reflect DNAemia observed in acute Q fever. [4] In our opinion, this should not be considered definite endocarditis. In addition, 8 of 18 patients (44%) without subsequent endocarditis started prophylactic treatment as late as 2–8 months after the diagnosis of acute Q fever, and, surprisingly, endocarditis developed within 2 months in 11 of 13 patients (85%) without prophylaxis. Moreover, most possible endocarditis cases had rather low immunoglobulin G phase I titers (1.800). Because the diagnosis of endocarditis in most patients with preexisting valvulopathy was based solely on marginally increased serological titers within a short time frame after acute Q fever, we are concerned that these cases may have been misdiagnosed and merely reflected increasing immunoglobulin G phase I titers, which can be observed until 6 months after acute Q fever [5].

Furthermore, potential side effects that accompany a 12-month antibiotic course with doxycycline and hydroxychloroquine were not discussed. In the study of 568 patients with a history of cardiac valve surgery living in an outbreak area in the Netherlands, reported by Kampschreur et al [6], Coxiella burnetii antibodies were detected in 20% of patients, of whom 8% had probable or proven Q fever endocarditis. If these patients had been offered prophylaxis, 92% of them would have unnecessarily received toxic antibiotics for 12 months.

Currently, in the Netherlands, routine evaluation for valvulopathies is not advised, based on prospective follow-up findings in a series of patients [7]. In a cohort of 85 patients with acute Q fever and a high prevalence of cardiac valvulopathy (39 of 85; 46%), chronic Q fever had not developed in any of them after 1 year of follow-up. The difficulty in the optimal workup after an episode of acute Q fever is also reflected in the recent formulations of the Centers for Disease Control and Prevention, which advise patients with acute Q fever to undergo careful clinical assessment, including assessment for vascular and heart valve defects, but make no specific recommendations on the most appropriate tools for this assessment [8]. In conclusion, prophylactic treatment for high-risk patients after an episode of acute Q fever can be beneficial, but which patients benefit from such strategy and the optimal duration of prophylaxis still need to be determined.

Note

Potential conflicts of interest. All authors: No reported conflicts.

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References

fever serologic findings (phase I immunoglobulin G ≥800) should be considered to have Q fever endocarditis [4] and treated accordingly.

Withdrawing the echocardiographic detection of silent valvulopathies during acute Q fever, as recommended in the Netherlands [5], is absurd because it differs from the usual recommendations; this explains the high numbers of unrecognized Q fever endocarditis cases, because no patients were provided antibiotic prophylaxis in the Netherlands.

Notes

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References


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