Antimicrobial susceptibility testing of *Bordetella pertussis* in Taiwan prompted by a case of pertussis in a paediatric patient

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**Introduction**

Pertussis, a highly contagious respiratory disease caused by *Bordetella pertussis*, remains a significant cause of morbidity in children and more recently in adults (Broder *et al.*, 2006; Celentano *et al.*, 2005; Lin *et al.*, 2007). For pertussis treatment and post-exposure prophylaxis, erythromycin has been the antimicrobial agent of choice (Bass, 1986; von König, 2005). Recently, azithromycin was shown to be as effective as and better tolerated than erythromycin for the treatment of pertussis in children (Langley *et al.*, 2004). Due to lack of a standardized protocol for MIC determination, and the rarity of resistance to antimicrobial agents, antimicrobial susceptibility testing for *B. pertussis* clinical isolates is not routinely performed. However, there have been a few reports presenting the emergence of erythromycin-resistant *B. pertussis* isolates (Bartkus *et al.*, 2003; Hill *et al.*, 2000; Korgenski & Daly, 1997; Lewis *et al.*, 1995; Wilson *et al.*, 2002). In Taiwan, pertussis is a notifiable disease with an incidence of less than 10 cases per million people in recent years (Lin *et al.*, 2007). In May 2007, the Centers for Disease Control, Taiwan, was informed of a 1-month-old pertussis patient who did not respond to erythromycin treatment. In this study, we report the result of antimicrobial susceptibility testing performed for the suspected erythromycin-resistant isolate, as well as for an additional 27 *B. pertussis* clinical isolates that represented almost all epidemiologically unrelated isolates obtained throughout Taiwan between 2003 and 2007. All isolates were fully susceptible to azithromycin, erythromycin, clarithromycin and trimethoprim/sulfamethoxazole (MIC ≤ 0.047 µg ml⁻¹). This result demonstrates the general susceptibility of *B. pertussis* to antimicrobial agents *in vitro* in Taiwan.

**Case report**

The male infant was born on March 15 2007 with a gestational age of 34 weeks and a low birth weight of 2460 g due to premature rupture of the amniotic membrane; he was admitted to the observation room and given antibiotic treatment (ampicillin and cefotaxime) for 5 days, and then discharged. Blood and urine cultures were negative. On April 14 2007, the patient was admitted to the observation room again due to cyanosis, rhinorrhea, and poor activity and appetite for 1 day. Pneumonia was suspected with bilateral increased interstitial infiltrations shown on chest X-ray, and an oxygen hood, and ampicillin and gentamicin were used to treat the patient. Two hours after admission, a sudden onset of apnea, bradycardia and cyanosis occurred; endotracheal intubation was performed, and the patient was transferred to the intensive care unit. Urine, blood and cerebrospinal fluid cultures were all negative. A haemogram, a cardiac echo and an electrocardiogram were normal. Brain
and antimicrobial susceptibility testing was requested.

**Methods**

**Bacterial isolates and culture.** Nasopharyngeal swabs in Regan–Lowes transport medium (Creative Microbiologicals) were taken from the patient suspected of pertussis delivered to the Centers for Disease Control, Taiwan, for culture confirmation. *B. pertussis* isolates were identified on Bordet–Gengou agar (Creative Microbiologicals), and characterized by biochemical reactions and slide agglutination test with Difco Bordetella antisera (Becton Dickinson). Isolates are stored in 15% glycerol or Protect beads (Technical Service Consultants) at −80 °C until use.

**Antimicrobial susceptibility testing.** Antibiotic MICs were determined by Etest (AB Biodisk) as described by Galanakis et al. (2007) and Gordon et al. (2001). Bacteria were taken out from a −80 °C freezer and subcultured onto Bordet–Gengou agar three times before susceptibility testing (Korgenski & Daly, 1997). Mueller–Hinton agar plates supplemented with 5% horse blood were inoculated with bacterial suspension equal to a 0.5 McFarland turbidity standard prepared by direct bacterial colony suspension (CLSI, 2006). The antimicrobial agents tested were azithromycin, erythromycin, clarithromycin and trimethoprim/sulfamethoxazole. Plates were incubated at 35 °C in an ambient atmosphere for 72 h. *B. pertussis* ATCC 9797 and *Streptococcus pneumoniae* ATCC 49619 were used as quality control strains both prior to and during testing of the 28 isolates. The former strain was expected to be sensitive to all four agents, and the latter strain was expected to fall in the ranges recommended by Clinical and Laboratory Standards Institute. The lowest concentration of the antimicrobial agent that completely inhibited bacterial growth is defined as the MIC. The MIC50 and MIC90 was the concentration of the antimicrobial agent that completely inhibited bacterial growth (one isolate). For the suspected erythromycin-resistant isolate, appeared to be susceptible to all four antimicrobial agents. All MICs were ≤0.047 μg ml⁻¹. The MIC50 was 0.016 μg ml⁻¹ for all four antimicrobial agents. The MIC90 was 0.016 μg ml⁻¹ for azithromycin, and 0.023 μg ml⁻¹ for erythromycin, clarithromycin and trimethoprim/sulfamethoxazole. For erythromycin, a MIC >0.016 μg ml⁻¹ was observed only in three isolates. These three isolates also had a MIC >0.016 μg ml⁻¹ for clarithromycin (all three isolates), azithromycin (one isolate) and trimethoprim/sulfamethoxazole (one isolate). For the suspected erythromycin-resistant isolate, the MICs for azithromycin, erythromycin and clarithromycin were 0.016 μg ml⁻¹, and the MIC for trimethoprim/sulfamethoxazole was 0.023 μg ml⁻¹. Our MIC values were comparable with those published by Galanakis et al. (2007), in the range of 0.016–0.19, 0.016–0.094 and 0.002–0.064 μg ml⁻¹ for azithromycin, erythromycin and

3% and a position tolerance of 1% was used to analyse the similarities among patterns. Cluster analysis was performed by UPGMA.

**Results and Discussion**

The suspected erythromycin-resistant isolate was obtained in April 2007 from a 1-month-old boy. An additional 27 *B. pertussis* clinical isolates representing almost all epidemiologically unrelated isolates in Taiwan from 2003 to 2007, including 7 isolates from 2003, 5 from 2004, 8 from 2005, 6 from 2006 and 1 from 2007 were also obtained. Together with the suspected erythromycin-resistant isolate, the 28 isolates in total were from 15 different cities and counties throughout the whole island of Taiwan, with 16, 6, 5 and 1 isolates in northern, central, southern and eastern Taiwan, respectively. A total of 16 of the 28 patients from whom the isolates came were female (16/28, 57.1%). The age distribution of the patients was: 16 (57.1%) patients younger than 6 months, and 3 (10.7%) patients each in the age groups of 7 months to 1 year, 2 to 10 years, 11 to 16 years and older than 16 years. Although vaccination information was not available, the patients younger than 6 months old apparently had not received a complete course of vaccination.

PFGE is performed routinely for all *B. pertussis* clinical isolates with *XbaI* digestion in our laboratory in order to monitor epidemiological trends by molecular methods. As shown in Fig. 1, among the 28 isolates tested for antimicrobial susceptibility, 18 isolates, including the suspected erythromycin-resistant one, belonged to PFGE group IIIb, which has been the most prevalent PFGE group since 2001 in Taiwan (Yao et al., 2005). Nine isolates belonged to PFGE group IIIa, which was the most prevalent PFGE group before being replaced by group IIb in 2001. One isolate collected in 2003 belonged to PFGE group II, which was last seen in 2003.

The MICs of azithromycin, erythromycin, clarithromycin and trimethoprim/sulfamethoxazole were determined (Table 1). All the clinical *B. pertussis* isolates, including the suspected erythromycin-resistant isolate, appeared to be susceptible to all four antimicrobial agents. All MICs were ≤0.047 μg ml⁻¹. The MIC50 was 0.016 μg ml⁻¹ for all four antimicrobial agents. The MIC90 was 0.016 μg ml⁻¹ for azithromycin, and 0.023 μg ml⁻¹ for erythromycin, clarithromycin and trimethoprim/sulfamethoxazole. For erythromycin, a MIC >0.016 μg ml⁻¹ was observed only in three isolates. These three isolates also had a MIC >0.016 μg ml⁻¹ for clarithromycin (all three isolates), azithromycin (one isolate) and trimethoprim/sulfamethoxazole (one isolate). For the suspected erythromycin-resistant isolate, the MICs for azithromycin, erythromycin and clarithromycin were 0.016 μg ml⁻¹, and the MIC for trimethoprim/sulfamethoxazole was 0.023 μg ml⁻¹. Our MIC values were comparable with those published by Galanakis et al. (2007), in the range of 0.016–0.19, 0.016–0.094 and 0.002–0.064 μg ml⁻¹ for azithromycin, erythromycin and
trimethoprim/sulfamethoxazole, respectively. For the quality control strains, MICs of azithromycin, erythromycin, clarithromycin and trimethoprim/sulfamethoxazole were as expected: 0.016, 0.016, 0.016 and 0.002 μg ml⁻¹, respectively, for *B. pertussis* ATCC 9797; and 0.125, 0.064, 0.032 and 0.125 μg ml⁻¹, respectively, for *S. pneumoniae* ATCC 49619.

The paediatric pertussis patient who prompted this investigation eventually recovered and his slow response to medication was rationalized as the cause for the initial therapeutic failure. Similarly, in 2006, a 4-month-old boy born at 26 weeks of pregnancy was documented as exhibiting treatment failure for pertussis in France (Bonacorsi et al., 2006). In the latter case, since the *B. pertussis* isolate was susceptible to erythromycin, the authors’ explanation for the treatment failure was the infant’s immunological immaturity. They further suggested that the gold standard of treatment with erythromycin for pertussis is likely to be insufficient in premature infants.

Our results demonstrated the general susceptibility of *B. pertussis* to antimicrobial agents *in vitro* in Taiwan. Nevertheless, even though they represented almost all epidemiologically unrelated isolates that were collected throughout Taiwan from 2003 to 2007, the number of isolates in our study was small. Since the first case of erythromycin-resistant *B. pertussis* was identified in Arizona, USA, in 1994 (Lewis et al., 1995), only four more cases were reported in Minnesota, California, Arizona and Utah, USA, (Bartkus et al., 2003; Hill et al., 2000; Korgenski & Daly, 1997). After screening 1030 *B. pertussis* isolates, 5

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**Fig. 1.** PFGE patterns of 28 *B. pertussis* clinical isolates with XbaI digestion.

**Table 1.** Antimicrobial susceptibility of 28 *B. pertussis* isolates by the Etest method

<table>
<thead>
<tr>
<th>Antimicrobial agent</th>
<th>MIC range (μg ml⁻¹)</th>
<th>MIC₅₀ (μg ml⁻¹)</th>
<th>MIC₉₀ (μg ml⁻¹)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Azithromycin</td>
<td>0.016–0.023</td>
<td>0.016</td>
<td>0.016</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>0.016–0.023</td>
<td>0.016</td>
<td>0.023</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>0.016–0.047</td>
<td>0.016</td>
<td>0.023</td>
</tr>
<tr>
<td>Trimethoprim/sulfamethoxazole</td>
<td>0.012–0.032</td>
<td>0.016</td>
<td>0.023</td>
</tr>
</tbody>
</table>
more isolates with a heterogeneous erythromycin-resistance phenotype were found, leading to the conclusion that the occurrence rate of erythromycin-resistant *B. pertussis* is less than 1% (Wilson *et al.*, 2002). Such a low rate probably could explain why no resistant isolates were found in our study and argue for maintaining the screening for resistance among *B. pertussis* clinical isolates that may yet emerge.

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References


