Prevalence of multidrug-resistant *Helicobacter pylori* in Bulgaria

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The aim of this study was to evaluate the presence and prevalence of multidrug antibacterial resistance in *Helicobacter pylori* in Bulgaria from 2005 to 2008. The resistance in 828 untreated adults, 124 treated adults and 105 untreated children was, respectively, 26.5, 50.8 and 16.2 % for metronidazole; 18.4, 45.2 and 19 % for clarithromycin; 1, 2.4 and 0 % for amoxicillin; 4.4, 10.6 and 1.9 % for tetracycline; and 9, 14.5 and 5.8 % for ciprofloxacin. Triple resistance to the evaluated agents was uncommon and was detected in 1 % of the untreated children, 3.5 % of the untreated adults and 13.6 % of the treated adults. Five *H. pylori* strains were resistant to amoxicillin, metronidazole and clarithromycin, two of them exhibiting quadruple resistance. Resistance to four of the five antibacterials tested was found in 0.7 % of the untreated and 1.8 % of the treated adults. The overall level of multidrug resistance in the treated adults (15.4 %) was higher than that in the untreated adults (4.2 %, \( P=0.0001 \)) and the untreated children (1 %, \( P=0.0001 \)). The presence of multidrug *H. pylori* resistance in Bulgaria could be associated with many factors, among them the slightly increasing national use of macrolides, lincosamides and streptogramins and of quinolones since 2000, the significant increase in primary *H. pylori* clarithromycin resistance, the high tetracycline use between 1994 and 1999, and, in individual cases, the use of azithromycin-based regimens or reuse of nitrimidazoles. In conclusion, for the first time in a European country during the last 5 years, *H. pylori* strains harboring a worrying quadruple antibacterial resistance were found in treated as well as in untreated patients. *H. pylori* susceptibility patterns have a tendency to become unpredictable and should be monitored constantly at both national and global levels.

INTRODUCTION

One important reason for the failure of *Helicobacter pylori* eradication is antibacterial resistance (Morgner et al., 2006). This resistance is most often due to point mutations and can result from inappropriate or frequent antibiotic use (Megraud & Lehours, 2007). The genes responsible for the mutations are the 23S rRNA gene for the macrolides, \( rdxA \) and \( frxA \) for metronidazole, \( gyrA \) for the quinolones, \( rpoB \) for rifampin, \( pbp1 \) for amoxicillin and the 16S rRNA gene for tetracycline (Megraud & Lehours, 2007). In addition, some non-specific proteins, such as HP1092 and the \( hefC \) gene product, have been associated with *H. pylori* multidrug resistance (Kutschke & de Jonge, 2005; Saidijam et al., 2006).

In adults, the primary *H. pylori* resistance rates to clarithromycin vary from 0 to 25 % (Megraud & Lehours, 2007). Macrolide resistance is sometimes higher in children than in adults because children are treated with macrolides for respiratory infections more often than adults (Koletzko et al., 2006). Primary resistance rates to metronidazole have been 20–40 % in the USA and Europe, but in developing countries, the rates have been higher (from 50 to >80 %), whilst conversely, in Japan, the rates have been low (1.1–12 %) (Kobayashi et al., 2007; Megraud & Lehours, 2007). Primary *H. pylori* resistance to amoxicillin is uncommon (often 0–2 %) and has been detected in only a few countries; similarly, tetracycline resistance is low except for several countries such as South Korea and Taiwan (Hu et al., 2007). Conversely, because of the increasing use of fluoroquinolones in many countries, quinolone resistance in *H. pylori* has increased and has reached >20 % in adult patients in Japan and Portugal (Megraud & Lehours, 2007; Miyachi et al., 2006). Post-treatment resistance to gatifloxacin has been found to be 47.9 % in Japan (Nishizawa et al., 2006). The double-drug *H. pylori* resistance rate has usually been <10 % in Europe (Koletzko et al., 2006; Megraud & Lehours, 2007), whilst triple resistance to amoxicillin, metronidazole and clarithromycin in *H. pylori* has been only occasional (Torres et al., 2001).
The aim of the present study was to evaluate the presence and prevalence of multidrug-resistant *H. pylori* in Bulgaria between 2005 and 2008.

**METHODS**

**Patients and specimens.** A total of 1057 consecutive *H. pylori* strains, isolated in 2005–2008, were evaluated, comprising strains from untreated adults aged 18–87 years (mean age 43.5 years, 828 cases), untreated children aged 3–17 years (mean age 12.0 years, 105 cases) and treated adults aged 18–75 years (mean age 46.5 years, 124 cases). The untreated children comprised 46 boys and 59 girls, the untreated adults 471 men and 357 women, and the treated adults 72 men and 52 women. The untreated children had chronic gastritis (86 cases), duodenal ulcer (nine cases), gastric ulcer (one case), gastroesophageal reflux disease (GORD; five cases) and other diseases (four cases). The untreated and treated adults had chronic gastritis (428 and 60 cases, respectively), duodenal ulcer (200 and 28 cases), gastric ulcer (58 and 12 cases), gastric cancer (six and one cases), GORD (125 and 16 cases) and other diseases, such as gastric polyp and hiatal hernia (11 and seven cases). Informed written consent was obtained from all adults and the parents of all children. The isolation and identification of strains were performed as described previously (Boyanova et al., 2008). Specimens from the treated patients were taken at least 1 month after the end of the *H. pylori* treatment. The most common eradication regimens involved: (i) a proton pump inhibitor (PPI; omeprazole or esomeprazole) + amoxicillin + clarithromycin (38 cases); (ii) PPI + amoxicillin + metronidazole (22 cases); (iii) PPI + amoxicillin + azithromycin (three cases); (iv) PPI + clarithromycin + metronidazole (one case); (v) metronidazole + tetracycline + bismuth compounds + PPI (four cases); (vi) PPI + amoxicillin + clarithromycin + bismuth compounds (one case); and (vii) more than one regimen (five cases). No data were available for the previous treatment of the remaining 50 patients.

**Microbiology.** The breakpoint susceptibility testing (BST) method is a simplified agar dilution method, using one to four consecutive concentrations of the antibacterial agent. In our previous study, the category agreement between the BST and the Etest or agar dilution method results was found to be high (93.3–100 %) (Boyanova et al., 2008). In the present study, BST was used for susceptibility testing of *H. pylori* as described previously (Boyanova et al., 2008). Briefly, *H. pylori* suspensions were inoculated onto Mueller–Hinton blood agar plates (National Centre of Infectious and Parasitic Diseases, Sofia, Bulgaria) containing one of the following drug concentrations: 8, 16 and 32 μg metronidazole ml⁻¹; 0.25, 0.5, 1 and 2 μg clarithromycin ml⁻¹; 0.5, 1 and 2 μg amoxicillin ml⁻¹; 4 μg tetracycline ml⁻¹; and 1 μg ciprofloxacin ml⁻¹. Susceptibility testing for ciprofloxacin was carried out as a marker for strain susceptibility to newer quinolones such as levofloxacin (Megraud & Lehours, 2007). The plates were incubated microaerobically (Campy Pak; BBL) at 35 °C for 2–3 days. Non-selective Mueller–Hinton blood agar plates were used as a control of strain viability.

The susceptibility patterns of 15 strains with multidrug resistance (eight randomly selected strains with triple resistance and all seven strains with quadruple resistance) were also evaluated by the agar dilution method for metronidazole and Etest (AB Biodisk and Oxoid) for the other agents. Bacterial suspensions (density of 2–3 McFarland standards) were prepared in Mueller–Hinton broth and inoculated onto Mueller–Hinton agar with 5 % sheep blood. Etest strips were placed on the plates (one strip per 90 mm diameter plate) and the plates were incubated at 35 °C for 48–72 h in microaerophilic conditions (as above). The results were read according to the supplier’s recommendations.

The breakpoints for resistance were >8 μg metronidazole ml⁻¹, >1 μg clarithromycin ml⁻¹, >0.5 μg amoxicillin ml⁻¹, >4 μg tetracycline ml⁻¹ and >1 μg ciprofloxacin ml⁻¹ (Megraud et al., 1999; NCCLS, 2000; Megraud & Lehours, 2007, Glocker et al., 2007). Secondary resistance was defined as resistance acquired during treatment by a strain that was susceptible to the agent before treatment. The control strains used for the BST and agar dilution method were two laboratory *H. pylori* isolates with known MICs, as well as *Staphylococcus aureus* ATCC 29213, *Escherichia coli* ATCC 25922, *Pseudomonas aeruginosa* ATCC 27853 and *Bacteroides fragilis* ATCC 25285 (with an appropriate anaerobic incubation).

**Statistical analysis.** Differences between the groups were assessed with a χ² test or Fisher’s exact test, as appropriate. *P* values <0.05 were considered significant.

**RESULTS AND DISCUSSION**

In the present study, *H. pylori* resistance rates in untreated adults and children were found to be: metronidazole 26.3 % (218/822 patients) and 16.2 % (17/105), respectively; clarithromycin 18.4 % (152/828) and 19.0 % (20/105); amoxicillin 1.0 % (8/825) and 0.0 % (0/105); tetracycline 4.4 % (33/744) and 1.9 % (2/103); ciprofloxacin 9.0 % (71/787) and 5.8 % (6/103); metronidazole + clarithromycin 8.0 % (66/822) and 6.7 % (7/105); and amoxicillin + metronidazole + clarithromycin 0.2 % (2/822) and 0 % (0/105). Primary resistance to metronidazone was significantly more common in untreated adults (26.5 %, 218/822 patients) than in untreated children (16.2 %, 17/105, *P*=0.022), whereas the differences in the resistance rates to the other agents were not significant (*P* ≥0.278).

The primary resistance rates of *H. pylori* were in the range of those frequently reported in Europe with slightly higher amoxicillin and tetracycline resistance rates and a lower metronidazole resistance rate in children. The primary resistance rate to clarithromycin was similar to that found in eastern and southern Europe (usually about 18 %) (Megraud & Lehours, 2007). The reported resistance of *H. pylori* in treated children and adults (35–68 % to metronidazole, 17–63 % to clarithromycin and 15–73 % to metronidazole + clarithromycin) can hinder the success of eradication (Chisholm et al., 2007; Gosciński et al., 2004; Kalach et al., 2007; Koletzko et al., 2006; Toracchio & Marzio, 2003; Tüzün et al., 2008). With the increasing number of prescriptions for *H. pylori* eradication and the involvement of new treatment regimens, post-treatment resistance to amoxicillin, tetracycline and quinolones has also been reported (Hsu et al., 2008; Koletzko et al., 2006; Nishizawa et al., 2006). Hsu et al. (2008) detected *H. pylori* resistance to amoxicillin and levofloxacin in 17 and 22 % of patients, respectively, after treatment with rabeprazole, bismuth compounds, amoxicillin and levofloxacin.

In the present study, *H. pylori* resistance rates in treated adults were: metronidazole 50.8 % (63/124 patients), clarithromycin 45.2 % (56/124), amoxicillin 24.2 % (3/124), tetracycline 10.6 % (13/123), ciprofloxacin 14.5 %
Multidrug resistance of \(H.\ pylori\) is occasional and found in individual countries or regions, for example in Sardinia, Mexico and Taiwan (Hu et al., 2007; Kwon et al., 2003). Resistance to amoxicillin, metronidazole and clarithromycin was detected in 6.8% of 44 Chinese children (Chen et al., 2004), as well as in 4% of the evaluated children and in 10.4% of the evaluated adults in Mexico (Torres et al., 2001). In the present study, five (0.5%) \(H.\ pylori\) strains of the 1051 strains tested for susceptibility to all five antibacterial agents, the total multidrug resistance rate in untreated adults (4.2%, 31/744, \(P=0.0001\)) and untreated children (1%, 1/103, \(P=0.0001\)). The triple and quadruple resistance rates were 1% (1/103 patients) and 0% (0/103) for the untreated children, 3.5% (26/744) and 0.7% (5/744) for the untreated adults, and 13.6% (15/110) and 1.8% (2/110), respectively, for the treated adults. It is of note that triple resistance to metronidazole, clarithromycin and tetracycline was found in an untreated 13-year-old girl with chronic gastritis.

It is known that the success of eradication of clarithromycin-resistant strains is 40–70% lower than that of susceptible strains (Megraud, 2004; Peitz et al., 2002). Metronidazole resistance is less important, usually decreasing the success of eradication by 25% (Bazzoli et al., 1999; Megraud & Lehours, 2007; Peitz et al., 2002). Amoxicillin resistance of \(H.\ pylori\) could also be clinically important. Although Kim et al. (2006) reported that amoxicillin resistance in \(H.\ pylori\) did not influence the success of eradication, other authors (Domingo et al., 2002) have detected decreased eradication success of strains with MICs \(\geq 0.032\) \(\mu\)g amoxicillin ml\(^{-1}\).

At present, the best-validated first-line regimen for \(H.\ pylori\) eradication consists of a PPI + clarithromycin + amoxicillin administered for 7–14 days (Malferttheiner et al., 2007). Within the strains tested for susceptibility to all five antibacterial agents in the present study, no significant differences were found between the resistance rate to both amoxicillin and clarithromycin (0%, 0/103 patients) in the untreated children and those in the untreated (0.3%, 2/744, \(P=1.000\)) and treated adults (3.6%, 4/110, \(P=0.122\)).

<table>
<thead>
<tr>
<th>Agents</th>
<th>Untreated children</th>
<th>Untreated adults</th>
<th>Treated adults</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No. of strains</td>
<td>No. resistant</td>
<td>% Resistant</td>
</tr>
<tr>
<td>Metronidazole + clarithromycin + ciprofloxacin</td>
<td>103</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Metronidazole + clarithromycin + tetracycline</td>
<td>103</td>
<td>1</td>
<td>1.0</td>
</tr>
<tr>
<td>Metronidazole + tetracycline + ciprofloxacin</td>
<td>103</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amoxicillin + metronidazole + clarithromycin</td>
<td>105</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amoxicillin + metronidazole + ciprofloxacin</td>
<td>103</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clarithromycin + tetracycline + ciprofloxacin</td>
<td>103</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Metronidazole + clarithromycin + tetracycline + ciprofloxacin</td>
<td>103</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amoxicillin + metronidazole + clarithromycin + tetracycline</td>
<td>103</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Amoxicillin + metronidazole + clarithromycin + ciprofloxacin</td>
<td>103</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total multidrug resistance*</td>
<td>103</td>
<td>1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

*Within the strains tested for susceptibility to all five antibacterial agents.
The prevalence of *H. pylori* strains with multidrug antibiotic resistances did not increase during the study period. Within the strains tested for susceptibility to all five antibacterial agents, the frequencies of *H. pylori* strains with multidrug antibiotic resistances in 2005–2006 and in 2007–2008 were 2.0 (1/50 cases) and 0.0 % (0/53, *P*=0.485) for the untreated children, 3.7 (16/436) and 5.2 % (16/308, *P*=0.312) for the untreated adults, and 19.6 (11/56) and 11.1 % (6/54, *P*=0.216) for the treated adults.

Except for amoxicillin, the MIC90 values of the antibacterial agents against all strains with multidrug resistance were very high (>32 μg ml⁻¹) (Table 3). The MICs for the strains with quadruple resistance to clarithromycin (MIC50 256 μg ml⁻¹ and MIC90 >256 μg ml⁻¹) and tetracycline (MIC50 >32 μg ml⁻¹) were higher than those for strains with triple resistance (MIC50 3 μg ml⁻¹, MIC90 64 μg ml⁻¹ for clarithromycin and MIC50 0.5 μg ml⁻¹ for tetracycline).

*H. pylori* strains harbouring triple or quadruple resistance could hinder the choice and success of the eradication regimen. According to one study, treatment using triple combinations containing amoxicillin was unsuccessful in a patient with *H. pylori* resistance to amoxicillin, clarithromycin and metronidazole (Han *et al.*, 1999). In Korea, 89.6 % of patients with eradication failure have been found to harbour *H. pylori* strains resistant to two or more antimicrobial agents (Kim, 2006).

Of the 48 strains with multidrug resistance to metronidazole and other agents, eight (16.7 %) had MICs of 16 μg metronidazole ml⁻¹. For similar strains, a quadruple therapy with lansoprazole, bismuth subsalicylate, metronidazole (reuse) and tetracycline for 14 days was found to be effective in >70 % of patients (Magaret *et al.*, 2001). Several empirical ‘rescue’ therapy regimens have been recommended for *H. pylori* eradication after failure of two eradication treatments, for example amoxicillin/PPI at high doses, rifabutin/amoxicillin/PPI or furazolidone/bismuth/tetracycline/PPI (Gisbert & Pajares, 2005). Adding non-antimicrobial agents (e.g. lactobacilli) to the eradication regimens can be beneficial to increase the eradication rate by up to 10 % or to minimize the side effects (Lesbros-Pantoflickova *et al.*, 2007). It is important to retreat unsuccessfully treated patients using a case-by-case approach and to perform a susceptibility-guided retreatment if available (Di Mario *et al.*, 2006).

Within the treated patients with a known previous eradication regimen, multidrug resistance was detected after treatment with PPI + amoxicillin + metronidazole (3/22 cases), PPI + amoxicillin + clarithromycin (2/38), PPI + amoxicillin + azithromycin (1/3), PPI + metronidazole + tetracycline + bismuth compounds(1/4), and in more than one regimen (1/5). The presence of multidrug resistance in *H. pylori* in Bulgaria could be associated with the slightly increasing national use of macrolides, lincosamides and streptogramins [0.1%, 1.75 defined daily doses per 1000 inhabitants per day (DID) in 2006] and

### Table 2. Characteristics of the seven patients with quadruple resistance, with previous resistance patterns for the treated patients

<table>
<thead>
<tr>
<th>No.</th>
<th>Sex</th>
<th>Age (years)</th>
<th>Disease</th>
<th>Treatment</th>
<th>R/S (MIC; μg ml⁻¹)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Amoxicillin</td>
</tr>
<tr>
<td>1</td>
<td>M</td>
<td>63</td>
<td>Duodenal ulcer</td>
<td>Untreated</td>
<td>R (1)</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>46</td>
<td>Chronic gastritis</td>
<td>Untreated</td>
<td>S (0.125)</td>
</tr>
<tr>
<td>3</td>
<td>M</td>
<td>28</td>
<td>Chronic gastritis</td>
<td>Untreated</td>
<td>S (≤0.125)</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>53</td>
<td>Chronic gastritis</td>
<td>Untreated</td>
<td>S (≤0.125)</td>
</tr>
<tr>
<td>5</td>
<td>F</td>
<td>51</td>
<td>Duodenal ulcer</td>
<td>Untreated</td>
<td>S (≤0.125)</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>27</td>
<td>Duodenal ulcer</td>
<td>Treated*</td>
<td>S (≤0.125)</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>42</td>
<td>GORD</td>
<td>Treated‖</td>
<td>R (1)</td>
</tr>
</tbody>
</table>

*Treated with omeprazole, amoxicillin and metronidazole.
§Resistant subpopulation.
‖No data about the treatment regimen.

### Table 3. MICs (μg ml⁻¹) of antibacterial agents against 15 multidrug-resistant *H. pylori* isolates by the agar dilution method (ADM) for metronidazole and Etest for the other agents

<table>
<thead>
<tr>
<th>Agent (method)</th>
<th>MIC50</th>
<th>MIC90</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clarithromycin (Etest)</td>
<td>6</td>
<td>&gt;256</td>
<td>0.023 to &gt;256</td>
</tr>
<tr>
<td>Metronidazole (ADM)</td>
<td>&gt;32</td>
<td>&gt;32</td>
<td>0.25 to &gt;32</td>
</tr>
<tr>
<td>Amoxicillin (Etest)</td>
<td>≤0.125</td>
<td>1</td>
<td>≤0.125 to 1</td>
</tr>
<tr>
<td>Tetracycline (Etest)</td>
<td>8</td>
<td>&gt;32</td>
<td>&lt;0.125 to &gt;32</td>
</tr>
<tr>
<td>Ciprofloxacin (Etest)</td>
<td>4</td>
<td>&gt;32</td>
<td>&lt;0.125 to &gt;32</td>
</tr>
</tbody>
</table>

http://jmm.sgmjournals.org
quinolones (J01M, 1.79 DID in 2006) since 2000 (European Surveillance of Antimicrobial Consumption data for 2006; http://www.esac.ua.ac.be/). Although its use has been decreasing since 2000 (to 2.42 DID in 2006), tetracycline use was very high (>4.2 DID) from 1994 to 1999 (Markova et al., 2005). Within the European countries in 2006, Bulgaria has been a country of moderate total antibiotic use (Muller et al., 2007). However, it is of note that, in Bulgaria, primary clarithromycin resistance in \( H. pylori \) has increased significantly from 10% in 1996–1999 to 17.9% in 2005–2007 (Boyanova et al., 2008). Overall primary metronidazole resistance was stable during this period. Other reasons for unsuccessful eradication and the appearance of multidrug resistance could be the use of azithromycin-based triple regimens in three cases, including one case with triple resistance of the strain, and the reuse of nitroimidazoles in one case. Anagnostopoulos et al. (2003) reported successful eradication after azithromycin-based triple regimens in only 62–71% of the evaluated patients.

In conclusion, multidrug (triple and quadruple) resistance to the key antibacterial agents for eradication of \( H. pylori \) infection was generally uncommon but was present in 1% (1/103 cases) of untreated children, in 4.2% (31/744) of untreated adults and in a higher proportion (15.4%, 17/110) of treated adults. Eradication of \( H. pylori \) strains harbouring multidrug resistance requires susceptibility testing of the isolate and should be determined with caution for individual patients. \( H. pylori \) susceptibility patterns tend to become unpredictable and should be monitored constantly at both national and global levels. 

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