Lack of evidence for mutation to erythromycin resistance in clinical strains of *Staphylococcus aureus*

R. W. LACEY

*From the Department of Pathology, West Norfolk and King’s Lynn General Hospital*

**SUMMARY** The properties of 100 erythromycin resistant strains of *Staphylococcus aureus* obtained from clinical material have been compared with the properties of mutants selected in *vitro* for resistance to erythromycin. The properties, including inducibility of the resistance and cross-resistance to spiramycin and lincomycin, of the two groups of isolates were always different. The risk that staphylococci will mutate to erythromycin resistance during therapy with this antibiotic is remote.

Soon after erythromycin was introduced, strains of *Staphylococcus aureus* and other species appeared that were resistant to this antibiotic. Erythromycin resistant organisms were also relatively easy to select from sensitive bacterial populations *in vitro*. These observations resulted in the recommendation that there should be some restriction in the use of erythromycin in order to limit the incidence of resistant bacteria. Also, erythromycin was often used either in short courses or combined with another antibiotic in order to reduce the apparent risk of mutation to resistance (Cruickshank *et al.*, 1973).

However, two aspects of erythromycin resistance in *Staph. aureus* posed problems:

1. The mutants selected *in vitro* were often slow growing and unstable, whereas resistant isolates from clinical material generally had normal growth rates and appeared to be fully virulent (Garrod *et al.*, 1973).

2. The nature of the resistant clinical isolates sometimes differed from the laboratory mutants in that the former could be resistant to erythromycin only (dissociated resistance; see Garrod (1957) and Weaver and Pattee (1964)) whereas the latter were always resistant to other macrolide antibiotics in addition to erythromycin.

These phenomena suggest that the laboratory manipulations may not always be a true reflection of the occurrence of events *in vivo*; ie, the explanation for erythromycin resistant bacteria appearing *in vivo* may not be a succession of mutants as presumably occurs with ‘training’ methods *in vitro*.

In this paper the properties of 100 naturally occurring erythromycin resistant strains of *Staph. aureus* are compared with those of isolates made resistant *in vitro*. In no instance has a clinical isolate been found to possess properties identical with those of laboratory mutants.

**Material and methods**

**STRAINS OF STAPHYLOCOCCUS AUREUS**

Twenty recent clinical isolates of different phage typing pattern were used in an attempt to select erythromycin resistant mutants *in vitro*. One hundred erythromycin resistant strains of *Staph. aureus* were collected from clinical material in Bristol (52) between 1969 and 1974 and in King’s Lynn and Wisbech (48) between 1974 and 1976. Each isolate was judged to be epidemiologically distinct, and the majority (72) had different sensitivity to antibiotics other than erythromycin or different phage typing patterns. The isolates were stored on nutrient agar slopes at room temperature without subculture. Before detailed examination, single colony isolates were obtained and stored on nutrient agar plates at 4°C.

**DETERMINATION OF SENSITIVITY**

Minimum inhibitory concentrations (MIC) of antibiotics were detected as previously, using an agar incorporation method generally with about 50 colony-forming units per inoculum (Lacey *et al.*, 1975).

**MEDIA**

Nutrient agar used throughout was Oxoid Blood Base No. 2. Peptone water was Oxoid (CM9).

Phage typing was performed as previously (Lacey...
Lack of evidence for mutation to erythromycin resistance

et al., 1975) with the inclusion of the new phages 94 and 96.

ANTIBIOTICS

Erythromycin ethyl succinate (Abbott), Spiramycin (May and Baker), and Lincomycin hydrochloride (Upjohn) were used in concentrations equivalent to each base. Erythromycin ethyl succinate was dissolved in ethylene glycol before addition to media.

Results

DEVELOPMENT OF ERYTHROMYCIN RESISTANCE IN VITRO

Nutrient agar plates (containing no antibiotics) were inoculated in duplicate from single colonies of each of 20 erythromycin sensitive (MIC = 0.25 μg erythromycin per ml) strains. Plates were then incubated for 18 h at 37°C and the surface cultures that resulted were combined for each strain into 10 ml quarter strength Ringer solution. Surface viable counts were performed on 0.1 ml of each of the resultant slurries, and then 1 ml of each of the slurries was applied in duplicate to the surface of the nutrient agar plates containing 0.1, 1, 5 or 50 μg erythromycin/ml. After drying the plates were incubated for 48 h at 37°C. As expected, the surface of all plates containing 0.1 μg erythromycin/ml contained confluent growth. All 20 strains yielded small discrete colonies on agar containing 1 μg/ml, but only seven strains produced any colonies on media containing 5 μg erythromycin/ml, and no bona fide mutants were detected on nutrient agar containing 50 μg erythromycin/ml. (During the course of these experiments a few highly resistant colonies were detected, but investigation of these, including phage typing pattern, indicated that none was Staph. aureus.)

The number of bacteria inoculated onto each plate varied from $8 \times 10^{11}$ to $2.0 \times 10^{13}$, so that from a total of about $5 \times 10^{14}$ bacteria applied not a single high-level (resistant to 50 μg erythromycin/ml) one-step mutant was obtained. However, since erythromycin resistance in clinical strains is usually inducible (see below), the failure to detect such mutants could be because the cultures had not been exposed previously to subinhibitory concentrations of erythromycin. To exclude this possibility, the slurry from agar containing 0.1 μg erythromycin/ml was applied to the surface of nutrient agar plates containing 50 μg/ml of the drug. After 48 h incubation at 37°C no colony appeared from an inoculum of $3 \times 10^{14}$ bacteria.

However, when the cultures were transferred as above from media containing 0.1 μg erythromycin/ml successively to 1, 5, 25, and then 50 μg/ml concentrations, each plate yielded either semiconfluent growth or discrete colonies. However, every resistant colony so produced was much smaller than equivalent colonies on similar media from naturally occurring resistant isolates, or from sensitive staphylococci inoculated onto antibiotic free media. Two colonies of each strain were picked from the agar containing 50 μg erythromycin/ml and examined further.

PROPERTIES OF ERYTHROMYCIN RESISTANT MUTANTS SELECTED IN VITRO

The 40 mutants were picked off onto nutrient agar, phage typed, and then inoculated into peptone water for MIC determination. All were inhibited by between 5 and 100 μg erythromycin/ml and between 25 and 1000 μg spiramycin/ml. All were more resistant, by a factor of at least fivefold, to spiramycin than to erythromycin (Table 1).

That some were inhibited by levels as low as 5 μg erythromycin/ml was due to instability of the resistance. Sixteen of the 40 isolates showed this after three subcultures, when the population of bacteria comprised a mixture of slow-growing erythromycin resistant colonies (colony diameters ≈ 0.5 mm) and normal growing colonies (colony diameter > 2 mm) that were either sensitive (MIC < 0.5 μg/ml) or only slightly resistant (MIC 0.5-5 μg/ml).

None of the mutants was resistant to high levels of lincomycin (MIC < 1.0 μg/ml).

It has been found that pre-incubation of resistant colonies from clinical material in peptone water containing 0.10 μg/ml erythromycin is adequate to cause full induction of erythromycin resistance (Weaver and Pattee, 1964). The mutants were therefore incubated in peptone water containing either 0.02 μg or 0.20 μg erythromycin/ml before determination of MICs. This treatment did not increase the level of resistance to either erythromycin, lincomycin or spiramycin, ie, the resistance of the mutants was non-inducible.

PROPERTIES OF ERYTHROMYCIN RESISTANT STRAINS OF STAPHYLOCOCCUS AUREUS ISOLATED FROM CLINICAL MATERIAL

All the isolates produced normal colonies morphologically and were coagulase and DNase positive. Sixty-one were obtained from lesions with pus. Single cell MICs were obtained after incubation in peptone water with or without the addition of 0.02 μg erythromycin/ml.

Three patterns of sensitivity resulted (Table 2):

1 Inducible resistance to erythromycin in 84 strains

In these, the MIC of erythromycin without pre-
incubation with the antibiotic varied from 1 to 25 
μg/ml. After pre-incubation, the MIC was always 
greater than 1000 μg/ml. These strains were sensitive 
to lincomycin (MIC < 1 μg/ml) and spiramycin 
(MIC < 25 μg/ml) whether or not the cultures were 
pre-incubated with erythromycin. On disk testing 
with lincomycin and erythromycin disks adjacent, all 
these strains showed ‘dissociated’ resistance in 
which the presence of erythromycin appeared to 
cause resistance to lincomycin (Garrod et al., 1973). 
However, by MIC determination erythromycin did 
not seem to induce lincomycin resistance (see above), 
so the explanation for this type of zone phenomenon 
on disk testing is unexplained. However, in other 
properties these isolates resembled those erythromycin 
resistant isolates described by Garrod (1957) as 
possessing dissociated resistance.

2 Constitutive resistance to erythromycin in 10 strains
In these, every cell of a culture was highly resistant to 
erthromycin (MIC > 1000 μg/ml) whether or not it 
had been pre-incubated with erythromycin. These 
strains were sensitive to lincomycin and spiramycin 
even after pre-incubation with erythromycin.

3 Constitutive resistance to erythromycin, lincomycin, and spiramycin in 6 strains
In these, every cell was resistant (MIC > 1000 μg/ml) 
to each of these antibiotics whether or not the 
cultures had been pre-incubated with subinhibitory 
concentrations of erythromycin.

Discussion
The difficulty with which erythromycin resistant 
mutants can be selected in vitro was notable. From 
more than a total of 10^{14} cells of 20 strains of 
sensitive staphylococci not a single one-step high-
level (MIC > 50 μg/ml) mutant could be obtained. 
This contrasts markedly with the ease with which 
one-step mutants resistant to novobiocin, streptomycin, 
or rifampicin can be selected in vitro (Lacey, 1972). However, by serial transfer of cultures in 
media containing increasing levels of antibiotic, 
colonies resistant to erythromycin could be isolated. 
The properties of these mutants were similar, 
namely, the resistant colonies were small and the 
resistance was unstable. Also, on first isolation the 
mutants showed resistance to both erythromycin and 
spiramycin. The level of resistance to spiramycin was 
always greater than that to erythromycin.

In contrast, none of the resistant isolates from 
clinical material showed any of these features. The 
majority possessed an inducible resistance to 
erthromycin and sensitivity to spiramycin and 
lincomycin. The minority showed either a high level 
constitutive resistance (MIC > 1000 μg/ml) to all 
three antibiotics or to erythromycin alone.

The two types of resistance shown by clinical and 
laboratory strains are therefore well defined and 
distinct. It is not possible to account for the appearance 
of these resistant clinical isolates on the basis of
laboratory manipulation as above. The origin of erythromycin resistance in clinical strains is obscure, but the following considerations are consistent with the proposal that a very few sets of genes are responsible for this resistance.

1 With one exception, the resistance in the strains in this survey was confined to staphylococci of phage groups I and III or strains that were non-typable. Such strains have probably evolved rapidly in nature with loss and gain of prophages and antibiotic resistance genes (Jevons et al., 1966; Lacey, 1975). Thus the presence of erythromycin resistant strains of diverse properties need not be due to the evolution of the resistance de novo in each isolate. Rather it could indicate that few erythromycin resistant strains have evolved over the years to produce a variety of resistant isolates due to the natural variation of these other unstable properties.

2 Erythromycin resistance has been shown to be plasmid mediated and can be transferred between strains of Staph. aureus by transduction (Lacey, 1975).

3 Because erythromycin resistance is inducible, a complex mechanism must exist to effect this. It is reasonable to conclude that this has evolved infrequently on the grounds of improbability. It is not surprising that none of the laboratory mutants showed inducibility.

The relevance of these findings for the clinical use of erythromycin may be considerable. If these findings are extended to the clinical situation the risk that a population of staphylococci initially uniformly sensitive will mutate to erythromycin resistance during therapy, however prolonged, appear to be slight. Any mutants that might appear will be expected to be slow-growing and probably non-pathogenic. Thus, in domiciliary patients, there seems to be no reason to withhold deliberately the use of erythromycin for fear of selecting resistance. This argument probably also applies to the use of this antibiotic against other bacteria, e.g., Streptococcus pyogenes, Streptococcus pneumoniae, and Haemophilus influenzae that have been less prone to acquire resistance than Staph. aureus. Indeed, it has been impossible to select in one step mutants of any of these bacteria highly resistant to erythromycin (MIC > 100 μg/ml).

In hospital environments where erythromycin resistant staphylococci exist there is a risk that the lavish use of erythromycin will select these isolates. However, this argument applies also to the use of other antibiotics, so that the use of erythromycin with care should not be expected to be specifically liable to select resistant bacteria.

References


Lack of evidence for mutation to erythromycin resistance in clinical strains of Staphylococcus aureus.
R W Lacey

*J Clin Pathol* 1977 30: 602-605
doi: 10.1136/jcp.30.7.602

Updated information and services can be found at:
http://jcp.bmj.com/content/30/7/602

These include:

**Email alerting service**
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/