Brucellosis Triggering Hemolytic Anemia in Glucose-6-Phosphate Dehydrogenase Deficiency

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Introduction

Brucellosis is a zoonotic infection caused by small, fastidious Gram-negative coccobacilli of the genus Brucella [1]. It has a worldwide distribution and is endemic in the Mediterranean basin and some developing countries [2]. Humans may be infected through the ingestion of raw milk, cheese, and insufficiently cooked or raw meat. The disease might also be acquired through direct contact with infected animals, products of conception, or animal excreta [1, 2].

Brucellosis may involve any organ system, but the most common complication is osteoarticular involvement. It might also involve hepatosplenomegaly, the nervous system, the genitourinary system, the skin, or the respiratory system [3]. In addition, brucellosis might have various hematological manifestations such as anemia, leukopenia, lymphomonocytosis and, rarely, thrombocytopenia, pancytopenia, and thrombotic microangiopathy [3–6]. The causes of pancytopenia and anemia in brucellosis might be hemophagocytosis, hypersplenism, bone marrow granulomas, bone marrow hypoplasia, immune destruction, and infiltration with malignant diseases [3, 5, 6].

Glucose-6-phosphate dehydrogenase (G6PD) deficiency is the most common red blood cell enzyme deficiency worldwide. It may lead to acute hemolytic anemia

Key Words
Glucose-6-phosphate dehydrogenase deficiency · Brucellosis · Acute hemolytic anemia

Abstract

Objectives: To present a case of acute brucellosis triggering acute hemolytic anemia in a subject with glucose-6-phosphate dehydrogenase (G6PD) deficiency. Clinical Presentation and Intervention: A 17-year-old male patient presented with fever, malaise and jaundice. His blood and bone marrow cultures yielded Brucella species. In addition, he was found to have acute hemolytic anemia due to previously undiagnosed G6PD deficiency. He was started on folic acid supplementation and given a combination of doxycycline and rifampicin for 6 weeks. His response to antibiotic therapy was optimal; the hemolytic anemia resolved. There were no further episodes of hemolysis. Conclusion: This case showed that the differential diagnosis of acute hemolytic anemia in subjects with G6PD deficiency should include brucellosis, especially in regions where the infection is endemic.
triggered by infection, the ingestion of certain drugs or broad beans (favisim) [7]. Until recently, acute hemolytic anemia triggered by acute brucellosis in G6PD deficiency has not been reported. Herein, we describe a patient with acute brucellosis and G6PD deficiency concurrently that resulted in acute hemolytic anemia.

Case Report

A 17-year-old male was hospitalized in our Clinical Bacteriology and Infectious Diseases Clinic in November 2005 with the complaints of malaise, fever of 2 weeks duration, sweating, low back pain, headache, jaundice, and darkening of urinary color of 1 week’s duration. He had been living in a village in the Edirne Province in the northwest of Turkey. The patient was a shepherd and his family herded sheep. He admitted consuming raw dairy products and having direct contact with the animals. His past medical history was not contributory: he denied the intake of any drugs, any infectious diseases or favism. His family history revealed cholecystectomy and splenectomy in 2 of his maternal uncles in the third decades of their lives. His initial vital signs were as follows: temperature 39.2 °C; blood pressure 110/60 mm Hg; heart rate 132/min, and respiratory rate 32/min. On physical examination, conjunctivae were pale, sclerae were subicteric, and the skin appeared yellow. Cervical and axillary lymph nodes were 2 cm in their greatest diameter and splenomegaly and hepatomegaly were evident (9 and 4 cm below the respective costal margin).

There was a grade II/VI systolic murmur in the mitral and pulmonary areas; examination of the respiratory system was normal. Neurologic system evaluation revealed no pathology. Whole blood count showed hemoglobin 8.2 g/dl, hematocrit 23.1%, mean corpuscular volume 84.8 fl, leukocytes 4,200/mm³, and platelets 208,000/mm³. The peripheral blood smear revealed polychromasia and nucleated red blood cells, but no schistocytes. The leukocyte differential was composed of 3% myelocytes, 3% metamyelocytes, 4% stabnuclei, 38% neutrophils, 2% basophils, 48% lymphocytes, and 2% monocytes. On biochemical analysis, total bilirubin was 3.1 mg/dl (normal <2.0 mg/dl), indirect bilirubin 2.4 mg/dl (normal <1.5 mg/dl), and lactate dehydrogenase 440 U/l (normal <192 U/l). Other biochemical values including urea, creatinine, electrolytes, ALT, AST, ALP, GGT were normal. Erythrocyte sedimentation rate was 55 mm/h and C-reactive protein 5.5 mg/dl (normal: 0–0.8 mg/dl). Bone marrow aspiration was hypercellular with erythroid hyperplasia (myeloid:erythroid ratio 43:41) and toxic granulation of the myeloid cells. The corrected reticulocyte count was 5.8% and serum haptoglobin level was low (<5.83 mg/dl). There was increased urinary uriculinogen, but no hemosiderinuria. Direct and indirect Coombs tests were negative; serum vitamin B₁₂ and folic acid levels were normal. The value of G6PD was 3.8 IU/g hemoglobin (normal: 4.6–13.5 IU/g hemoglobin). Any forms of Plasmodium spp. were not seen on the peripheral blood smear prepared on three separate occasions when the patient had high fever. Serologic tests for HBsAg, antiHBS IgG, antiHBC, antiHCV, anti-HIV, antiCMV IgM and IgG, antitoxoplasma IgM and IgG, and the monospot and Grubal-Widal tests were negative. Serum slide agglutination (Rose-Bengal) test was positive, and the standard tube agglutination (Wright) test for Brucella spp. was positive at a titer of 1/20,480 on the 4th day of admission. The antigens in these tests (obtained from Pendik Veterinary Research Laboratory, Istanbul, Turkey) were prepared from B. abortus S-99 strain. Brucella species were isolated from both blood and bone marrow cultures on the 9th day of admission. The species of Brucella could not be identified because further identification tests for Brucella strain could not be performed.

The patient was diagnosed with acute hemolytic anemia due to G6PD deficiency triggered by acute brucellosis. Thorax computed tomography (CT) revealed only axillary lymph nodes 2 cm in maximal diameter. Abdominopelvic CT showed hepatomegaly (19 cm) and splenomegaly (20 cm). Electrocardiography and cranial CT were normal. Radiographic studies of the spine and sacroiliac joints showed no pathology. The patient was started on folic acid after the initial laboratory tests indicated noimmune hemolysis. He was put on doxycycline 200 mg/day and rifampicin 600 mg/day after the positive tube agglutination test. His fever continued during the first 5 days of antibiotic therapy. After 1 week of antibiotic therapy, his hemoglobin level was 6.5 g/dl, hematocrit 19.4%, leukocytes 3,300/mm³, platelets 118,000/mm³, corrected reticulocytes 11.5%, lactate dehydrogenase 1,565 U/l. He was transfused with 2 units of red blood cell suspensions. Thereafter, his whole blood count parameters began to improve and his hemolysis stopped. He was discharged after 2 weeks of antibiotic therapy and completed therapy with doxycycline and rifampicin for 6 weeks. On his last follow-up in May 2008, nearly 2.5 years after his initial presentation, he was well, with no complaints and complications; he had a normal whole blood count with no hemolysis and normal biochemical tests. The patient’s two follow-up G6PD levels were lower than his initial value.

Discussion

Brucellosis is a multisystemic infectious disease with a worldwide distribution [1]. Patients with active brucellosis might have various hematological manifestations such as anemia, leukopenia, and relative lymphomonocytosis [3, 4]. Less frequently, there might be thrombocytopenia, pancytopenia, and hemolysis [5, 6, 8].

Anemia and pancytopenia in brucellosis might be explained by different mechanisms. One of the causes is hemophagocytosis [6, 9]. In one large series including 202 patients, more than half of the bone marrow aspirations and biopsies showed histiocytic hyperplasia with prominent phagocytosis of erythrocytes, leukocytes, platelets, and their precursors [6]. Another cause is bone marrow granulomas which have no caseation necrosis [9]. Hyper-splenism might be a contributory factor for cytopenias. However, the spleen is usually not huge and cytopenias improve before resolution of splenomegaly, and therefore it seems to play a minor role [6]. Bone marrow hypoplasia is a rarely reported cause for cytopenias. Infiltration of the bone marrow with solid or hematological malignancies might also result in cytopenias in brucellosis patients.
Hemolytic Anemia due to Brucellosis

References


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