Short reports

**Mycobacterium gordonae: a new pathogen?**

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*Mycobacterium gordonae* is a slow growing scotochromogenic acid fast bacillus (Runyon group II) with specific cultural and biochemical characteristics. It is a contaminant of water, soil, and raw milk and is usually considered to be saprophytic and non-pathogenic in man. We have recently seen two cases of pulmonary disease that may have been due to *M. gordonae*, and we now report these and review our recent experience of this organism.

**Case reports**

**CASE 1**

A 76 year old man was admitted in November 1983 to a geriatric assessment unit for rehabilitation. He was noted to be frail and anorexic and a chest radiograph showed extensive shadowing in the right upper zone. Acid and alcohol fast bacilli were seen in three sputum samples. He was given antituberculosis chemotherapy with rifampicin 450 mg and isoniazid 300 mg, supplemented by ethambutol 1000 mg daily for the first 12 weeks. During the next six months his general condition improved, he put on 6 kg in weight, and there was considerable clearing of the radiological shadowing in the right upper zone. Culture of all three sputum samples produced a pure growth of innumerable orange colonies of an atypical mycobacterium. This organism was scotochromogenic at both 25°C and 37°C. A nitrate reductase test gave a negative result and a Tween hydrolase test a positive result. In vitro it was sensitive to rifampicin but resistant to both isoniazid and ethambutol. *M. tuberculosis* was not isolated from this specimen. The chest radiograph, however, showed progressive clearing of the areas of consolidation and shrinkage of the apical cavities and a sputum test was negative. It was thought that he was responding to the chemotherapy and therefore ethambutol was stopped after three months and rifampicin and isoniazid were continued to complete a standard nine months' regimen of antituberculosis chemotherapy. Sputum culture for mycobacteria in February 1985 failed to grow any organisms.

**OTHER CASES**

At the Scottish Mycobacteria Reference Laboratory, City Hospital, Edinburgh, during 1983 and 1984 *M. gordonae* was isolated from specimens from 14 patients. Their mean age was 70 years and five were women. In 10 patients, including the two reported here, the organism was cultured from the sputum; in one case it was grown from bronchial aspirate taken at bronchoscopy; and in the remaining three it was isolated from early morning urine samples. Apart from the two patients we describe, less than 30 colonies were grown from each isolate and in none of the remaining 12 patients was *M. gordonae* considered to be a pathogen. In two cases *M. gordonae* was isolated from sputum one month after previous sputum culture had grown *M. tuberculosis*. In vitro testing of the organism showed consistent sensitivity to rifampicin and cycloserine and resistance to most other commonly used antituberculosis drugs.

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Non-tuberculous mycobacteria have been the focus of increasing interest as their role as occasional human pathogens has been recognised. *M. gordonae*, formerly known as *Mycobacterium gordonae*, is considered to be among the least pathogenic of this group of organisms and when cultured is usually thought to be a water-borne contaminant. A cluster of *M. gordonae* isolates were obtained from bronchoscopy specimens from 52 patients in one hospital but in none of these was this organism thought to be causing infection.3 There have been four reports of disseminated *M. gordonae* infection associated with meningitis in a hydrocephalic child who had multiple shunts, prostatic avulse endocarditis, oedema, bursitis, and peritonitis,5 and two cases associated with malignancy.6 Only one case of pulmonary infection with *M. gordonae* has been reported—a chronic alcoholic who died with extensive pulmonary cavitation and fibrosis. In both of our cases, acid and alcohol fast bacilli were seen on examination of the initial sputum smear, but *M. tuberculosis* was not grown and large numbers of colonies of *M. gordonae* alone were isolated on culture. We are aware of the possibility that *M. tuberculosis* could have been masked by an overgrowth, but the colonial appearances of the organisms isolated made this unlikely. The organisms fulfilled the biochemical criteria for *M. gordonae*, being scotochromogenic at both 25°C and 37°C, nitrate reductase negative, and Tween hydrolysis test positive. In the second case a turbulin test also gave a negative result, confirming that the infection was probably due to a non-tuberculous organism. Despite the in vitro sensitivity test results, both patients responded to standard antituberculosis chemotherapy and repeat sputum cultures failed to grow any organisms. This suggests that, as with other non-tuberculous mycobacterial infections,7 there is a poor correlation between in vitro resistance and the results of treatment.

During 1983 and 1984 *M. gordonae* was isolated from specimens sent to our laboratory from 12 other patients. In none of these cases was this organism thought to be causing infection. The findings in our two cases suggest that *M. gordonae* may cause pulmonary disease and should be considered as an occasional pathogen.

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**References**


**Book notices**


Gas Mixing and Distribution in the Lung, edited by Ludwig Engel and Manuel Paiva, represents the latest addition to the series of monographs in the series "Lung Biology in Health and Disease". The editors, a physician and physicist, are to be congratulated on the imaginative concept of inviting contributions not only from physicians but also from scientists and engineers. As early as 1667 it was recognised that the flow of fresh gas into the lungs was fundamental to the preservation of life. Many defects remain in our knowledge of the disorders of ventilation and gas mixing, which are so often impaired in the early stages of respiratory disease. The topics covered include concepts of molecular diffusion, anatomical factors influencing gas mixing and distribution, gas transport in the conducting airways, alveolar ventilation at high frequencies, regional ventilation distribution, and gas mixing in the lung. While each chapter is autonomous, the global concept is apparent and the book provides an invaluable survey of this important, ill understood area of respiratory physiology. Furthermore, the text does not lose sight of the practical clinical problems confronting the respiratory physician. This is a well written, carefully illustrated text, with accurate and up to date references. Editorial discipline has prevented the repetition which readers find irritating in multiauthor volumes. The book is highly recommended for the library of respiratory physiologists; individual chapters would be particularly helpful for a research worker embarking on studies in this interesting area of investigation.—RMC


The second international symposium on the mitral valve was held in California in 1982. This book contains the contributions made by acknowledged authorities from both the United States and Europe. The emphasis is on the function of the normal and diseased valve and surgical reconstruction or replacement. Given the two years that have elapsed since the symposium, this book offers a most valuable and comprehensive survey of the subject, which should be an essential addition to any cardiac surgery unit library. It is not easy to select from the many admirable contributions, but the thoughtful and amusing review by Donald Ross and the section that attempts to obtain a consensus view on the ideal valve replacement are of particular interest. The latter employs a novel way of eliminating personal bias. The discussants, most of whom are associated with a particular prosthesis or technique, are asked to name their second choice of valve substitute—with reasons. The management of congenital abnormalities is dealt with comprehensively. Cardiac surgeons will find much to stimulate and interest them in this book.—DBC