary, and filamentous forms in the smear were labelled as ‘*Streptothrix*’. Most of these infections were caused by *Actinomyces israelii,* but at least in one case *Nocardia asteroides* was responsible. Likewise organisms associated with granulomatous conjunctivitis and suppurative preauricular lymphadenitis were classified as ‘*Leptothrix*’, which then settled the identification. This organism most likely represents the fastidious microaerophilic species *Nocardia tenuis.*

*Leptothrix* is the generic name of a nonpathogenic Gram-negative, nonbranching, ensheathed, marine bacterium, totally unrelated to Actinomycetales. To complicate matters, the names of both *Streptothrix* and ‘*Leptothrix*’ have been applied to anaerobic and aerobic as well as microaerophilic species of the Actinomycetales. Therefore it is useful to abandon ‘*Streptothrix*’ and ‘*Leptothrix*’ as nomina dubia and make every effort to identify members of the Actinomycetales to species level.

Because of the ubiquitous distribution of nocardia it is possible to predict that the incidence of ocular infections is higher than would seem from published
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reports. In fact increasing use of immunosuppressive agents may lead to an appreciable increase in nocardial infections. True, isolation of the Actinomycetales can be difficult, as Actinomyces grow anaerobically, and even some species of Nocardia, such as those associated with Parinaud's oculoglandular syndrome, have optimal growth under microaerophilic conditions. Therefore suitable transport media for eye swabs that support both the aerobic and microaerophilic species of Nocardia as well as the anaerobic Actinomyces should be used.

Identification of Nocardia species is no easy matter and should be left to microbiologists, since in fact it is not possible sharply to characterise Nocardia species by morphological and routine biochemical criteria. Definite identification is based on cell wall type and whole cell sugar patterns.

References


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