Reply to Rokx et al

We thank Dr Rokx and colleagues for their interesting comments on our brief report recently published in Clinical Infectious Diseases and titled “Hemophagocytic lymphohistiocytosis associated with Bartonella henselae infection in an HIV-infected patient” [1].

Positive diagnosis of disseminated Bartonella henselae infection was based on the association of liver biopsy data (including peliosis hepatitis and positive Warthin-Starry [WS] staining) and strongly positive B. henselae serology (immunoglobulin G = 1/8192). The B. henselae serology used in our laboratory has more than 95% specificity for titers ≥1/128 [2]. A frozen sample was not available for molecular diagnostic confirmation. No other pathogen cross-reacting with WS staining was isolated (negative serology for syphilis and Lyme disease, negative stool and liver cultures for microsporidiosis).

Second, other causes of secondary hemophagocytic lymphohistiocytosis (HLH) were ruled out:

- Plasma polymerase chain reaction (PCR) for Herpes simplex virus type 1 and 2, Varicella-Zoster virus and Cytomegalovirus (CMV) was negative and there was no picture of CMV hepatitis.
- Visceral leishmaniasis and disseminated histoplasmosis were excluded by negative liver and bone marrow stainings and cultures, as well as negative plasmatic specific PCR. Moreover, favorable outcome without specific treatment makes these diagnoses highly unlikely.
- Epstein-Barr virus (EBV) viremia is frequently observed in human immunodeficiency virus (HIV) patients with HLH, whatever its infectious or malignant trigger [3]. Therefore, we believe that high EBV viral load found in HIV-infected patients with hemophagocytic syndrome should not be considered as the direct trigger of HLH (except in cases of EBV primary infection, which was ruled out by serology profile in our patient).
- Positive plasmatic HHV8 PCR (4 log copies per mL) led to discuss the possibility of multicentric Castleman disease (MCD). The authors stated in their reply that a normal positron emission tomography (PET) scan does not exclude but only lowers the MCD likelihood. We did not find any evidence for this in the literature [4] and as shown in the article by Polizzotto [5] quoted in their reply, “the most common abnormality during disease activity was symmetric hypermetabolic lymphadenopathy, present in all patients.” Other aggressive lymphoproliferations were also unlikely due to PET scan normality and lymph node biopsy was not obtained in a setting of HLH-related bleeding disorder. Lymphadenopathy was then assumed to be secondary to HLH and/or B. henselae disseminated infection.

Clinical outcome was favorable but biological data were unavailable as the patient refused further biological sampling. These data altogether make B. henselae-related HLH the most likely diagnosis, as it has already been described in another immunodeficiency setting [6]. Bartonella henselae should therefore be considered in immunocompromised patients with HLH, especially for those having a cat at home.

Note

Potential conflicts of interest. All authors: No reported conflicts. All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

References


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