Table 1. Comparison of antimicrobial susceptibility of the case isolate to those of isolates of *Nocardia pseudobrasiliensis* reported previously [1].

<table>
<thead>
<tr>
<th>Antimicrobial agent</th>
<th>Usual MIC range (µg/ml)</th>
<th>Interpretation</th>
<th>No. of isolates within given range (%)</th>
<th>Case isolate MIC (µg/ml)</th>
<th>Agreement of case isolate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ciprofloxacin</td>
<td>≤0.5</td>
<td>S</td>
<td>38/40 (95)</td>
<td>0.5</td>
<td>+</td>
</tr>
<tr>
<td>Minocycline</td>
<td>≥8</td>
<td>MS-R</td>
<td>22/31 (71)</td>
<td>8</td>
<td>+</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>≤0.5</td>
<td>S</td>
<td>29/32 (91)</td>
<td>0.5</td>
<td>+</td>
</tr>
<tr>
<td>Sulfamethoxazole</td>
<td>≤32</td>
<td>S</td>
<td>29/31 (94)</td>
<td>2</td>
<td>+</td>
</tr>
<tr>
<td>Amikacin</td>
<td>4–16</td>
<td>S</td>
<td>21/31 (68)</td>
<td>4</td>
<td>+</td>
</tr>
<tr>
<td>Cefotaxime</td>
<td>≤32</td>
<td>S</td>
<td>28/36 (78)</td>
<td>NA</td>
<td>+</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>≤32</td>
<td>S</td>
<td>25/36 (69)</td>
<td>16</td>
<td>+</td>
</tr>
<tr>
<td>Amoxicillin/clavulanic acid</td>
<td>≥8/2</td>
<td>R</td>
<td>22/32 (69)</td>
<td>32/2</td>
<td>+</td>
</tr>
</tbody>
</table>

**NOTE.** MS = moderately susceptible; NA = not available; R = resistant; S = susceptible.

Because of the association of this organism with invasive or disseminated disease and a different susceptibility pattern, it seems prudent to recommend screening of all *N. brasiliensis* isolates associated with pulmonary, CNS, or disseminated disease in order to rule out possible *N. pseudobrasiliensis*. Testing of susceptibility to ciprofloxacin by the disk-diffusion method provides a rapid screening test, as 95% of *N. pseudobrasiliensis* strains are susceptible compared with none of *N. brasiliensis* strains [1]. The current case is the first case to be described in South America or Brazil (for which both organisms were named). Further attention to the clinical setting for *N. brasiliensis* may allow recognition of this new species more readily.

**Successful Triple-Antibiotic Therapy for Cutaneous Infection Due to *Mycobacterium chelonae***

*Mycobacterium chelonae* belongs to the Runyon group 4, atypical mycobacteria, which are characterized by rapid growth and high resistance to antibiotics, antiseptics, and disinfectants [1, 2]. They are widespread in nature and also in hospital environments. *M. chelonae* is associated with local cutaneous and bone infections that occur after penetrating injury, injection, or contamination of surgical wounds [3]. Hematogenous dissemination is uncommon and affects primarily immunocompromised individuals. We describe an immunocompetent individual with subcutaneous nodules on the left hand and forearm that appeared after she received an infusion in this arm.

A 72-year-old woman presented for evaluation of multiple erythematous, fluctuant subcutaneous nodules on the posterior surface of her left hand and the extensor area of her left forearm (figure 1). Other medical problems included non-insulin-dependent diabetes mellitus and heart failure due to atrial fibrillation. The patient was taking the following medications: aenocoumarol; tobutamide, 500 mg q.d.; bumetanide, 2 mg q.d.; captopril, 25 mg b.i.d.; and digoxin, 0.25 mg q.d.

The skin nodules appeared a few days after hospital treatment for cardiac failure consisting of iv infusion in the left forearm. She did not recall any adverse experiences, and she was not feeling ill. She did not have any fevers, night sweats, or shortness of breath. Histopathologic evaluation of a biopsy specimen obtained from a nodule on her left arm revealed a granulomatous infiltrate in the dermis. Ziehl-Neelsen staining of the biopsy specimen dem-
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onstrated acid-fast bacilli, and cultures of specimens from ab-

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