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Q fever as a cause of fever of unknown origin in a patient on hemodialysis

Fiebre Q como causa de fiebre de origen desconocido en un paciente en hemodiálisis



Dear Editor,

Q fever is a worldwide zoonosis caused by *Coxiella burnetii* acquired mainly by inhalation.¹ Clinical manifestations of acute Q fever include self-limited flu-like illness, pneumonia, and mild hepatitis. Chronic infection usually presents as a culture-negative endocarditis, but other uncommon forms of persistent focalized infection and secondary non-Hodgkin lymphoma are also possible.^{2,3}

We present the case of a 70-year-old man with a history of hypertension, type 2 diabetes mellitus, and chronic ischemic dilated cardiomyopathy. The patient was also being monitored by Hematology due to a monoclonal gammopathy of undetermined significance and had stage V chronic kidney disease, secondary to mesangiocapillary glomerulonephritis with heavy chain deposition. A Quantiferon-TB Gold plus had been performed with positive results and therefore he had been taking rifampicin 600 mg QD for 4 months as treatment for latent tuberculous infection. Regarding the immunosuppressive treatment, in December 2022 the patient received induction treatment with methylprednisolone pulses and a single Rituximab dose, due to progressive kidney failure. He finally started chronic hemodialysis program 2 days/week through a tunneled central venous catheter at the end of December 2022. A blood test in January 2023 revealed low IgG (488 mg/dL) with normal IgM and IgA levels.

In April 2023, he consulted after a hemodialysis session complaining of general malaise, impaired mobility, pain in the

right hypochondrium and moderate fevers for 2 weeks. The analytical findings suggested an infectious process: C-reactive protein (CRP) 364 mg/L, procalcitonin 1.71 ng/mL, leukocytosis 19,200/mm³, Hb 11.9 g/dL, LDH 300 U/L, GGT 211 U/L, ferritin 1452 ng/mL. He was referred to the emergency department (ED) where an abdominal ultrasound and CT scan were performed, describing multiple small nodular liver images, with a hypodense center and ring enhancement, suggestive of microabscesses. Chest-X ray was normal. The patient was then admitted to our Infectious Diseases Unit and antibiotics stopped. Initial microbiological and analytical results are included in [Table 1](#). After all these diagnostic proceedings yielded no result, a liver biopsy was performed. The patient was sent home pending results and he felt much better without any antimicrobial being started. CRP and procalcitonin declined spontaneously and the patient remained on close monitoring as an outpatient.

6 weeks thereafter (June 2023) the patient visited the ED again complaining of right hypochondrium pain, general discomfort, hematuria, and low-grade fever. Blood CRP was >480 mg/L and procalcitonin 6.73 ng/mL. He was readmitted to our Infectious Diseases Unit again. Second abdominal CT was carried out with similar results than the first one. [Table 1](#) shows all microbiological results.

The patient was diagnosed of Q fever based on serological results and the result of the liver biopsy ([Fig. 1](#)). According to this, doxycycline was started (100 mg BID for 28 days). He became afebrile, and another blood analysis had normal para-

Table 1 – Relevant results of the two hospital admissions.

	First admission (April 2023)	Second admission (June 2023)
SARS-CoV-2 PCR nasal swab	Negative	Negative
Blood cultures (venipuncture and through hemodialysis catheter)	Negative	Negative
Urine culture	Negative	Negative
HIV	Negative	
CMV	IgG positive	
EBV	IgG positive	
Herpes 1/2	IgG positive	
VZV	IgG positive	
Hepatitis A	IgG positive	
Hepatitis B	Anti-HBs positive	
Hepatitis C	Negative	
Measles	IgG positive	
<i>Coxiella burnetii</i>	IgG positive	IgG positive
- Phase I IFA	- Negative	- Negative
- Phase II IFA	- Negative	- Positive 1/128
<i>Bartonella henselae</i>	Negative	Negative
<i>Rickettsia conorii</i>	Negative	Negative
<i>Brucella melitensis</i>	Negative	Negative
<i>Francisella tularensis</i>		Negative
<i>Echinococcus granulosus</i>	Negative	
<i>Toxoplasma gondii</i>	IgG positive	
<i>Leishmania</i> spp.	Negative	
Blood beta-D-glucan	Negative	
Transthoracic echocardiogram	No signs of endocarditis	
Antinuclear antibodies	Negative	
Extractable antinuclear antigen	Negative	
Anti-LKM Ab	Negative	
Anti-mitochondrial Ab	Negative	
Anti-smooth muscle Ab	Negative	
Bone-marrow aspiration		
- <i>Mycobacterium tuberculosis</i> PCR		- Negative
- Non-tuberculous mycobacteria PCR		- Negative
- <i>Leishmania</i> spp. PCR		- Negative
PCRs in deparaffinized liver biopsy		
- <i>Francisella tularensis</i>		- Negative
- <i>Rickettsia</i> spp.		- Negative
- <i>Coxiella burnetii</i>		- Negative
- <i>Bartonella henselae</i>		- Negative
- <i>Leishmania</i> spp.		- Negative

meters including CRP and procalcitonin. Follow-up serology 7 months after first admission was performed with negative phase I and positive phase II with a titer of 1/200. All liver lesions resolved in a control CT-scan.

C. burnetii infection is a well-known cause of prolonged fever all over the world. Acute infection usually manifests as an atypical pneumonia or mild hepatitis, although most patients experience an acute self-limiting infection.^{4,5} Granulomatous hepatitis with fibrin-ring granuloma is the classic pathological form in liver biopsy but this is non-specific and non-sensitive because Q fever can produce other forms of granulomatous hepatitis.^{6,7} We found a report of a kidney transplant patient who suffered acute Q fever presenting liver and spleen abscesses with a splenic biopsy that showed extensive abscess formation and focal poorly formed non-necrotizing granulomatous inflammation.⁸

There is a wide differential diagnosis for a patient with granulomatous liver disease and prolonged fever. Diagnostic options may be grouped into several categories: sarcoidosis, autoimmune (primary biliary cirrhosis above all), infectious diseases (tuberculosis being the main, *Mycobacterium avium-intracellulare* complex in immunocompromised patients, fungal infections like histoplasmosis, unfrequently viral infections, and zoonosis like *Rickettsia conorii* and *C. burnetii*), drugs, cancer and idiopathic.⁹

Some diagnostic issues may be highlighted with respect to Q fever: gold standard is still IFA serology, and it usually takes 2–4 weeks to turn positive. *C. burnetii* has a peculiarity called antigenic phase variation: phase I has the more complex lipopolysaccharide (LPS) and it is the virulent-infectious phase. *C. burnetii* quickly turns into phase II, with a loss in the LPS complexity, virulence and infectivity.¹⁰

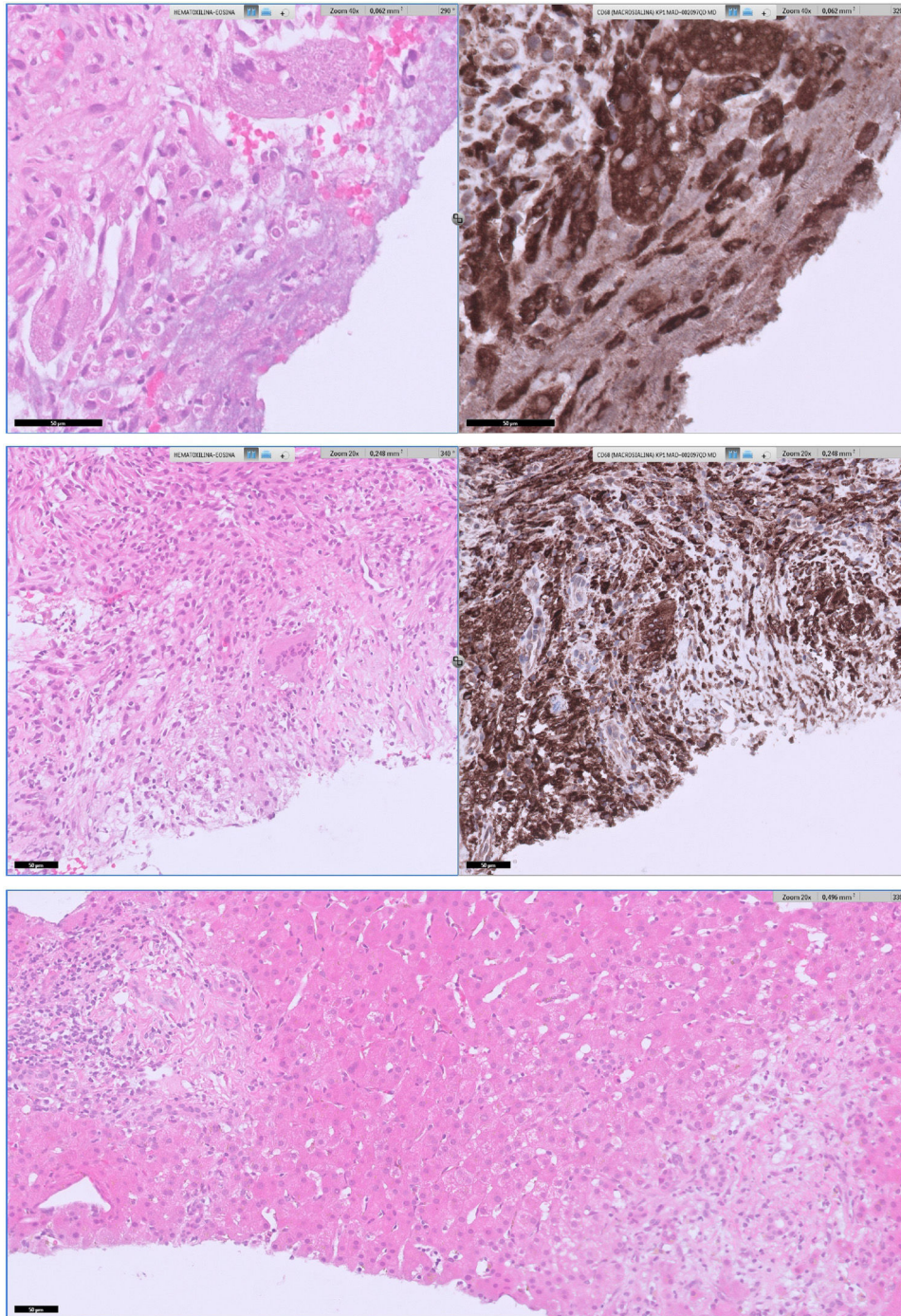


Fig. 1 – Upper section: areas of necrosis with portal and lobular involvement produced an alteration in the hepatic architecture. A histiocytic ring surrounding the necrosis is highlighted with CD68 immunostaining, configuring histiocytic granulomas of variable size. No fibrin-ring granulomas were not observed on the serialized slides nor ancillary techniques performed. Middle section: giant cells were scarce, localized in the lobule, and their presence was more detectable with CD68 staining. Lower section: in addition, some portal-periportal inflammation with T lymphocytes prevalence, scarce B lymphocytes and very few plasma cells, with focal extension to interphase and lobules was present.

Phase II serology positivity is found in acute infection. Serological diagnosis of acute Q fever can be made either with phase II IgG $\geq 1/128$ or IgM $\geq 1/32$ or a 4-fold increase between two serum samples taken 3–6 weeks apart.^{1,11} IFA serologies

used by our reference laboratory do not differentiate IgG from IgM.

On the contrary, high phase I serology (usually IgG $\geq 1/800$) is suspicious of chronic Q fever and should lead to further tes-

ting (echocardiogram, PET-CT). The general recommendation is to perform serological follow-up until 1–2 years after acute infection in patients at risk of progression (immunocompromised, chronic valvular disease, vascular graft, etc.).¹

Some patients can be diagnosed by PCR in blood or tissue samples, but PCR is not widely available. PCR in blood specimens has high specificity but sensitivity is only good enough during the first days of the disease and when antimicrobials have not yet been started. PCR for *C. burnetii* targets the IS1111a insertion element.¹² We performed a PCR in deparaffinated liver biopsy which resulted negative but deparaffination could reduce sensitivity of this technique. We didn't start doxycycline until a positive phase II serology because we still had tuberculosis in our differential diagnosis and the patient became suddenly afebrile and asymptomatic before his second hospital admission.

An interesting question is whether anti-CD20 therapy could justify a longer duration of the febrile process and delay *C. burnetii* serology turning positive. There is a clear negative association between anti-CD20 therapies and SARS-CoV-2 seroconversion after SARS-CoV-2 mRNA vaccine.¹³ There is also an association between rituximab and low immunoglobulins just like the case of our patient. It would be reasonable to hypothesize of a low level of phase II antibodies in patients under anti-CD20 therapy who suffer acute Q fever.

To conclude we would like to suggest an initial protocol for the diagnosis and management of patients with prolonged fever (>7 days). In stable patients a first set of explorations should be performed: chest-X ray, serial blood cultures (also through catheters if available), urine culture, and an initial round of viral PCRs (influenza, RSV, SARS-CoV-2) and serologies (basic are EBV, CMV and HIV). If all these results are negative and the patient has a slight elevation of liver enzymes, LDH and CRP/procalcitonin, we recommend a therapeutic trial with doxycycline. Doxycycline is an antibiotic with a good efficacy/security profile. It is administered at a dose of 100 mg twice daily and do not require adjustment in any grade of renal or hepatic failure.¹⁴ Confirmative serology for *C. burnetii* (and other zoonosis like *Rickettsia* spp., *Leptospira interrogans* and *Bartonella henselae*) will always take time, and maybe longer in immunosuppressed patients who may also suffer from atypical or more prolonged forms of the disease. A high index of suspicion is required to better reach this diagnosis.

Funding

All authors declare no financial interest that could influenced the work presented in this paper.

Authors' contribution

Emilio Guirao-Arrabal: Conceptualization, writing-original draft. Ana Delgado-Ureña: supervision, collected patient data and informed consent, writing-review and editing. Elena Borrego-García: conceptualization, writing-review and editing. Rosa Ríos-Pelegrina: writing-original draft, collected pathological figures. All authors revised, read, and approved the final manuscript.

Informed consent statement

Written informed consent was obtained from the patient.

Conflict of interest

All authors declare no competing interest that could influenced the work presented in this paper.

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<https://doi.org/10.1016/j.nefro.2024.06.004>

Ecografía del acceso vascular en manos de los profesionales de la nefrología y de la enfermería nefrológica en las unidades de enfermedad renal crónica avanzada: una herramienta para mejorar la calidad asistencial

Ultrasonography of vascular access in the hands of nephrology and nephrological nursing professionals in advanced chronic kidney disease units: a tool to improve the quality of care



Sr. Director,

El éxito de la hemodiálisis (HD) como técnica de terapia renal sustitutiva depende en gran medida de un adecuado acceso vascular (AV), que puede condicionar por sí solo el éxito o el fracaso de un determinado programa de HD^{1,2}. La utilización de la ecografía en la unidad de enfermedad renal crónica avanzada (ERCA)^{3,4}, así como el trabajo interdisciplinar^{5,6}, tienen una importante labor en este cometido.

Las guías clínicas presentan cierta discordancia respecto a la realización del mapa vascular preoperatorio y el seguimiento ecográfico de las fistulas arteriovenosas (FAV) en la etapa ERCA⁷⁻⁹. Se presentan los resultados de nuestra unidad ERCA tras la introducción de la ecografía del AV. Nuestra hipótesis de que la realización del mapa vascular preoperatorio y el seguimiento ecográfico mejora la calidad asistencial, de acuerdo con las recomendaciones de las Guías Clínicas Españolas del GEMAV⁷, se confirma.

Nuestra unidad atiende un área sanitaria de 430.000 habitantes con 343 pacientes prevalentes en HD. Dada la importancia de optimizar los recursos y las actuaciones para aumentar el número de pacientes incidentes y prevalentes con fístula arteriovenosa nativa (FAVn), así como, reducir sus complicaciones y aumentar su longevidad, en junio de 2020 el servicio de nefrología de nuestro hospital, inauguró una consulta específica de ecografía del AV, asociada a la unidad ERCA, y gestionada por el mismo equipo. Tras la incorporación de la consulta ecográfica del AV, el siguiente paso, en busca de mejorar la gestión y con ello los resultados del AV, fue la creación de un programa de acceso vascular para hemodiálisis,

basado en la formación e implementación de un equipo interdisciplinar formado por nefrología, enfermería nefrológica, cirugía cardiovascular (CCV) y radiología vascular intervencionista (RVI) con asignación de funciones específicas para cada uno.

Para el análisis del impacto de la puesta en marcha del programa en junio de 2020, se evaluó el número de pacientes que iniciaron HD con FAV en 4 periodos: 2 años previos a la creación de la consulta (2019-2020) y 2 posteriores (2021-2022) (fig. 1). De estos periodos se analiza un total de 154 pacientes incidentes en HD procedentes de la unidad ERCA. El porcentaje de pacientes que iniciaron HD a través de las FAV, fueron el 63,27% (n = 31), 50% (n = 16), 74,36% (n = 29) y 85,29% (n = 29) en el 1.º, 2.º, 3.º y 4.º período, respectivamente. La Chi-cuadrado de Pearson muestra que hay más frecuencia esperada de fistulas en el periodo 4, mientras que hay menos frecuencia de la esperada en el período 2 (p < 0,05). El porcentaje actual de FAV en los pacientes prevalentes en las unidades de HD de nuestra área a 31 de diciembre de 2023 es del 76,49% (n = 244) y de catéteres el 23,51% (n = 75). El cambio de prevalencia desde el 1/06/2020 (inicio de la consulta ecográfica del AV) a 31/12/2023 se muestra en la figura 1. Se ha incrementado la prevalencia de FAV del 65,88% (n = 222) al 76,49% (n = 244) y se ha reducido la prevalencia de catéteres de un 34,12% (n = 115) a un 23,51% (n = 75).

Nuestra área actualmente cumple con los estándares establecidos por el GEMAV respecto a la incidencia de pacientes procedentes de la unidad ERCA que inician HD con FAV, así como la prevalencia de pacientes en HD con FAV, siendo ambas superiores al 75%⁷.