Seronegative disseminated Bartonella spp. infection in an immunocompromised patient

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1. Introduction

Bartonella spp. is a genus that includes facultative, intracellular, gram-negative bacteria with the potential to cause prolonged intraerythrocytic bacteremia in mammals [1]. Analysis of the 16 s rRNA gene has allowed a phylogenetic reorganization of the genus identifying between 30 and 40 species [2,3]. The main species pathogenic to humans are Bartonella henselae (B. henselae), Bartonella quintana and Bartonella bacilliformis (B. bacilliformis), all of which are etiologies to a series of diseases such as Cat’s Scratch Disease, Trench Fever, Chronic Lymphadenopathy, Endocarditis, Hepatic Peliosis and Carrion’s disease [4].

We report an unusual presentation of Bartonella spp. infection with hepatic, splenic and renal involvement, diagnosed by PCR in a seronegative immunocompromised patient.

2. Case report

An 11 year old, hispanic girl with a history of B-cell acute lymphoblastic leukemia (B-ALL) came to the emergency department with a history of hyporexia, asthenia, nausea, vomiting, fever and myalgias that had begun 2 weeks earlier. The patient did not report any abdominal pain and neither rashes nor lymphadenopathies were evidenced during the exam. The patient's hometown is Tingo Maria in Huanuco, a rural central region in Peru. Her household had access to basic services and her family reported they had two cats, a dog, a hamster and a parrot at home. A month before the presentation, the patient received induction chemotherapy IA for B-cell acute lymphoblastic leukemia with Cytarabine, Dexamethasone and Methotrexate; however, the induction IB was delayed due to a septicemia by positive Kiebsiella pneumonia ESBL.
On physical examination, the patient was wielding a Port catheter. She did not appear under distress and did not appear toxic. Further examination revealed an axillary temperature of 38.2 °C, blood pressure 110/65 mmHg, a heart rate 120 bpm. Examination of the lungs, heart and abdomen were normal. No lymphadenopathies, skin rashes or hepatosplenomegaly were evident.

A complete blood count evidenced leukocytosis with 22.21 × 10³ cells/mL and 90% neutrophils. She had a hemoglobin of 9.5 g/dL and her platelets were at 299 × 10³. C-reactive protein was elevated at 13.46 mg/dL. Her liver function tests, creatinine and urea were within normal limits.

Blood and urine cultures were repeatedly negative during the patient's hospital stay. Blood samples cultured for fungi, and tuberculosis were negative. Cultures from the Port catheter were ordered, but came back negative. Moreover, serologic tests for Cryptococcus neoformans, Histoplasma capsulatum, TORCH, Hepatitis B virus, HIV and B. henselae were also negative.

An abdominal Computerized tomography (CT) was ordered revealing hypodense lesions in the liver, spleen and kidneys (Figure 1A, C, E). The lesions in the liver measured 3.3 cm in segment VI and 2.1 cm in segment VIII as opposed to the diffuse distribution of the lesions found in the spleen and kidney that measured between 0.9 cm and 1.6 cm. The CT also revealed bilateral axillary adenopathies.

A liver biopsy was ordered and the results showed a filiform distortion with a complete disruption of the architecture composed of cicatricial tissue with both an acute and chronic inflammatory process. The liver samples were histochemically stained with Gram, Ziehl–Neelsen, Giemsa and periodic acid Schiff, all of which came back with negative results.

The biopsy specimen was sent to the Molecular Laboratory at the Institute of Nutritional Research in Lima–Peru for a molecular study. DNA was extracted from the sample and the 16S rRNA gene from Bartonella spp. was amplified following the conditions described by del Valle et al [13]. The results were positive and the diagnosis of disseminated Bartonella spp. infection was established (Figure 2). Henceforth, the antibiotic treatment with Vancomycin, Meropenem and Caspofungin, initiated based on a clinical suspicion of bacteremia or fungemia, was suspended and replaced with a daily course of Azithromycin.

The patient's clinical condition improved gradually with the new antibiotic regimen. The fever decreased and the patient no longer reported myalgias, nausea or vomiting, even though hyporexia persisted. A follow-up Abdominal CT scan was

Figure 1. Computer tomography before and after the treatment.

Transverse view showing nodular hypodensities measuring between 9 and 16 mm in the spleen and kidneys (A with red arrows, and C with white arrow). The largest hypodensity is seen in the liver measuring 33 mm (black arrow, E). Most of the lesions in the spleen and kidneys remitted 2 months after treatment (B, D, F). The hepatic lesion decreased in size (F).
ordered after a 26 day-course of antibiotic treatment with Azithromycin had begun and it showed a significant reduction in the size and number of the lesions in the liver, spleen and kidneys (Figure 1). The patient continued with a favorable clinical course. Eventually she was discharged with stable clinical conditions and was later followed up to continue the induction therapy for LLA-B.

3. Discussion

*Bartonella* spp. are responsible for a worldwide distribution of zoonotic infections [5]. The clinical course varies from a self limited infection by *B. henselae* [6], to fatal cases seen in patients infected by *B. bacilliformis* where mortality rates can reach 85% if left untreated [7]. In Peru, the incidence of *B. bacilliformis* infection is 12, 7/100 person-years, and it increases to 38/100 person-years in children below the age of 5 [8]. *B. henselae* infection is also reported and it mainly affects the household cats. In contrast, transmission of *B. henselae* is suspected for our patient's case due to the history of two cats [9]. In our case report, the patient had a diagnosis of ALL-B and her immunity was further suppressed with induction therapy. This may explain the resulting hepatosplenic and renal involvement.

The gold standard for the diagnosis of *B. henselae* is serology [26]. Assays for *B. henselae* can detect IgM and IgG and may support the clinical diagnosis. Sensitivities vary between 14% and 100% for IgG and 2%–50% for IgM whereas the specificities are 34%–100% and 86%–100% respectively [6].

Cross-reactivity with other microorganisms may contribute to false positives and also, these tests may be inaccurate in immunocompromised patients due to a diminished antibody response [27]. The latter may explain the persistent seronegativity evidenced in our patient. Amplification of the 16s rRNA Bartonella gene via PCR is an alternative molecular diagnostic test with higher sensitivities and specificities reported [4]. In our seronegative patient, this method was essential for the etiologic diagnosis of *Bartonella* spp. infection under the suspicion of fever of unknown origin, and for the consequent adjustment of treatment suspending unnecessary antibiotics.

IDSA guidelines recommend treatment with Azithromycin for cat scratch disease affecting skin and soft tissue [28], however definite treatment for disseminated *Bartonella* spp. infection has not been established [29]. A cohort studied the efficiency certain antibiotics for Cat Scratch disease in immunocompetent patients [30] but to our knowledge a study evaluating antibiotic efficiency for disseminated *Bartonella* spp. infection in immunocompromised patients, has not been published. Appropriate treatment is paramount in these patients due to the likelihood of a complicated disseminated infection that may lead to a critical condition or death.

This study presents the first reported case in Peru of molecular identification of *Bartonella* spp. via PCR of a hepatic tissue specimen from an immunocompromised patient diagnosed with LLA-B and seronegative on multiple occasions for *B. henselae*.

In conclusion, *Bartonella* spp. infection should have a particular diagnostic consideration in immunocompromised patients with Fever of Unknown Origin and further investigation regarding the patient's past exposures with cats should also be elicited. In this case, the definitive diagnosis was made by a molecular technique after serology came back negative, stressing the importance of PCR in a complicated and rare presentation of *Bartonella* spp. infection. Prolonged treatment with Azithromycin alone proved effective in this patient, however there is a need for consensus on the treatment for immunocompromised patients.

Conflict of interest statement

We declare that we have no conflict of interests.

References


