1996-12-01


Gary V. Doern
University of Massachusetts Medical School

Let us know how access to this document benefits you.
Follow this and additional works at: https://escholarship.umassmed.edu/oapubs

Part of the Medical Microbiology Commons

Repository Citation

This material is brought to you by eScholarship@UMassChan. It has been accepted for inclusion in Open Access Publications by UMass Chan Authors by an authorized administrator of eScholarship@UMassChan. For more information, please contact Lisa.Palmer@umassmed.edu.
Prevalence of Antimicrobial Resistance among 723 Outpatient Clinical Isolates of *Moraxella catarrhalis* in the United States in 1994 and 1995: Results of a 30-Center National Surveillance Study

GARY V. DOERN, ANGELA B. BRUEGGEMANN, GARY PIERCE, TRICIA HOGAN, H. PRESTON HOLLEY, JR., AND ALAN RAUCH

Clinical Microbiology Laboratories, University of Massachusetts, Worcester, Massachusetts 01655, and Medical Affairs, Glaxo Wellcome, Inc., Research Triangle Park, North Carolina 27709

Received 28 May 1996/Returned for modification 27 August 1996/Accepted 6 October 1996

Seven hundred twenty-three isolates of *Moraxella catarrhalis* obtained from outpatients with a variety of infections in 30 medical centers in the United States between 1 November 1994 and 30 April 1995 were characterized in a central laboratory. The overall rate of β-lactamase production was 95.3%. When the National Committee for Clinical Laboratory Standards MIC interpretive breakpoints for *Haemophilus influenzae* were applied, percentages of strains found to be susceptible to selected oral antimicrobial agents were as follows: azithromycin, clarithromycin, and erythromycin, 100%; tetracycline and chloramphenicol, 100%; amoxicillin-clavulanate, 100%; cefixime, 99.3%; cefodoxime, 99.0%; cefaclor, 99.4%; loracarbef, 99.0%; cefuroxime, 98.5%; cefprozil, 94.3%; and trimethoprim-sulfamethoxazole, 93.5%.

*Moraxella catarrhalis* is now recognized as a common cause of a variety of localized, community-acquired infections, in particular, acute otitis media, maxillary sinusitis, and acute purulent exacerbation of chronic bronchitis (3, 7, 10). Most clinical isolates of *M. catarrhalis* are found to produce one of two β-lactamases, BRO-1 and BRO-2 (5, 8, 11, 12). Both of these enzymes hydrolyze penicillin, ampicillin, and amoxicillin, although to differing degrees (i.e., BRO-1 hydrolyzes them to a greater extent than BRO-2) (5, 11). As a result, MICs of penicillin, ampicillin, and amoxicillin are elevated for β-lactama-producing strains of *M. catarrhalis*, especially BRO-1 enzyme producers (1, 4, 6, 12). Whether production of either enzyme is associated with clinical failures in patients treated with these β-lactams has not been determined. Until such information is available, however, prudence would dictate that all infections caused by β-lactamase-producing *M. catarrhalis*, irrespective of which enzyme is produced, be considered refractile to management with penicillin, ampicillin, or amoxicillin.

Two recent large multicenter surveillance studies in the United States revealed overall rates of β-lactamase production of 84.1% in 1987 and 1988 (6) and 92.0% in 1992 and 1993 (1). Interestingly, there is some evidence that prior to 1976, in both the United States and Europe, *M. catarrhalis* rarely if ever produced β-lactamase (12).

Because the β-lactamases of *M. catarrhalis* are inhibited by clavulanate, the combination drug amoxicillin-clavulanate has been consistently active against this species (1, 4, 6). The same is true of oral cephalosporins, excepting cephalexin and cefadroxil (4). Erythromycin and tetracycline resistance has been reported (2); however, the two most recent countrywide surveillance studies in the United States during 1987 and 1993 failed to identify a single macrolide-or tetracycline-resistant strain among a total of >1,000 isolates of *M. catarrhalis*. In contrast, trimethoprim-sulfamethoxazole (TMP-SMX) resistance is being reported with greater frequency (1).

The intent of the present study was to systematically determine the prevalence of antimicrobial resistance among current isolates of *M. catarrhalis* in the United States. Between 1 November 1994 and 30 April 1995, a total of 723 different isolates of this organism were prospectively collected from various specimens from outpatients in 30 different U.S. medical centers. For further characterization, isolates were transported to the University of Massachusetts Medical Center on rayon swabs immersed in 12 ml of Amies semisolid transport medium containing charcoal. Stock cultures were prepared with an absorbent-bead system (ProLab Diagnostics, Austin, Tex.), and organisms were stored at −70°C until further use. All organisms were subcultured twice on sheep blood agar plates prior to further characterization. Isolates were confirmed as *M. catarrhalis* on the basis of Gram stain morphology and production of oxidase and butyric acid esterase.

**Susceptibility studies.** MICs were determined by a broth microdilution procedure (100-μl total volume per well; final inoculum concentration, ca. 5 × 10^5 CFU/ml) in cation-adjusted Mueller-Hinton broth (Difco Laboratories, Detroit, Mich.), with trays incubated at 35°C in ambient air for 22 to 24 h prior to determination of results. Sixteen antibiotics, obtained from their respective manufacturers as laboratory-grade powders, were each tested in 12 different concentrations in an attempt to limit the number of off-scale results. The antimicrobial agents were penicillin, ampicillin, amoxicillin, amoxicillin-clavulanate (2:1), cefaclor, loracarbef, cefprozil, cefuroxime, cefixime, cefpodoxime, erythromycin, azithromycin, clarithromycin, TMP-SMX (1:19), chloramphenicol, and tetracycline. *Staphylococcus aureus* ATCC 29213 and *Escherichia coli* ATCC 25922 were used as controls. β-Lactamase production was assessed with all isolates by the nitrocefin disk assay (Cefinase; Becton Dickinson Microbiology Systems, Cockeysville, Md.).

A total of 723 isolates of *M. catarrhalis* were characterized (mean number contributed per medical center = 24.1; range =
14 to 43). Males were the source of 57.2% of isolates. The percentages of isolates obtained from patients in different age groups were as follows: 0 to 5 years, 33.3%; 6 to 10 years, 4.8%; 11 to 20 years, 3.1%; 21 to 50 years, 18.2%; and >50 years, 40.6%. The percentages of isolates obtained from different specimens were as follows: middle ear fluid, 4.5%; sinus aspirates, 5.4%; conjunctival specimens, 7.4%; lower respiratory tract, 80.3%; blood, 1.7%; and other, 0.8%.

Of the 723 isolates, 689 (95.3%) produced β-lactamase. MIC results for 16 antimicrobial agents are listed in Table 1. MICs of all 10 β-lactam antimicrobial agents examined in this study were higher for β-lactamase-positive than for β-lactamase-negative strains. Overall, ampicillin was equivalent to amoxicillin in activity; both were more active than penicillin. The National Committee for Clinical Laboratory Standards (NCCLS) currently does not provide MIC interpretive breakpoints for β-lactam agents. Therefore, the MIC range for β-lactamase-negative strains was defined as ≤0.06-32 μg/ml.

The activities of six oral cephalosporins were also examined in this study. On the basis of current NCCLS Haemophilus influenzae breakpoints (9), the percentages of strains determined to be susceptible to the cephalosporins were 99.3% for cefixime, 99.0% for cefpodoxime, 99.4% for cefaclor, 99.0% for loracarbef, 98.5% for cefuroxime, and 94.3% for cefprozil. All nonsusceptible strains produced β-lactamase. With the exception of the cefprozil MICs, the cephalosporin MICs obtained with those strains categorized as not susceptible were only a single doubling concentration higher than the susceptible MIC breakpoints for the respective antimicrobial agents. In the case of cefprozil, for 12 isolates (1.6% of the total) the MICs were ≥32 μg/ml, and these isolates would have been categorized as resistant according to current NCCLS breakpoints for H. influenzae (9).

Again on the basis of current Haemophilus breakpoints (9), all isolates of M. catarrhalis were susceptible to the macrolides examined in this study (erythromycin, azithromycin, and clarithromycin). The same was true of chloramphenicol and tetracycline. With TMP-SMX, the MICs for 6.5% of the isolates were ≥1.0 μg/ml, and therefore, those isolates would have been classified as intermediate (MICs 1 to 2 μg/ml; n = 41) or resistant (MICs, ≥4 μg/ml; n = 6) according to the NCCLS Haemophilus interpretive breakpoints (9).

It is apparent from the results of this study that today nearly all clinical isolates of M. catarrhalis produce β-lactamase and as a result should probably be managed with agents other than penicillin, ampicillin, or amoxicillin. Fortunately, this organism remains uniformly susceptible to amoxicillin-clavulanate and nearly uniformly susceptible to five oral cephalosporins, cefixime, cefpodoxime, cefaclor, loracarbef, and cefuroxime. Among these five agents, cefixime is clearly the most active.

As can be seen from the range of MICs listed in Table 1, not all β-lactamase-negative strains would have been categorized as ampicillin resistant according to the NCCLS Haemophilus influenzae breakpoint of ≥4 μg/ml (9). Indeed, for 136 (19.7%) of the 689 β-lactamase-positive isolates, the MICs were ≥2 μg/ml. It is likely that these strains produced the BRO-2 enzyme, which is known to be associated with low penicillin and ampicillin MICs due to small amounts of enzyme produced and low substrate affinity (5, 11).

The activities of six oral cephalosporins were also examined in this study. On the basis of current NCCLS Haemophilus breakpoints (9), the percentages of strains determined to be susceptible to the cephalosporins were 99.3% for cefixime, 99.0% for cefpodoxime, 99.4% for cefaclor, 99.0% for loracarbef, 98.5% for cefuroxime, and 94.3% for cefprozil. All nonsusceptible strains produced β-lactamase. With the exception of the cefprozil MICs, the cephalosporin MICs obtained with those strains categorized as not susceptible were only a single doubling concentration higher than the susceptible MIC breakpoints for the respective antimicrobial agents. In the case of cefprozil, for 12 isolates (1.6% of the total) the MICs were ≥32 μg/ml, and these isolates would have been categorized as resistant according to current NCCLS breakpoints for H. influenzae (9).

Table 1. MICs of 16 antimicrobial agents obtained with 723 recent clinical isolates of M. catarrhalis

<table>
<thead>
<tr>
<th>Antimicrobial agent</th>
<th>β-Lactamase-positive isolates (n = 689)</th>
<th>β-Lactamase-negative isolates (n = 34)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MIC50</td>
<td>MIC90</td>
</tr>
<tr>
<td>Penicillin</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Ampicillin</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Amoxicillin</td>
<td>4</td>
<td>16</td>
</tr>
<tr>
<td>Amoxicillin-clavulanate</td>
<td>0.25</td>
<td>0.5</td>
</tr>
<tr>
<td>Cefaclor</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Loracarbef</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Cefprozil</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Cefuroxime</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Cefixime</td>
<td>0.25</td>
<td>0.5</td>
</tr>
<tr>
<td>Cefpodoxime</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>0.25</td>
<td>0.25</td>
</tr>
<tr>
<td>Azithromycin</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>0.06</td>
<td>0.12</td>
</tr>
<tr>
<td>TMP-SMX</td>
<td>0.5</td>
<td>0.5</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>0.5</td>
<td>1</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>0.5</td>
<td>0.5</td>
</tr>
</tbody>
</table>

* MIC90 and MIC50, MICs at which 50% and 90% of isolates, respectively, are inhibited.

We thank Brendan Curley for technical assistance, Greg Giguerre for statistical analysis, and Debbie McQuaid for excellent secretarial support. In addition, we thank the following individuals for provision of clinical isolates of M. catarrhalis: Melodie Beard, Rush-Presbyterian St. Luke’s Medical Center; Paul Bourbeau, Geisinger Medical Center; Joseph Campos, Children’s Hospital National Medical Center; Kimberly Chaplin, University of South Alabama; Carla Clausen, Seattle Children’s Hospital; Frank Cockerill, Mayo Clinic; Judy Daly, Primary Children’s Medical Center; Gerald Dennis, Methodist Hospital; Phyllis Della-Latta, Columbia Presbyterian Hospital; Michael Dunne, Henry Ford Hospital; Peter Gilligan, University of North Carolina.
School of Medicine; Paul Granato, SUNY Health Sciences Center—Syracuse; Dwight Hardy, Strong Memorial Hospital; Bob Jerris, Dekalb General Hospital; Karen Sue Kehl, Milwaukee Children’s Hospital; Susan Marrone, Kaiser Hospital—Portland; Pat Mickelson, Stanford University Medical Center; Margie Morgan, Cedars-Sinai Hospital; Ann Robinson, Hartford Hospital; Susan Rossmann, Texas Children’s Hospital, Dan Sahm, Jewish Hospital; Michael Saubolle, Good Samaritan Hospital; Susan Sharp, Mt. Sinai Hospital; Paul Southern, University of Texas Southwestern Medical Center; Ronald St. Amand, University of Massachusetts Medical Center; Richard Thompson, Evanston Hospital; Grace Thorne, Boston Children’s Hospital; Allan Truant, Temple University School of Medicine; John Washington, Cleveland Clinic; and Michael Wilson, Denver General Hospital.

This study was supported by a grant from Glaxo Wellcome, Inc.

REFERENCES