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Case Report

Disseminated cat-scratch disease in an adult with selective IgA deficiency

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ABSTRACT

A 51-year-old man with history of undiagnosed pulmonary nodules 4 years prior, presented with right-sided chest pain. Acute cardiac workup was negative, and a chest computed tomography examination demonstrated marked improvement in bilateral pulmonary nodules. A concordant abdominal computed tomography examination showed new subcentimeter hypodense lesions throughout the liver and spleen, mild progressive abdominopelvic lymphadenopathy, and new small lytic lesions of T11 and L4 vertebrae. A positron emission tomography examination demonstrated hypermetabolic activity of these abdominopelvic lesions suggesting metastatic disease. Extensive laboratory workup was negative, aside from IgA deficiency. Eventually, biopsy of a hepatic lesion was performed and compatible with Bartonella species. An elevated Bartonella IgG titer was noted, consistent with Bartonella Hensalae infection, or “cat-scratch disease.” Radiographic findings showed marked improvement after clinically appropriate antibiotic therapy.

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Case report

A 51-year-old man presented to the emergency room with right-sided chest pain. Initial workup, including electrocardiogram and troponins were negative for acute myocardial ischemia. Of note, the patient had a medical history of multiple pulmonary nodules 4 years before the current admission (Fig. 1A). Subsequent wedge resection during that admission demonstrated giant cell reaction and caseation necrosis. Acid fast and fungal pathologic workup were negative, and there was no evidence of

primary neoplasm or other metastatic disease. During the current admission, the computed tomography (CT) chest examination demonstrated resolution of the pulmonary nodules (Fig. 1B).

A concurrent abdomen and/or pelvis CT examination revealed multiple ill-defined hypoenhancing hepatic lesions (Fig. 2A), splenomegaly with hypoenhancing lesions (Fig. 2B), T11 lytic osseous lesion, and L4 lytic osseous lesion (Fig. 2C). A subsequent positron emission tomography scan demonstrated hypermetabolic activity within the hepatic lesions (Fig. 3A), splenic lesions (Fig. 3B), and osseous lytic lesions

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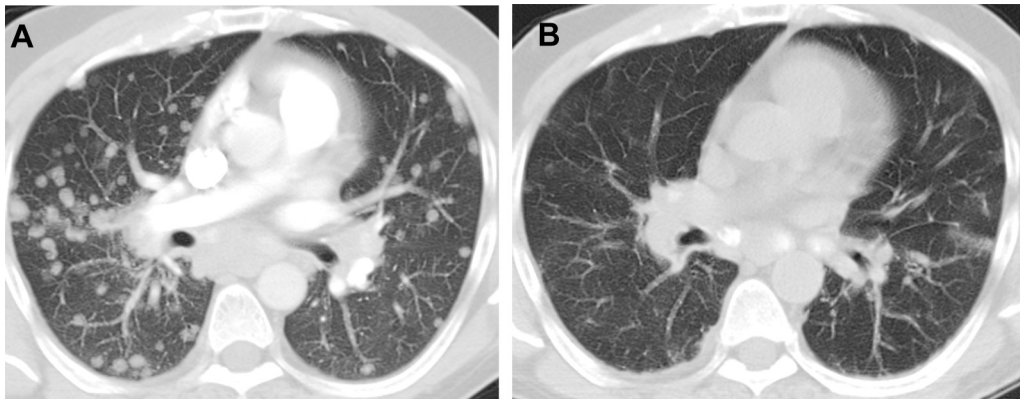


Fig. 1 – (A) Axial CT 4 years before current admission showed numerous bilateral noncalcified pulmonary nodules and (B) CT chest at the time of admission demonstrating interval resolution.

(Fig. 3C). Medical evaluation for lymphoma, metastatic disease, and atypical infection was performed. All pertinent laboratory workup, including but not limited to human immunodeficiency virus, aspergillus, acid-fast bacillus, fungal culture, antineutrophil cytoplasmic antibody, and perinuclear antineutrophil cytoplasmic antibody was negative. However, IgA deficiency with a value of less than 10 was discovered (normal range ≥ 15).

A CT-guided liver biopsy of the largest hepatic lesion was performed and demonstrated granulomatous hepatitis with scattered non-necrotizing granulomas, associated granulation tissue and/or fibrosis, and scattered apoptotic hepatocytes. A special silver stain (Steiner) was positive for organisms morphologically compatible with *Bartonella* species. A concordant elevated *Bartonella* IgG >1:1024 was diagnostic for *Bartonella Hensalae* infection.

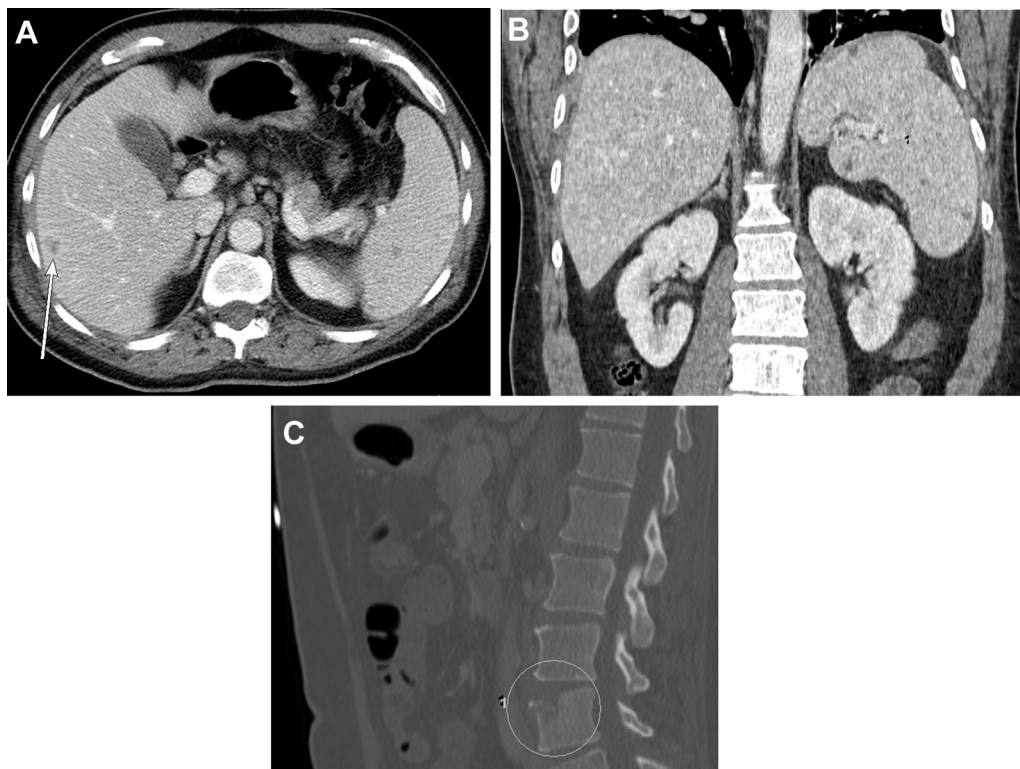


Fig. 2 – (A) Axial scontrast-enhanced CT abdomen at the time of current admission shows low-density right hepatic lobe lesion (arrow delineating low density hepatic lesion), (B) coronal contrast-enhanced CT imaging demonstrates mild splenomegaly with multiple low-density lesions, and (C) sagittal CT imaging demonstrates low attenuation lytic osseous lesions at L4 (circle encompassing L4 lytic osseous lesion).

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