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β-Lactamase-Producing Nontypeable *Haemophilus influenzae* Fails To Protect *Streptococcus pneumoniae* from Amoxicillin during Experimental Acute Otitis Media

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Acute otitis media (AOM) is the most common reason for outpatient antimicrobial therapy. Mixed infections pose a potential problem, since the first-line drug used for the treatment of AOM, amoxicillin, can be neutralized by β-lactamase-producing pathogens of the upper respiratory tract. To study the effects of a 5-day course of amoxicillin on a mixed middle ear infection, rats were challenged with *Streptococcus pneumoniae* alone or in combination with β-lactamase-producing nontypeable *Haemophilus influenzae*. Amoxicillin was introduced at the clinical peak of the infection. Local and systemic changes were monitored by otomicroscopy, bacterial culture, and analysis of histological changes and the expression of the transforming growth factor beta (TGF-β) gene. β-Lactamase-producing *H. influenzae* did not demonstrate an ability to protect *S. pneumoniae*. Amoxicillin eradicated the pneumococci in all treated animals but increased to some degree the ability of *H. influenzae* to persist at the site of infection. Thus, only an insignificant acceleration of the resolution of the AOM caused by a mixture of pathogens was observed during treatment. Moderate to major morphological changes could not be avoided by treatment of the mixed infections, but a slight downregulation of TGF-β expression was observed. In contrast to infections caused by a single pathogen, the mixed infections induced white plaques in the tympanic membrane at a remarkably high frequency independent of treatment. These experimental findings constitute support for further studies of antimicrobial drugs and AOM caused by bacteria with and without mechanisms of antibiotic resistance.

Acute otitis media (AOM) is one of the most common bacterial infections in pediatric patients. The predominant pathogens causing AOM are *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *Moraxella catarrhalis* (22). Of these three agents *S. pneumoniae* has the lowest spontaneous clearance rate, and it is the microorganism most often associated with severe and fatal complications of AOM (1, 18, 25). As a consequence, the antimicrobial drug used for the treatment of AOM in routine practice must have a spectrum which covers this bacterium to be efficacious.

Hitherto, amoxicillin has been the first-line therapeutic choice in several countries (10, 14). Its pharmacokinetic and pharmacodynamic profiles are attractive, but its utility is sometimes compromised by an increasing proportion of β-lactam-resistant isolates. About 14 to 65% of the nontypeable (NT) *H. influenzae* isolates from the middle ear produce β-lactamase (16, 20, 22, 24). For *M. catarrhalis* isolates the frequency is virtually 100% (20, 22, 24). Because of the high rate of β-lactamase production in these two species, the use of β-lactamase-resistant drugs such as macrolides and trimethoprim-sulfamethoxazole is often recommended (9). However, many of these antibiotics are not entirely effective as empirical treatment for AOM, especially macrolides for the treatment of infections caused by NT *H. influenzae*, and they may increase the rates of nasopharyngeal carriage of resistant organisms and promote their spread (7, 8, 28).

It has been suggested that β-lactamases not only protect the producing bacteria themselves but also frustrate the therapy of concomitant infections caused by penicillin-susceptible respiratory tract pathogens with penicillins, resulting in a sheltering effect. There is experimental evidence for such a sheltering effect for *Staphylococcus aureus* in group A beta-hemolytic streptococcal abscesses (3) and *M. catarrhalis* in pneumococcal pneumonia (21). *S. pneumoniae* and NT *H. influenzae* coexist in up to 10% of the samples of middle ear fluid (16). The activity of amoxicillin against the pneumococcus in a mixed infection could thereby be threatened.

In order to explore a possible sheltering effect for β-lactamase-producing NT *H. influenzae* in amoxicillin-treated pneumococcal AOM, a well-established rat model of AOM was used. Apart from the clinical and bacteriological outcomes, protection against reinfection, morphological changes, and expression of transforming growth factor beta (TGF-β) were also analyzed.

**MATERIALS AND METHODS**

**Animals and surgical procedures.** Healthy male Sprague-Dawley rats (weight, 250 to 350 g) were used. The study protocol was approved by the Ethics Committee of Lund University, and the animals were managed as described previously (31). During anesthesia induced with chloralhydrate (Apteksbolaget, Malmö, Sweden) and after a blunt dissection of the soft tissue in the neck, approximately 50 μl of a bacterial suspension was inoculated directly into the middle ear cavity through the bony wall of the bulla. The tympanic membrane was left intact, and correct inoculation was verified with an otomicroscope.
from these frozen stocks onto solid medium. The media used were chocolate and

- Morphological changes on days 8, 28, 32, and 56; middle ear fluid cultures

- Serum amoxicillin concentration determination; cytokine gene expression on
day 56; middle ear fluid cultures

- Otomicroscopy on days 3, 8, 28, 32, and 56; middle ear fluid cultures

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A bacterial and media. Two bacterial strains isolated at the Department of Medical Microbiology at Malmö University Hospital were used: S. pneumoniae type 3 (amoxicillin MIC and minimal bactericidal concentration [MBC], 0.032 and 0.125 mg/liter, respectively; ampicillin MIC and MBC, 0.016 and 0.064 mg/liter, respectively) and H. influenzae strain 3144-hybo II (amoxicillin MIC and MBC, 128 and >256 mg/liter, respectively; ampicillin MIC and MBC, 32 and >256 mg/liter, respectively). The MICs and MBCs were determined by Etest,

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of these animals belonged to untreated group C with mixed infections, whereas the remaining four belonged to either treatment group B with mixed infections \( (n/H10052) \) or group D with untreated pneumococcal infections \( (n/H10052) \). The courses of these contralateral infections were relatively short, and they were resolved on day 7 in all but two animals. These two animals belonged to untreated pneumococcus-infected group D and exhibited opaque effusions behind the tympanic membrane on day 8. Seven animals (9%) developed severe, systemic infections and died. Four of these animals (57%) had bilateral infections. In group A, the deaths \( (n = 2) \) occurred early and before or just after the antibiotic treatment of the pneumococcal AOM had been initiated, i.e., on days 3 and 4. In group B, which consisted of animals with treated mixed infections, the animals succumbed \( (n = 2) \) on days 4 and 5, and in group C, which consisted of animals with untreated mixed infections, the animals succumbed on days 4 \( (n = 1) \) and 6 \( (n = 2) \). All seven animals were excluded from further studies.

The otomicroscopic aspects of untreated and amoxicillin-treated AOM are shown in Fig. 1. The treatment accelerated the resolution of the infection. The most rapid clearance took place in group A (treated pneumococcal infections), which was statistically faster than that observed in the groups with mixed infections, groups B (treated) and C (untreated). The only group in which all animals had a normal status on day 8 was untreated group E, challenged with NT \( H. influenzae \). There was, however, no substantial difference between this group and groups B \( (P = 0.06) \) and C \( (P = 0.08) \). Opaque effusions could be observed only in animals in group B (treated mixed infections) and group D (untreated pneumococcal infections) after day 7.

The proneness to develop AOM after rechallenge of the left middle ear was similar among animals in groups A to C. The protective rate is presented in Table 2. The otomicroscopic appearance of the right tympanic membrane was also evaluated in these three groups. On day 56, the presence of white plaques in the tympanic membrane was substantial in the right ears of all animals with resolved mixed infections. The plaques extended over both the pars flaccida and the pars tensa of the tympanic membrane, and this was independent of antibiotic therapy. In animals challenged with the pneumococcal strain alone, the white plaques in the right tympanic membrane were limited to the pars tensa. After rechallenge the myringosclerosis-like changes were restricted to the vessel area of the pars tensa in the left ears of animals in all groups.

**Antibiotic and bacteriological data.** There were no differences in the levels of water consumption between the animal groups, and the treatment was well tolerated. The daily dose of amoxicillin was 58 ± 9 mg/kg of body weight, as deduced from the level of water consumption. Serum amoxicillin concentrations were 4 ± 3 μg/ml (range, 1.7 to 6.1 μg/ml).
The frequencies of positive middle ear fluid cultures on days 3 and 8 in the various groups are shown in Table 2. On day 3, 96% of the middle ear fluid cultures were positive, and for 56% of the animals with mixed infections, NT _H. influenzae_ overgrew the pneumococci. The effect of amoxicillin on pneumococcal growth was significant in both animals with mixed infections and animals with pure pneumococcal infections. None of the specimens from animals in treatment groups A and B yielded growth of pneumococci on day 8, whereas the values for untreated groups C and D were 40% (_P = 0.04_) and 100% (_P = 0.003_), respectively. In contrast to the pneumococci, the β-lactamase-producing NT _H. influenzae_ exhibited a slight tendency to persist at the infection site during treatment (Table 2, groups B and C). This tendency was not statistically significant (_P = 0.08_).

**Structural observations and expression of TGF-β.** The structural changes are summarized in Table 3. On day 3, the specimens were categorized into two groups. In the group with major changes, specimens exhibited a massive inflammatory response with abundant inflammatory cells (Fig. 2a). The degree of epithelial proliferation could not be determined due to the inflammatory changes. Sclerosis occurred in one specimen. On day 8, the degree of inflammation had decreased in three animals treated with amoxicillin. All but one of the specimens with mixed infections were assigned to the category with major changes, with numerous inflammatory cells still present. Gland-like formations and polyps in the fossa nasalis extended into the middle ear cavity in some specimens, and sclerosis occurred. Ciliated cells and goblet cells were increased in number and were also present in the inner epithelium of the pars flaccida. After 56 days, the middle ears of treated animals challenged with _S. pneumoniae_ had no or minor changes (Fig. 2b) or moderate changes, whereas the specimens from the groups with mixed infections exhibited moderate changes (Fig. 2c) or major changes (Fig. 2d). The major changes were characterized by extensive alterations in the epithelium in the fossa nasalis, with several newly formed layers of epithelial cells and connective tissue and increased numbers of ciliated and secretory cells. Islands of epithelial cells were observed in subepithelial tissue, and polyps extended into the middle ear cavity. The pars flaccida was thickened, and ciliated cells were present in the inner epithelium. Three of four specimens from the animals with amoxicillin-treated mixed infections (group B) and three of five specimens from the animals with untreated mixed infections (group C) were assigned to this category.

The expression of TGF-β differed between the animal groups with mixed infections. The transcript levels were lower for animals in group B (amoxicillin treated; mean, 25.9 ± 11.1 fg) than animals in group C (untreated; mean 35.4 ± 27.5 fg), but the difference was not statistically significant (_P = 0.34_).

**DISCUSSION**

In vitro and in vivo studies have demonstrated the ability of β-lactamase-producing strains to protect penicillin-susceptible

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**TABLE 2. Frequency of positive middle ear fluid cultures during primary infection and protective rate after rechallenge**

<table>
<thead>
<tr>
<th>Animal group</th>
<th>Inoculum</th>
<th>Growth (no. of specimens with growth/total no.) on:</th>
<th>Protective rate (no. of animals protected/total no. [%])</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Pnc</td>
<td>Day 3: 0/10 Day 8: 2/4 (50)</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Pnc and NTHi</td>
<td>Day 3: 0/11 (Pnc), 5/11 (NTHi) Day 8: 4/10 (Pnc), 1/10 (NTHi)</td>
<td>5/8 (62)</td>
</tr>
<tr>
<td>C</td>
<td>Pnc and NTHi</td>
<td>Day 3: 3/3 Day 8: 3/3</td>
<td>4/8 (50)</td>
</tr>
<tr>
<td>D</td>
<td>Pnc</td>
<td>Day 3: 3/3 Day 8: 2/6</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviations: 0, no changes; a, minor changes; b, moderate changes; c, extensive changes; NA, not applicable; ab, antibiotic treatment.

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**TABLE 3. Summary of structural changes in pars flaccida and fossa nasalis in relation to time and challenge group**

<table>
<thead>
<tr>
<th>Day</th>
<th>Category</th>
<th>Histological findings</th>
<th>Category assignment by challenge group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Inflammatory cells</td>
<td>Metaplasia</td>
</tr>
<tr>
<td>3</td>
<td>Moderate changes</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>Major changes</td>
<td>+++</td>
<td>+++</td>
</tr>
<tr>
<td>8</td>
<td>Moderate changes</td>
<td>+</td>
<td>+/+</td>
</tr>
<tr>
<td></td>
<td>Major changes</td>
<td>++</td>
<td>++/+++</td>
</tr>
<tr>
<td>56</td>
<td>No or minor changes</td>
<td>0</td>
<td>0/+</td>
</tr>
<tr>
<td></td>
<td>Moderate changes</td>
<td>0/+</td>
<td>++</td>
</tr>
<tr>
<td></td>
<td>Major changes</td>
<td>++</td>
<td>++/+</td>
</tr>
</tbody>
</table>

Abbreviations: 0, no changes; a, minor changes; b, moderate changes; c, extensive changes; NA, not applicable; ab, antibiotic treatment.
FIG. 2. Light micrographs representing pars flaccida after challenge. (a) major changes prior to treatment on day 3; (b) no or minor changes on day 56 after treatment of pneumococcal infection, (c) moderate changes on day 56 caused by mixed infections; and (d) major changes on day 56 caused by mixed infections. Magnifications, ×336.
bacteria in localized mixed infections at various sites (3, 4, 19, 21). In contrast to that work, the present study could not demonstrate this phenomenon. Despite the presence of NT H. influenzae cells, which produced sufficient amounts of β-lactamase to protect themselves, the pneumococci were successfully eradicated from the rat middle ear by the amoxicillin treatment. These findings indicate that the degrading effect may vary with the type of β-lactamase and the microorganism producing the β-lactamase. Thus, the presence of β-lactamase-producing upper respiratory tract pathogens or commensal organisms in polymicrobial infections or in the immediate surroundings does not automatically render penicillins ineffective against otherwise susceptible bacteria. Results similar to the present results have been demonstrated in a surgical animal model by Renneberg and Walder (33) and indirectly in a clinical study by Joki-Erkkilä et al. (23).

Although H. influenzae did not frustrate the amoxicillin treatment of S. pneumoniae infections, the inadequate antibiotic coverage against this microorganism resulted in moderate to major structural changes in the middle ear mucosa. These changes did not affect the protective rate, but in the majority of the group B animals with treated mixed infections the changes were more extensive than those usually observed after untreated AOM induced by NT H. influenzae (31). The substantial myringosclerotic-like changes found in all animals with mixed infections, independent of treatment, also indicate that considerable injury to the tympanic membrane was caused by the combination of gram-positive and gram-negative bacteria. The development of white plaques in both the pars flaccida and the pars tensa in 100% of the animals has not previously been observed in this model of AOM. The fact that the first case of sclerosis was recorded on day 3 and the fact that the antibiotic treatment did not reduce the frequency of white plaques in the tympanic membrane, their distributions, or the morphological alterations to the mucosa suggest that the initial tissue injury was established early during the course of AOM and was probably established prior to the introduction of antibiotic treatment.

How the two bacterial species may interact with each other in the middle ear cavity is not known, but Elliott and coworkers (11) have shown that the relationship can be close and of a parasitic or symbiotic nature. In the present study, the overgrowth of NT H. influenzae in the middle ear tissue cultures on day 3 and the shift from early to late deaths when NT H. influenzae was added to the inoculum support the idea of a bacterial interaction or local competition. Despite a possibly competitive situation that might limit bacterial expansion to some extent, a mixed infection in the middle ear appeared to increase the strain on host tissues and defenses. Mixed infections are most common in AOM patients with treatment failure (16). To avoid long-standing mixed infections, measures in the form of tympanocentesis and a change of treatment to an antibiotic with a broader spectrum of activity should probably be taken without delay in suspected cases.

The widespread use of antibiotics for the treatment of AOM has lately led to prevalent β-lactamase production among the leading gram-negative pathogens of the middle ear, so why insist on using amoxicillin and not amoxicillin-clavulanate (AMC) as the first-line drug? Apart from differences in virulence and spontaneous recovery rates between gram-positive and gram-negative pathogens, ecological issues must be considered. The impact of AMC on the gastrointestinal flora is not negligible (15, 29), but of more concern is its effect on the nasopharyngeal flora. A wider spectrum of bacteria is eradicated by AMC than amoxicillin (5), and the competitive balance between pneumococci and commensal organisms could thereby be disturbed (17). Cultures of nasopharyngeal specimens from otitis-prone children show low numbers of alpha-hemolytic streptococci with activity that interferes with common pathogens that cause otitis (34), and significantly fewer children recently treated with amoxicillin than those treated with AMC have been shown to be prone to otitis (2). Furthermore, in the work of Joki-Erkkilä et al. (23), the presence of β-lactamase-producing M. catarrhalis, but not β-lactamase-producing H. influenzae, appeared to prevent the development of penicillin resistance among pneumococcal isolates in the nasopharynx, presumably by reducing the selection pressure. In this context, it is interesting to compare the remarkably low frequency of isolation of M. catarrhalis and the high frequency of isolation of penicillin-resistant pneumococcus in Spain with the corresponding frequencies found in northern Europe and the United States (6, 9, 24).

In an era with a high prevalence of resistance among pathogens of the middle ear, the potential benefit to the individual who is treated with antibiotics must be weighed against the public health risk for the emergence of resistant microorganisms. In Scandinavia the frequency of isolation of pneumococci with reduced susceptibilities to penicillin is lower than that in most European countries (12, 26, 27), and penicillin V is still, after more than 45 years, the drug of choice for the treatment of AOM, with S. pneumoniae as the primary target. The step from treatment with penicillin V and amoxicillin to AMC might appear to be short, but it requires consideration and should probably not be taken unless it is called for.

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