Clinical case

Rhodococcus equi pneumonia in a Foal – A case report

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Summary

Anamnesis: a 4 month-old creole filly was presented to the Universidad Nacional’s Large Animal Clinic with a history of respiratory signs. Clinical and laboratory findings: on clinical examination, the filly presented bilateral thick muco-purulent nasal discharge and increased both laringo-tracheal sounds and coughing reflex response. On lung auscultation it showed increased bronchial sounds and crackles. The diagnostic rule outs included abscess bronchopneumonia by R. equi, pulmonary dyctiocaulosis and pneumonia by Streptococcus equi subesp. zooepidemicus. Tracheal wash culture was positive for R. equi. Treatment approach: the filly was started on IV sodium penicillin and once R. equi was isolated, therapy was switched to oral combination of TMS plus rifampin during 27 days. Conclusion: this could be the first report of R. equi bronchopneumonia in the scientific veterinary literature in Colombia.

Key words: broncopneumonia, equine, R. equi.

Resumen

Anamnesis: equino hembra de 4 meses de edad remitido a la clinica de grandes animales de la Facultad de Medicina Veterinaria y de Zootecnia de la Universidad Nacional, con historia de problemas respiratorios. Hallazgos clínicos y de laboratorio: al examen clínico se observó secreción nasal bilateral mucopurulenta, aumento de soplo laringotraqueal y del reflejo tussígeno, estertores y aumento de los sonidos bronquiales. Los diagnósticos diferenciales planteados fueron: neumonía bacteriana por R. equi, Dyctiocaulosis y Neumonía por Streptococcus equi subesp. zooepidemicus. El cultivo microbiológico del lavado traqueal fue positivo para R. equi. Aproximación terapéutica: el tratamiento inicial fue penicilina sódica intavenosa, una vez se aisló R. equi.
Introduction

Foal respiratory diseases and mainly bacterial pneumonia have been found to be one of the most important causes of death in USA (Cohen, 1994) and Ireland (Galvin and Corley, 2010). Castillo and Oliver (2006) reported that respiratory diseases in foals are prevalent in Colombia, although they are under-diagnosed.

*R. equi* is a soil saprophytic bacteria that multiplies within the infected alveolar macrophages and it is the commonest cause of foal bronchopneumonia (Songer and Post, 2005; Giguère et al., 2011a). The clinical picture is a chronic pyo-granulomatous pneumonia with abcessation in 3 to 24 weeks old foals but rarely in adult horses (Sellong et al., 2001; Heidmann et al., 2006; Sellong and Long, 2007; Leclere et al., 2011; Giguère et al., 2011b; Muscatello, 2012). It may also cause acute pneumonia, fever, respiratory distress, and produce extra pulmonary disorders (EPD) such as enterocolitis, tiphylis, abdominal abscesses, peritonitis, septic arthritis, spondilitis, osteomyelitis, and immune-mediated synovitis (Sellong and Long, 2007; Reuss et al., 2009; Giguère et al., 2011b).

*R. equi* pneumonia occurs endemically on some farms, but sporadically or not at all on other farms (Muscatello, 2012). It has worldwide distribution and has been reported in many countries including United States, Canada, Mexico, Australia, United Kingdom, Czech Republic, Japan, Hungary, Poland, Ireland, Japan, Slovenia, Spain, Thailand, South Korea, etc. (Ocampo-Sosa et al., 2007). In South America, *R. equi* pneumonia has been reported in Argentina, Chile and Brazil (Becu et al., 1997; Paredes et al., 2000; Garcia Ribeiro et al., 2005). Median morbidity in Texas endemic farms has been determined to be 6.6% with 38% of the farms having more than 10% of foals affected (Chaffin et al., 2003). In Australia 10% of thoroughbred foals are diagnosed with *R. equi* pneumonia annually with mortalities ≤ 1% observed (Muscatello et al., 2007; Muscatello, 2012).

Inhalation of virulent *R. equi* is the major route of pulmonary infection in foals (Giguère et al., 2003; Heidmann et al., 2006) and foals with adequate maternal antibody titers develop protective immune responses but the susceptibility to *R. equi* infection is complex and multifactorial (Giguère et al., 2011b).

The definitive diagnosis of *R. equi* bronchopneumonia is based on bacteriologic culture or amplification of the Vap A gene using PCR from transtracheal wash (TW) fluid from a foal with one or more clinical findings: lower respiratory disease signs, evidence of septic airway inflammation and/or evidence of bronchopneumonia by either radiography or ultrasound (Sellong et al., 2001; Giguère et al., 2003; Heidmann et al., 2006; Giguère et al., 2011a; Leclere et al., 2011).
R. equi has a great in vitro susceptibility to antimicrobials such as aminoglycosides, rifampin, vancomycin, enrofloxacin, erythromycin, azithromycin, sulfonamide-trimethoprim (TMS), and chloramphenicol. However, to treat R. equi bronchopneumonia, antibiotics must penetrate both infected cells and abscesses (Giguère et al., 2011a). The treatment of choice has been the combination of erythromycin plus rifampin (Giguère et al., 2003; Heidmann et al., 2006). Recently the association between clarithromycin and rifampin offer better results (Giguère et al., 2004) but macrolide-resistant R. equi strains demand different combinations (Buckley et al., 2007).

The main objective of this paper is to report a case of R. equi bronchopneumonia in a 4-month old creole foal presented to the Large Animal Clinic at the Facultad de Medicina Veterinaria y de Zootecnia, Universidad Nacional de Colombia (FMVZ-UN).

**Patient examination**

**Anamnesis**

A 4 month-old creole filly weighing 60 kg whose dam was used as an urban draft horse was presented to the Large Animal Clinic at the FMVZ-UN with a history of 15-day duration muco-purulent nasal discharge, normal appetite, and no previous treatment.

**Clinical findings**

On admission the filly showed normal demeanor, congested oral and conjunctiva membranes, 38.5 ºC rectal temperature, respiratory rate was 16 breaths per minute, and heart rate was 60 beats per minute. It also presented a bilateral thick muco-purulent and mal odoruous nasal discharge (Figure 1), increased coughing reflex, increased tracheal sounds, increased and coarse bronchial sounds, and crackles and dull sounds on percussion throughout both lung fields but mainly in the right lung.

Based on these findings, the main diagnostic rule outs were bacterial bronchopneumonia by R. equi, parasitic bronchitis by Dityicaulus viviparous, and bronchopneumonia caused by Streptococcus equi subsp. zooepidemicus.

Further diagnostic evaluation included hemogram (on days 1 and 20), fecal parasitological examination, TW for cytological evaluation, and culture and lung X-rays on admission.

Hemogram and plasma total protein on admission showed a reactive leukocytosis with neutrophilia and a left-shift eosinophilia and hyperproteinemia (Table 1). On day 20th of evolution all blood parameters were within normal ranges but hyperproteinemia remained.

**Table 1. Hemogram, total plasma proteins and fibrinogen Values (Jain, 1993).**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Day 1</th>
<th>Day 20</th>
<th>Reference Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematocrit %</td>
<td>32</td>
<td>36</td>
<td>24 – 44</td>
</tr>
<tr>
<td>Hemoglobin gr/dl</td>
<td>10.64</td>
<td>12</td>
<td>8 – 14</td>
</tr>
<tr>
<td>RBC (cél/ul)</td>
<td>20,600</td>
<td>11,350</td>
<td>6,000 – 12,000</td>
</tr>
<tr>
<td>Neutrophils</td>
<td>12,772</td>
<td>5,108</td>
<td>2,260 – 8,500</td>
</tr>
<tr>
<td>Bands</td>
<td>206</td>
<td>-</td>
<td>0 – 100</td>
</tr>
<tr>
<td>Limphocytes</td>
<td>6,592</td>
<td>5675</td>
<td>1,500 – 7,700</td>
</tr>
<tr>
<td>Eosinophils</td>
<td>1,030</td>
<td>567</td>
<td>0 – 1,000</td>
</tr>
<tr>
<td>TPP gr/dl</td>
<td>8.9</td>
<td>9.2</td>
<td>5.8 – 8.7</td>
</tr>
<tr>
<td>Fibrinogen mg/dl</td>
<td>900</td>
<td>-</td>
<td>100 – 400</td>
</tr>
</tbody>
</table>
Fecal exam showed an infestation with *Parascaris equorum* (800 epg) and *Strongylus spp* (1200 epg).

The TW cytology showed increased mucus and an inflammatory mixed response evidenced by a differential count of 40% neutrophils (reference range: 3-21%), 40% mononuclear cells (reference range 64-91%), and 10% eosinophil (reference range:0-5%) (Pardo *et al*., 1989). *R. equi* was isolated from the TW fluid using the protocol described by Mac Faddin (1980) and Vadillo (1997). The lung x-rays showed areas of an alveolar pattern compatible with areas of consolidation (Figure 2).

The filly was discharged on the 35th hospitalization day fully recovered.

**Discussion**

Respiratory problems in 1 to 6 month-old foals are commonly caused by *R. equi* alone or in association with other respiratory pathogens such as β hemolytic *Streptococcus* and *Actinobacillus* (Giguère *et al*., 2003; Leclere *et al*., 2011). Usually, *R. equi* causes chronic bronchopneumonia with abscessation characterized by fever, depression, anorexia, dyspnea, mucous to purulent nasal discharge, cough, pulmonary crackles and wheezes and in some cases with EPD (Giguère *et al*., 2011b). In this case, the clinical presentation was restricted to the lungs and the lameness was considered due to trauma given the response to NSAID and no evidence of infection or joint distension.

*R. equi* infections cause leukocytosis with neutrophilia and hyperproteinemia, the latter due to increased fibrinogen and globulins produced during active inflammatory processes as was observed in the present case (Heidmann *et al*., 2006; Leclere *et al*., 2011); however, it was not measured on day 20 given the clinical improvement. Globulin increase is a response to active antigen-antibody reaction that takes place during active chronic inflammatory process of the lower respiratory tract as the one experienced by this filly (Jain, 1993; Meyer and Harvey, 2004). The observed eosinophilia suggested either an allergic processes or a parasitic migration; the latter is probably the cause of this increase in eosinophils given the parasite load detected and the capacity of these parasites to migrate to other organs (Jain, 1993; Meyer and Harvey, 2004).

Based on the criteria for a definitive diagnosis of *R. equi* bronchopneumonia proposed by ACVIM (American College of Veterinary Internal Medicine), this case meets all the following requirements: a positive *R. equi* isolation from TW, a septic inflammatory response evidenced in the tracheal wash fluid, signs of lower airways inflammatory disease, and radiographic evidence of bronchopneumonia (Giguère *et al*., 2011a).

Since *Streptococcus equi subsp. zooepidemicus* pneumonia was a diagnostic rule out and the
treatment needed for *Rhodococcus equi* bronchopneumonia is highly expensive, it was elected to start therapy with penicillin at the highest recommended dose awaiting for the TW culture results. Once the *Rhodococcus equi* isolation was determined, it was placed on a combination of TMS and rifampin instead of the treatment of choice that is the combination of erythromycin and rifampin (Giguère *et al.*, 2011a) due to severe economic constraints. The use of TMS in the treatment of *Rhodococcus equi* infections have been somewhat effective despite the 68.3% in vitro susceptibility (Dowling *et al.*, 2002) but in a more recent research on macrolide-resistant *Rhodococcus equi* strains 75% of the isolates were susceptible to TMS (Giguère *et al.*, 2010). The use of TMS in combination with rifampin was based on their high liposolubility that allows them to penetrate abscess and infected cells, along with the fact that this combination has been shown to be synergistic (Macingwana *et al.*, 2012).

**Conclusion**

Based on the search available on several databases, this could be the first report of *Rhodococcus equi* bronchopneumonia in the scientific veterinary literature in Colombia.

**References**


