**Bartonella** sp. Bacteremia in Patients with Neurological and Neurocognitive Dysfunction

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We detected infection with a *Bartonella* species (B. *henselae* or B. *vinsonii* subsp. *berkhoffii*) in blood samples from six immunocompetent patients who presented with a chronic neurological or neurocognitive syndrome including seizures, ataxia, memory loss, and/or tremors. Each of these patients had substantial animal contact or recent arthropod exposure as a potential risk factor for *Bartonella* infection. Additional studies should be performed to clarify the potential role of *Bartonella* spp. as a cause of chronic neurological and neurocognitive dysfunction.

*Bartonella* *henselae* causes a prototypical illness characterized by fever and regional lymphadenopathy following a cat scratch or bite (8, 9). Cat scratch disease (CSD) is usually self-limited, and antibiotic therapy has minimal impact on the clinical course (11, 34). However, a spectrum of neurological manifestations, including ischemic stroke, cerebral arteritis, transverse myelitis, radiculitis, grand mal seizures, epilepsy partialis continua, status epilepticus, coma, and fatal encephalitis, in patients with CSD have been described previously (21, 34). Chronic neurological or neurocognitive syndromes associated with persistent *Bartonella* bacteremia are less well characterized. Neurological symptoms following a cat scratch have also been described in association with *B. quintana* infection, and recent evidence indicates that cats can harbor *B. quintana* (6, 13, 32, 37).

Although CSD is considered to be self-limiting, persistent intravascular infection of a child with *B. henselae* for 4 months after a cat scratch has been reported previously (2). Furthermore, we recently described chronic intravascular infection with both *B. henselae* and *B. vinsonii* subsp. *berkhoffii* in immunocompetent people with occupational animal contact and arthropod exposure (5). Cats are the primary reservoir hosts for *B. henselae*, whereas to date, *B. vinsonii* subsp. *berkhoffii* has been isolated only from dogs, coyotes, foxes, or people (9, 27). Domestic and wild canines serve as the primary environmental reservoir for *B. vinsonii* subsp. *berkhoffii*, and dogs can be involved in the transmission of *B. vinsonii* subsp. *berkhoffii* and *B. henselae* to people (7, 9, 10, 27, 36).

In this study, we report the isolation of *B. henselae* or *B. vinsonii* subsp. *berkhoffii* from, or the molecular detection of these pathogens in, blood samples from six people who exhibited a spectrum of neurological and neurocognitive abnormalities.

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TABLE 1. Ages, genders, and neurological abnormalities of immunocompetent patients in this study and Bartonella species detected in the blood samples

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Age (yr)</th>
<th>Gender</th>
<th>Bartonella species in blood sample(s)</th>
<th>Reciprocal titer of antibodies to: B. henselae, B. vinsonii subsp. berkhoffii, B. quintana</th>
<th>Primary symptoms</th>
<th>Other abnormalities</th>
<th>Duration of illness</th>
<th>Potential risk factor(s)</th>
<th>Additional diagnosis(es)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>23</td>
<td>F</td>
<td>B. henselae (H1)</td>
<td>256 128 256</td>
<td>Seizures, fatigue, memory loss/disorientation, headaches</td>
<td>D, I, IN, BV</td>
<td>3 yrs</td>
<td>Exposure to cats</td>
<td>CSD, epilepsy</td>
</tr>
<tr>
<td>2</td>
<td>41</td>
<td>F</td>
<td>B. henselae (SA2 and H1)</td>
<td>128 256 128</td>
<td>Fatigue, headaches</td>
<td>T, D, I, ML/D, BV</td>
<td>2 yrs</td>
<td>Exposure to cats, ticks, fleas, biting flies</td>
<td>Parvovirus infection</td>
</tr>
<tr>
<td>3</td>
<td>44</td>
<td>F</td>
<td>B. vinsonii subsp. berkhoffii (type II), B. henselae (H1)</td>
<td>&lt;32 &lt;32 &lt;32</td>
<td>Fatigue, headaches, blurred vision</td>
<td>T, I, ML/D</td>
<td>5 yrs</td>
<td>Exposure to cats, ticks, fleas, biting flies</td>
<td>Lyme disease, Babesiosis</td>
</tr>
<tr>
<td>4</td>
<td>54</td>
<td>F</td>
<td>B. henselae (H1)</td>
<td>32 32 32</td>
<td>Fatigue, headaches</td>
<td>D, I, IN, ML/D</td>
<td>5 yrs</td>
<td>Exposure to cats, ticks, fleas, ticks</td>
<td>Rosacea, arthritis, depression</td>
</tr>
<tr>
<td>5</td>
<td>49</td>
<td>M</td>
<td>B. henselae (SA2)</td>
<td>&lt;32 &lt;32 &lt;32</td>
<td>Paralysis, fatigue</td>
<td>T, D, I, IN</td>
<td>6 mos</td>
<td>Exposure to cats, ticks, fleas, ticks</td>
<td>Viral neuropathy, multiple sclerosis</td>
</tr>
<tr>
<td>6</td>
<td>14</td>
<td>M</td>
<td>B. henselae (H1)</td>
<td>128 256 128</td>
<td>Fatigue, migraines</td>
<td>D, I, IN, ML/D, BV</td>
<td>1 mo</td>
<td>Exposure to cats, ticks</td>
<td>Debilitating migraines</td>
</tr>
</tbody>
</table>

* F, female; M, male.
* B. henselae H1 and SA2 and B. vinsonii subsp. berkhoffii genotype II strains were identified by ITS sequencing.
* Titters are reported as the reciprocal of the end-point titer.
* D, depression; I, insomnia; IN, incoordination; BV, blurred vision; T, tremors; ML/D, memory loss/disorientation.
TABLE 2. Serological, PCR, and culture results for a 23-year-old woman with progressive neurological dysfunction, seizures, and persistent *B. henselae* infection

<table>
<thead>
<tr>
<th>Date (mo/day/yr) and sample type</th>
<th>IFA reciprocal titers(^a) of antibodies to:</th>
<th>PCR-BAPGM culture result(^c) after:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>B. henselae</em></td>
<td><em>B. quintana</em></td>
</tr>
<tr>
<td>5/26/2005, blood</td>
<td>256</td>
<td>128</td>
</tr>
<tr>
<td>6/27/2005, blood</td>
<td>256</td>
<td>64</td>
</tr>
<tr>
<td>9/20/2005, blood</td>
<td>256</td>
<td>128</td>
</tr>
<tr>
<td>2/10/2006, CSF</td>
<td>NT</td>
<td>NT</td>
</tr>
<tr>
<td>8/31/2006, blood</td>
<td>64</td>
<td>64</td>
</tr>
</tbody>
</table>

\(^a\) CSF, cerebrospinal fluid.  
\(^b\) Titers are reported as the reciprocal of the end-point titer.  
\(^c\) Asterisks denote 16S-23S ITS DNA sequencing results.

Medical care, diagnostic evaluations, the timing of sample collection for *Bartonella* testing, and treatment interventions, including plasmapheresis, antibiotics, corticosteroids, intravenous immunoglobulin, anticonvulsants, and other drugs, were extensive and varied among patients. In all instances, there was an evaluation by one or more neurologists. In addition to receiving other symptomatic treatments, patients 1, 5, and 6 were treated specifically for their *Bartonella* infections and experienced progressive improvement (patients 1 and 5) or the resolution of disease manifestations (patient 6). Patient 1 was initially treated with doxycycline for 6 weeks, remained healthy, and has experienced no seizures during a 36-month follow-up period while receiving an anticonvulsant medication. Patient 5 was initially treated with doxycycline for 5 weeks, followed by azithromycin for 6 weeks and then by levofloxacin for 9 weeks. There was a progressive improvement in neurological status (improved muscle strength and coordination accompanied by a return to work as a veterinary surgeon). During the past year, this individual received doxycycline and rifampin, in conjunction with other treatments, which resulted in continued improvement in muscle strength, improved coordination when walking, less myoclonus, and no relapses, which typically occurred prior to the addition of antibiotics to the treatment regimen. Patient 6 was treated with azithromycin for 6 weeks, with a rapid and progressive decrease in the severity of migraines following the initiation of antibiotics. The boy gradually returned to all preillness activities with no residual neurological abnormalities. Patients 2 and 3 were treated with doxycycline without obvious long-term benefits. Patient 4 has received continuous doxycycline treatment for the past 2 years for rosacea and has experienced a decrease in headaches, back pain, and joint pain, although there are still occasional flare-ups of pain in the joints.

Serological testing at the Centers for Disease Control and Prevention identified antibodies to *Bartonella* spp. (IFA reciprocal titers of 64 or greater) in samples from three of six patients (patients 1, 2, and 6). Antibodies were not detected in samples from patients 3 (six serum samples spanning July 2005 to 14 September 2006), 4 (three serum samples spanning June to November 2006), and 5 (one serum sample). For patient 1, IFA titers of antibodies to *B. henselae*, *B. quintana*, and *B. vinsonii* subsp. *berkhoffii* in samples spanning a 4-month period remained stable and were decreased but still detectable 1 year later, following antibiotic treatment (Table 2). Patient 2 had reciprocal titers of antibodies to *B. henselae*, *B. quintana*, and *B. vinsonii* subsp. *berkhoffii* of 256, 128, and 128, respectively, when initially tested on 4 January 2005, after which a significant drop in antibodies occurred following antibiotic treatment, with reciprocal titers of less than 64 for all three test antigens in samples collected on 12 May 2005 and 11 September 2006. Patient 6 seroconverted to *B. vinsonii* subsp. *berkhoffii* antigens, developed the highest IFA titers of antibodies to this organism, and had a decremental decrease in titers following treatment with azithromycin (Table 3).

Based upon DNA sequencing of the ITS region, *B. henselae* was detected in blood samples from five individuals and coinfection with *B. vinsonii* subsp. *berkhoffii* and *B. henselae* was found in patient 3 (Table 1). Considering only the initial BAPGM blood culture results, *Bartonella* DNA was detected following direct extraction from the blood samples of four patients whereas *Bartonella* DNA was amplified only following BAPGM enrichment culture of samples from patients 2 and 5.

TABLE 3. Serological, PCR, and culture results for a 14-year-old boy with migraine headaches following recent tick exposure

<table>
<thead>
<tr>
<th>Date (mo/day/yr) of blood sample</th>
<th>IFA reciprocal titer(^d) of antibodies to:</th>
<th>PCR-BAPGM culture result(^b) after:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>B. henselae</em></td>
<td><em>B. henselae</em></td>
</tr>
<tr>
<td>9/01/2005</td>
<td>256</td>
<td>128</td>
</tr>
<tr>
<td>9/05/2005</td>
<td>512</td>
<td>256</td>
</tr>
<tr>
<td>9/29/2005</td>
<td>512</td>
<td>256</td>
</tr>
<tr>
<td>10/27/2005</td>
<td>128</td>
<td>128</td>
</tr>
<tr>
<td>10/12/2006</td>
<td>128</td>
<td>128</td>
</tr>
</tbody>
</table>

\(^d\) Titers are reported as the reciprocal of the end-point titer.  
\(^b\) Unable to sequence the amplicon obtained using *Bartonella* genus ITS primers.
Following the subculture of aliquots from the liquid BAPGM enrichment cultures, isolates \((B. henselae)\) were obtained from samples from patients 1, 2, 3, 4, and 6. Based upon sequential enrichment culture attempts, five individuals were found to be infected at more than one testing time point, as illustrated for patient 1 in Table 2. For this patient, the same \(Bartonella\) species and strain was detected in blood and cerebrospinal fluid samples obtained 9 months apart. Patient 6 had the shortest duration of symptoms and was assumed to have a recently acquired infection; seroconversion was documented, and after treatment with azithromycin, \(Bartonella\) bacteremia was not detected by blood culture or PCR (Table 3). For patient 2, an isolate of \(B. henselae\) (San Antonio 2 [SA2] like) was initially identified by sequencing, whereas \(B. henselae\) (Houston-1 [H1]-like) sequences were obtained only from blood extracted 6 months later, following the administration of clindamycin for gingivitis and a tooth root abscess. The \(B. henselae\) reciprocal IFA titer decreased from 128 to 32 during this same time interval. Patient 3 was coinfected with \(B. vinsonii\) subsp. \(berkhoffii\) and \(B. henselae\), and patients 4, 5, and 6 were infected with \(B. henselae\) (H1 or SA2). At no time during this study was DNA amplified from an extraction control or from an uninoculated BAPGM culture control.

**DISCUSSION**

All six patients in this study were infected with \(B. henselae\), and as has been reported previously for people and for dogs, patient 3 was coinfected with \(B. henselae\) and \(B. vinsonii\) subsp. \(berkhoffii\) (5, 15, 16). Patient 6 was either coinfected or was chronically infected with \(B. henselae\), the organism that was isolated, and subsequently infected with \(B. vinsonii\) subsp. \(berkhoffii\), as reflected by the documentation of seroconversion. Historically, \(B. henselae\) infection when associated with CSD has been considered a self-limiting illness (8, 9, 34). Our results from a previous study and from this study and our unpublished data indicate that some immunocompetent individuals develop persistent intravascular \(B. henselae\) infections (5). Based upon the findings reported in published studies, the culture of patient blood samples by using an insect-based liquid culture enrichment medium can enhance the success of obtaining a subculture isolate or, alternatively, can increase \(Bartonella\) bacterial numbers to a level such that organism-specific DNA sequences can be detected by PCR (5, 6, 15, 25). Similar to the subjects in a previous study in which the preenrichment approach was used, each person in this study was immunocompetent and each had a history of animal or arthropod contact (5). Also, consistent with the data in the previous report, patients 2, 3, and 4 were middle-aged women who reported neuropsychiatric abnormalities including fatigue, insomnia, memory loss, disorientation, and frequent headaches. The intermittent detection of bacteremia in some untreated immunocompetent individuals suggests that \(B. henselae\) can induce a relapsing pattern of bacteremia or that the organism load in blood is at times below the level of detection afforded by the combined preenrichment culture-PCR approach (5). It is important to emphasize that the isolation of \(B. henselae\) and \(B. vinsonii\) subsp. \(berkhoffii\) from, or the molecular detection of these pathogens in, samples from the patients in the study does not confirm causation. Three of six individuals appeared to respond to antibiotic treatments, whereas the responses in three patients were minimal or transient.

The neuropathogenesis of \(B. henselae\) infection remains incompletely understood. \(B. henselae\) can invade and colonize human dendritic cells, CD34 progenitor cells, erythrocytes, and vascular endothelial cells (14, 28). In vitro intracellular infection of feline microglial cells has also been demonstrated previously (31). In a previous study involving a patient with classical CSD accompanied by encephalopathy, \(B. henselae\) DNA was amplified from an epitrochlear mass and from the cerebrospinal fluid (18). The involvement of the central nervous system in patients with CSD is infrequent, and the spontaneous resolution of neurological abnormalities, without residual neurological dysfunction, is the most frequently reported outcome (18). However, there may be exceptions, as illustrated by the case of a 17-year-old girl who developed episialia partialis continua 6 weeks after being scratched by a cat, followed by residual partial epilepsy (34). We hypothesize that patient 1 in this study developed persistent intravascular \(B. henselae\) infection and progressive neurological involvement following a cat scratch. Despite reporting other neurological problems, this patient denied having a history of muscle pain, loss of sensation, numbness, and joint pain, which were frequently reported abnormalities in two previous studies (5, 22). Identical \(B. henselae\) 16S-23S ITS sequences were amplified from samples obtained from patient 1 on three independent occasions. These DNA sequences were obtained by five different approaches, including direct extraction from blood (two samples), BAPGM enrichment blood culture, BAPGM enrichment cerebrospinal fluid culture, and isolation from an agar plate subculture. These results were also obtained at three different sample collection and processing times spanning 9 months, during which time the patient maintained stable \(B. henselae\) antibody titers. Based upon ITS sequences, all isolates obtained from this individual were most similar to the H1 type strain of \(B. henselae\) (ATCC 49882), which was originally isolated from the blood of a human immunodeficiency virus-infected person.

Patient 5 had the most severely debilitating neurological abnormalities. This previously healthy 49-year-old veterinarian developed progressive muscle weakness, myoclonus, paresis, and severe fatigue, which followed an acute febrile illness. Initially, a viral infection was diagnosed, and subsequently, multiple sclerosis was diagnosed. Neurological dysfunction resulted in a curtailment of prior athletic activities, such as jogging, and ultimately this individual required assistance during extended walks. Previously, a chronic inflammatory demyelinating polyradiculoneuropathy was reported as a complication of CSD in a 3-year-old boy (29). Six weeks after the onset of classical CSD, the boy developed difficulty in walking, an inability to run or climb stairs, and susceptibility to frequent falling, which became progressively worse during the subsequent 8 weeks (29). Potentially, \(B. henselae\) infection in patient 5 in this study induced an immune-mediated demyelinating central nervous system disease that mimicked multiple sclerosis.

Blood from the 14-year-old boy described in this study was provided by the attending neurologist when the boy’s mother, a companion animal veterinarian, contacted our laboratory, to which she routinely submitted diagnostic samples for testing for tick-borne organisms in the blood of cats and dogs. Al-
though vector competence has not been established for tick transmission of *Bartonella* species, there is both case-based and seroepidemiological evidence supporting transmission by *Rhipi-cephalus sanguineus* and *Ixodes scapularis* (4, 8, 9). Several recent studies have found *Bartonella* DNA in questing ticks, ticks attached to animals, or ticks attached to human beings (1, 23, 35). In addition, there are previously described case studies in which tick attachment preceded the onset of illness and the documentation of *B. henselae* infection in children or adults (24, 26). Unfortunately, concurrent or prior exposure to cats or kittens and the potential for persistent *B. henselae* infection in children or adults with a history of tick attachment limit the utility of case-based evidence of *B. henselae* transmission by ticks. More recently, investigators from the United States and Poland have documented concurrent infection of the central nervous system with *Borrelia burgdorferi* and *B. henselae*, supporting the possibility of the cotransmission of these pathogens by *Ixodes* spp. (20, 33). Similar to patients 2, 3, 4, and 6 in this study, four individuals residing in a region where *B. burgdorferi* was endemic reported frontal headaches, cognitive dysfunction, and fatigue in a study by Eskow and colleagues, and *B. henselae* DNA was amplified from the blood and/or cerebrospinal fluid samples (20). Also, similar to the 14-year-old boy in this study, one individual in the study by Eskow et al. became ill within a week after the removal of two attached ticks, whereas a second individual became ill 3 months after the removal of a tick from the scalp and, for the other two chronically ill patients, the timing of tick attachment was unknown. Evolving evidence appears to support the potential for the transmission of *B. henselae* to people following tick attachment.

Most recently, our research group has amplified and sequenced DNA of four *Bartonella* species from saliva samples obtained from healthy or sick dogs (17). Although the finding of *Bartonella* DNA does not confirm the presence of viable *Bartonella* organisms in an animal’s mouth, it does indicate that bites or contact with saliva from cats or dogs may be an incompletely defined risk factor for the transmission of these organisms to people (17). Prospective studies are needed to determine the variability in the duration of infection and the prevalence of *Bartonella* bacteremia among healthy humans and various patient populations and to evaluate bite wounds as a mode of *Bartonella* transmission to people and the clinical relevance of long-term intravascular infection with these bacteria. Other authors have proposed that *Bartonella* spp. represent an exceptional example of a “stealth pathogen,” suggesting that chronic vascular infection can ultimately predispose to complex disease expression, including but perhaps not limited to angiogenesis (30). Comparative medical data obtained from *Bartonella*-infected dogs and people would strongly support this contention (8, 9). As cats and dogs serve as reservoir hosts for *B. henselae* and *B. vinsonii* subsp. *berkhoffii*, respectively, pet contact may represent an incompletely defined risk for disease transmission to people, particularly individuals such as veterinarians, animal handlers, and farmers with extensive animal contact (3, 7, 10, 17, 36). The additional use of a combined approach of enrichment culture and PCR should assist in the microbiological detection of *B. henselae* and *B. vinsonii* subspp. *berkhoffii*. Clearly, joint efforts by physicians and veterinarians are required to further address the role of *Bartonella* species as con-temporary pathogens in sick animals and in human patients (8, 9, 19).

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**REFERENCES**


