EDITORIAL

New horizons in the bacteriology, antimicrobial susceptibility and therapy of animal bite wounds

In the UK approximately 200,000 persons suffer dog bites each year [1]; in the USA 4.7 million persons, or 1.8% of the population, are bitten annually and 800,000 of these people seek medical attention [2, 3]. The 20% of patients who seek medical attention are often those that are more seriously affected, have some complication such as infection and are the focus of published reports. In addition, 400,000 persons in the USA annually are bitten by cats, 45,000 by snakes and an unknown number by other domestic small pet mammals, feral and wild animals, and other human beings, the most aggressive animal of all. Most bite victims do not need, nor do they seek, medical attention. Relatively few large-scale, systematic studies address any of the various issues concerning the full spectrum of bacteriology of these wounds or the various elements of therapy [4, 5]. Most data come from small studies or anecdotal case reports.

Dog bites occur more frequently in males <20 years old, whereas cat bites are more common in 30–40-year-old women. More bites occur in the warm weather months and during middle afternoon around 4 pm. Most animal bite wounds are provoked and the biting animal is usually owned by, or known to, the victim. Bite wounds may be lacerations, evulsions, or punctures and may be accompanied by extensive trauma and crush injury. Infectious complications occur in 15–20% of injuries and include cellulitis, abscess, septic arthritis, osteomyelitis, and bacteraemia. From 1979 to 1994, dog attacks resulted in 279 deaths in the USA [6], one-third of which were associated with pit bull terriers or rottweilers. Children account for 75% of fatalities and may also suffer more severe bite injuries, such as skull fractures, dural tears and blood vessel perforation [6, 7].

The bacteriology of paediatric and adult animal bite wounds has been the focus of several studies [4, 5] that noted aerobes in 85% of wounds and anaerobes in 15–20% of injuries and include cellulitis, abscess, septic arthritis, osteomyelitis, and bacteraemia. From 1979 to 1994, dog attacks resulted in 279 deaths in the USA [6], one-third of which were associated with pit bull terriers or rottweilers. Children account for 75% of fatalities and may also suffer more severe bite injuries, such as skull fractures, dural tears and blood vessel perforation [6, 7].

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The bacteriology of these wounds generally reflected the oral flora of the biting animal. Among aerobes, Pasteurella spp. are recognised as common isolates from feline and canine bite wounds, but most studies have not differentiated them into the newly described species and P. multocida subspecies. Mutters et al. [9] recognised 13 taxa in DNA hybridisation studies. Subsequently, Holst et al. [10], in describing 159 human clinical isolates, noted various ecological differences and tropisms between certain species. P. multocida subsp. multocida and subsp. septica were often isolated from more serious infections, with the latter having a tropism for the central nervous system. Furthermore, P. canis was isolated only from dog bites while the other species were isolated routinely from cat bite wounds and scratches.

In early studies of anaerobes isolated from bite wounds, 'Bacteroides' (including many species since renamed) were the most common isolates, followed by fusobac-
F. nucleatum and peptostreptococci. These isolates did not produce β-lactamases. In our recent study [8] we identified the presence of many new genera and species. In addition, we have previously isolated 40 strains of Porphyromonas: 26 from 54 cat bites and 14 strains from 48 dog bites. When further characterised by biochemical tests and arbitrarily primed PCR [11], Por. salivosa (11 isolates), Por. gingivalis (10) and Por. canoris (8) were most frequent; other isolates included Por. caningivalis (3), Por. circumdentaria (2), Por. cansulci (1), Por. levi-like strains (1) and some unidentified species (4). Supplemented brucella agar supports growth of all these species, but 66% failed to grow on unsupplemented brucella blood agar, 38% on Columbia blood agar and 30% on tryptic soy blood agar without haemin or vitamin K1 supplementation [12]. In a comparison of the Rapid ID ANA II system, An-Ident panels and API ZYM strips, it was found that the latter performed best because of the presence of tests for trypsin and chymotrypsin; however, detection of glycosidase activity by the API ZYM strips was less sensitive than in the other systems. None of the three test systems was able to identify all the isolates or species [13]. The WEE-TAB system, a single tube, triple substrate system to detect certain pre-formed enzymes (N-acetyl-β-D-glucosaminidase, α-D-galactosidase, β-D-galactosidase, α-fucosidase, trypsin-like activity and chymotrypsin) was recently evaluated and compared with the API ZYM and RapidID-ANA II systems and was found to be useful and accurate in identification of most of these Porphyromonas spp. Por. circumdentaria and Por. cansulci could not be identified by any of the three systems because they are enzymically inert [12].

Several saccharolytic Bacteroides and Prevotella spp. are often isolated from dog and cat bite wounds. B. tectum is a frequent isolate and may be mistaken for Pr. bivia by colonial morphology and by test kit identification numbers; it may be differentiated by its growth in bile 20% and by aesculin hydrolysis [13]. PCR fingerprinting suggests as many as four subgroups in this heterogeneous species. Pr. heparinolytica, also a common animal bite wound isolate, may be confused with B. uniformis because of a positive indole test, but is sensitive to bile and easily distinguished from Bacteroides sensu stricto (the B. fragilis group). Pr. zoogloeformans is an occasional bite wound isolate that may also resemble Pr. heparinolytica except for its negative indole test. Pr. buccae and Pr. oris, which are also biochemically similar to Pr. zoogloeformans and are indole negative, may be distinguished as they do not form a zoogleal mass in PRAS (pre-reduced anaerobically sterilised) broth media; also Pr. buccae does not produce α-L-fucosidase and Pr. oris isolates are positive for α-L-arabinosidase [13]. Because of the slow growth of some of these bite isolates, microbiologists are advised to keep the plates for 7 days to ensure their isolation and accurate culture results.

The principles of therapy consist of irrigation, cautious debridement, elevation, recognition of and monitoring for common complications and appropriate antimicrobial therapy [14]. In vitro studies with several newer antimicrobial agents have been published [15–18], but few clinical trials involving bite wound infections have been reported.

The new fluoroquinolones, levofloxacin, trovafloxacin, DU-6859a and Bay 12-8039, have excellent activity against almost all gram-positive and gram-negative aerobic isolates including all species and subspecies of Pasteurella, Actinobacillus and Haemophilus. Weekella zoohelcum, EF-4a, Capnocytophaga spp., Eikenella corrodens, Neisseria weaveri, S. aureus, S. epidermidis and streptococci [15–17]. The older fluoroquinolones, ciprofloxacin and ofloxacin, are less active against streptococci. All fluoroquinolones have limited or poor in vitro activity against F. nucleatum and other Fusobacterium spp., but good activity against B. tectum, Por. salivosa and Por. gingivalis. Trovafloxacin, Bay 12-8039 and DU 6859a exhibit good activity against peptostreptococci and other Porphyromonas spp. (levofloxacin, ofloxacin and ciprofloxacin are relatively less active), Pr. heparinolytica and other Prevotella spp. (ofloxacin and ciprofloxacin are less active).

Azithromycin is more active than erythromycin against many aerobes including P. multocida and E. corrodens. It is also two–four-fold more active than clarithromycin against aerobes such as Actinobacillus spp., Haemophilus spp., Moraxella spp. and Pasteurella spp., including all P. multocida subsp. For some isolates of P. canis, P. dagmatis, P. stomatis and P. testudinis, MICs of clarithromycin are 4–8 μg/mL. Clarithromycin is more active than azithromycin against some anaerobes such as B. tectum, Porphyromonas and Prevotella spp. [16]. It is unclear whether this difference in anaerobic activity is related to the presence of CO2 in the atmosphere of incubation, which lowers the agar surface pH and would have a greater effect on the activity of the dibasic azithromycin.

HMR 3004 is a new ketolide with a 3-keto group on a 14-membered erythronolide ring. It has greater activity against bite wound pathogens than its macroclide relatives. Almost all fastidious and aerobic isolates, including P. multocida, B. tectum, Prevotella spp., Porphyromonas spp. and peptostreptococci are inhibited at a concentration of 0.5 μg/mL, but F. nucleatum and other fusobacteria are more resistant (MIC90 16 μg/mL).

Cefuroxime and cefpodoxime have modest activity against gram-positive aerobes and limited activity against Prevotella spp. (other than Pr. heparinolytica), fusobacteria and some B. tectum strains [16]. Cefprozil has modest to poor activity against gram-positive
aerobes and, like loracarbef, poor activity against peptostreptococci [18].

The choice of antimicrobial therapy favours an agent that is active against all the Pasteurella spp., S. aureus, streptococci and the anaerobic species such as B. tectum, Pr. hep branolytica, Por. salivosa, fusobacteria and peptostreptococci. Other considerations include the patient's allergy history as well as possible side-effects, drug interactions and other contra-indications.

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References

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