Nocardia for identification and susceptibility testing whenever possible.

TREATMENT

Nocardiosis

Trimethoprim-sulfamethoxazole (TMZ-SMX) is the drug of choice for most cases **(Tables 174-11** and **174-2)**. Reported rates of TMP-SMX susceptibility have varied widely, and controversy has ensued about the reliability of sulfonamides for therapy. However, clinical responses to appropriate sulfonamide treatment around the world are usually satisfactory. At the outset, 10–20 mg/kg of TMP and 50–100 mg/kg of SMX are given each day in two divided doses. Later, daily doses can be decreased to as little as 5 mg/kg and 25 mg/kg, respectively. In persons with sulfonamide allergies, desensitization usually allows continuation of therapy with these effective and inexpensive drugs.

Clinical experience with other oral drugs is limited. Minocycline (100–200 mg twice a day) is often effective; other tetracyclines are usually less effective. Linezolid is the most consistently active antimicrobial agent, but adverse effects become common and limiting in many patients after 2–3 weeks. Amoxicillin (875 mg) combined with clavulanate (125 mg), given twice a day, has been effective in *N. brasiliensis* cases and some *N. farcinica* cases. Among the quinolones, moxifloxacin and gemifloxacin appear to be most active.

Amikacin, the best-established parenteral drug except in cases involving the *N. transvalensis* complex, is given in doses of 5–7.5 mg/kg every 12 h or 15 mg/kg every 24 h. Serum drug levels should be monitored during prolonged therapy in patients with diminished renal function and in the elderly. Ceftriaxone and imipenem are usually effective except as indicated in Table 174-1. Tigecycline appears to be active in vitro against some species, but little clinical experience has been reported.

Patients with severe disease are initially treated with a combination including TMP-SMX, amikacin, and ceftriaxone or imipenem. Clinical improvement is usually noticeable after 1–2