Correspondence

Correct Dose of Azithromycin for Patients Scheduled to Undergo Dental Procedures

SIR—The important review article on infectious complications of dental and periodontal disease in the elderly population by Shay [1] is very carefully written and clearly documented. However, table 1, which lists recommendations for antibiotic prophylaxis for bacterial endocardtitis in patients scheduled to undergo dental procedures, indicates the wrong dose of azithromycin or clarithromycin. According to the reference cited [2], the dose of azithromycin should be 500 mg administered 1 h before the procedure, instead of 2.0 g.

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Isolated Splenic Cat Scratch Disease

SIR—We read with great interest the article by Gilad et al. [1] that reported the first case of isolated splenic cat scratch disease (CSD) in an immunocompetent adult woman. In this report, the diagnosis was obtained after splenectomy had been performed. Two other cases of isolated splenitis have been described in adults after splenectomy [2, 3]. In 2001, we reported a case of *Bartonella henselae* infection in a 40-year-old patient who presented with fever, weight loss, night sweats, elevated lactate dehydrogenase level, and multinodular splenomegaly. The diagnosis of CSD was established by serological testing for *B. henselae*. After 2 weeks of antibiotic therapy (with ciprofloxacin), CT of the abdomen was performed and showed complete disappearance of the splenic lesion. Splenectomy was not performed [4]. We emphasize that a diagnosis of CSD should be systematically considered in such clinical circumstances before more-invasive approaches, such as splenectomy, are performed. Splenic CSD is an exceptional diagnosis in adults and can easily be mistaken for splenic lymphoma, thereby leading to unnecessary splenectomy.

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Reply

SIR—We would like to thank Bernard et al. [1] for their interest in our article on isolated splenic cat scratch disease (CSD) in an immunocompetent adult. The 2 other cases [2, 3] cited by the authors were actually discussed in our article. The first case, which was reported by Tappero et al. [2], was, in fact, a case of hepatosplenic CSD and not isolated splenitis, because impaired liver function was present as well. The second case, which was reported by Mulvany and Billson [3], was bacillary angiomatosis of the spleen of an immunocompromised adult and not CSD, which are different pathological conditions. We were not aware of the case reported by Ghez et al. [4] because it was published simultaneously with the submission of our manuscript, and we appreciate that it has now been brought to our attention. This case shares a similarity with ours: both cases presented with *Bartonella henselae* infection masquerading as splenic lymphoma [4].

We agree, as emphasized in our article, that splenic CSD should be ruled out in certain clinical circumstances before a diagnostic splenectomy is performed, to prevent an unnecessary invasive procedure. What is most striking in our case and in the case reported by Ghez et al. [4] is that the history of exposure to cats and kittens was reported only after repeated questioning. We believe that obtaining a thorough and focused medical history, a somewhat lost art in this era of sophisticated medical