Detection of ampicillin resistant *Haemophilus influenzae* in United Kingdom laboratories

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**SUMMARY** Susceptibility of *Haemophilus influenzae* clinical isolates to ampicillin reported by 23 laboratories, using a variety of methods, was compared with results obtained following retesting at The London Hospital Medical College. Beta lactamase production was not detected on initial isolation in 25 of 157 isolates (16%) found to be positive on retest. One hundred β lactamase negative isolates, which gave reduced zone diameters (<20 mm) around 2 µg discs and required 1–64 mg/l ampicillin for inhibition, were detected at The London Hospital. Eighty five of these had been reported as sensitive to ampicillin by the laboratories of origin. Many of these 100 isolates showed reduced susceptibility to other β lactam antibiotics.

Accurate detection of non-enzymic reduced susceptibility to ampicillin may emerge as an important guide to the likely sensitivity of *H influenzae* isolates to the enzyme stable β lactams.

The prevalence of β lactamase production among United Kingdom clinical laboratory isolates of *Haemophilus influenzae* increased from 1.6% in 1977 to 5.8% in 1981. Following the third similar survey conducted by this department in 1986 we reported that the prevalence of β lactamase production had remained stable at 6.2% overall. In contrast, β lactamase negative *H influenzae*, which showed reduced susceptibility to ampicillin, increased in prevalence during the five years between 1981 and 1986. Data on β lactam susceptibility were available for 2458 isolates collected in 1986. One hundred (4%) of these showed zone diameters of <20 mm to 2 µg ampicillin discs and required between 1 and 64 mg/l ampicillin for inhibition of growth compared with 39 (2%) similar isolates among the 1841 collected in 1981.

Details of the susceptibility testing methods used by the 23 laboratories that participated in the 1986 United Kingdom survey of resistance among clinical isolates of *H influenzae* were obtained. The prevalence of β lactamase-mediated and non-enzymic resistance to ampicillin among the survey isolates, as reported by the centres of origin, were compared with our own results following retesting by the methods used in all three surveys.

**Material and methods**

The following methods were used for retesting at The London Hospital.

**DISC DIFFUSION TESTING**

Five hour broth cultures (nutrient broth with 5% (v/v) inactivated Filde's supplement) were diluted 1/100 in peptone water for swab inoculation of DST (Oxoid) agar plates supplemented with 0.25% (v/v) lysed horse blood and 10 mg/l NAD. Ampicillin discs (2 µg) were applied.

**MINIMUM INHIBITORY CONCENTRATION (MIC)**

The diluted suspension was also used for Denley multipoint inoculation (about 10⁴ cfu/spot) of the same agar, containing doubling dilutions of ampicillin (ranging from 256–0.008 mg/l for isolates giving reduced zone diameters (<20 mm) on disc testing, and 2 mg/l for those with zone diameters of ≥20 mm). All plates were incubated in 5% carbon dioxide and 95% air for 18 hours at 37°C.

**DETECTION OF β LACTAMASE**

Isolates producing reduced zone diameters and those reported as ampicillin resistant by the laboratories of origin were tested for β lactamase production by both acidimetric (Oxoid β lactamase strips) and iodometric methods.

Details of methods used in the external laboratories were collected at the start of the survey by means of questionnaires.

**Results**

The two methods of β lactamase detection used at The
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London Hospital (acidometric and iodometric) showed 100% agreement in detecting 157 positive isolates. Beta lactamase production was not reported by external laboratories in 25 of these, 12 of which had been reported as ampicillin resistant and beta lactamase negative. Eleven of the 13 originally reported as ampicillin sensitive had not been tested for enzyme production because they had been considered to be sensitive on disc testing according to criteria adopted by the laboratory of origin. The remaining 14 had been tested but beta lactamase was not detected. Discrepancies between the London Hospital and external laboratory results are summarised in table 1.

Table 2 shows the correlation between the failure of beta lactamase detection and any one method used. The numbers tested are too small for definite conclusions to be drawn, but the acidometric test detected 93% of isolates producing beta lactamase compared with 86% detected by chromogenic cephalosporin methods. Beta lactamase was not found at the London Hospital in two isolates originally reported as positive; both showed reduced susceptibility to ampicillin and to augmentin (amoxycillin and clavulanic acid), indicating the presence of non-enzyme-mediated resistance.

There was a pronounced discrepancy between the London Hospital and the reporting centres in the recognition of the 100 beta lactamase negative isolates considered to have reduced susceptibility to ampicillin on retesting. Eighty-five of these had been reported as ampicillin sensitive by the laboratory of origin, of which 26 originated from centres which performed a beta lactamase test without disc testing on non-invasive H influenzae. Of the remaining 59 isolates, 38 were from laboratories using 5 or 10 mu ampicillin discs and 21 came from laboratories using 2 mu discs. The 15 which had been reported as resistant included eight from centres using 10 mu discs, and five from those using 2 mu discs, together with the two isolates originally thought to be beta lactamase positive.

Table 3 summarises the different susceptibility testing methods in use by the participants. The media and disc sizes used differed greatly between participating laboratories so that no conclusions could be drawn regarding their influence on the detection of reduced susceptibility. Information collected on preparation and estimation of inoculum size and methods of interpretation were so variable that no two laboratories followed identical criteria.

Discussion

Agreement between external laboratories and the London Hospital on the presence of beta lactamase increased from 73% (77 of 105 isolates) in 1981 to 84% (132 of 157 isolates) in 1986. In contrast, 85 of the 100 isolates considered to possess some degree of non-enzymic (intrinsic) ampicillin resistance after retesting had been reported as ampicillin sensitive by

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Table 1: Comparison of London Hospital results with susceptibility reported by external laboratories

<table>
<thead>
<tr>
<th>Result at the London Hospital</th>
<th>Ampicillin sensitive</th>
<th>Beta lactamase positive</th>
<th>Ampicillin resistant plus beta lactamase negative</th>
<th>Percentage correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta lactamase positive (n = 157)</td>
<td>13</td>
<td>132*</td>
<td>12</td>
<td>84</td>
</tr>
<tr>
<td>Ampicillin resistant (MIC ampicillin $\geq 4$ mg/l), beta lactamase negative (n = 38)</td>
<td>26</td>
<td>1</td>
<td>11*</td>
<td>29</td>
</tr>
<tr>
<td>Intermediate ampicillin resistance (MIC ampicillin 1 or 2 mg/l), beta lactamase negative (n = 62)</td>
<td>59</td>
<td>1</td>
<td>2*</td>
<td>3</td>
</tr>
</tbody>
</table>

*In agreement with London Hospital result.

Table 2: Methods in use for detection of beta lactamase by participating laboratories

<table>
<thead>
<tr>
<th>Method</th>
<th>No of Laboratories</th>
<th>No of beta lactamase producers detected</th>
<th>No tested but reported negative</th>
<th>Total No of beta lactamase producers missed</th>
<th>Overall correlation with London Hospital results (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acidometric (strip)</td>
<td>8</td>
<td>68</td>
<td>5</td>
<td>7</td>
<td>91</td>
</tr>
<tr>
<td>Acidometric (tube)</td>
<td>1</td>
<td>21</td>
<td>2</td>
<td>2</td>
<td>91</td>
</tr>
<tr>
<td>Nitrocefin</td>
<td>9</td>
<td>33</td>
<td>5</td>
<td>11</td>
<td>75</td>
</tr>
<tr>
<td>Chromogenic cephalosporin discs</td>
<td>5</td>
<td>10</td>
<td>2</td>
<td>5</td>
<td>67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>132</strong></td>
<td><strong>14</strong></td>
<td><strong>25</strong></td>
<td><strong>84</strong></td>
</tr>
</tbody>
</table>
the laboratory of origin. This large discrepancy poses the question as to whether the degree of resistance detected at The London Hospital was real or due to adoption of inappropriate parameters for assessment of resistance.

Evidence that these small changes in apparent susceptibility to ampicillin are important has been provided by results of determining the in vitro activity of other $\beta$ lactam antibiotics. The agents studied at The London Hospital included cefaclor, aztreonam, and amoxycillin combined with clavulanate. Thirty one (82%) of the 38 isolates which required $\geq 4$ mg/l ampicillin for inhibition and 33 (53%) of the 62 inhibited by 1 or 2 mg/l showed reduced susceptibility—that is, an MIC of $\geq 3$ doubling dilutions above the mode for ampicillin sensitive and $\beta$ lactamase positive groups—to at least one, and often several, of these other antimicrobial agents. Only 1% of ampicillin sensitive and $\beta$ lactamase producing isolates showed a similar reduction in susceptibility to one or more of these $\beta$ lactams.

The three United Kingdom surveys conducted by this department used identical methods for disc diffusion susceptibility testing, MIC determination, and interpretation. Williams and Kattan described the merits of a 2 $\mu$g disc applied to the medium used in the surveys and showed a correlation between zone sizes less than 20 mm and MICs of $\geq 1$ mg/l ampicillin. They also showed a definite inoculum effect on the apparent sensitivity of isolates possessing intrinsic resistance to ampicillin. Mendelman et al reported that the correlation between MIC and zone size was improved by using an inoculum size of $10^3$ or $10^4$ rather than $10^2$ for MIC determination by agar dilution and that a 2 $\mu$g disc was far superior at detecting reduced susceptibility among $\beta$ lactamase negative isolates, irrespective of the medium (supplemented brain heart infusion, chocolate or Mueller-Hinton chocolate agars) used. More recently, Doen et al have shown that with an inoculum size of $10^6$ cfu, MIC values using a broth dilution method correlated better with zone sizes with 2 or $10 \mu$g discs when supplemented Mueller-Hinton agar was substituted for chocolate agar.

Clearly there are several important variables to be considered when determining susceptibility by disc testing or MIC determination. Nevertheless, we consider that zone sizes of $< 20$ mm have proved to be a useful indicator of reduced susceptibility to $\beta$ lactams despite the relatively low ampicillin MIC values obtained from 62 isolates (36 requiring 1 mg/l and 26 requiring 2 mg/l ampicillin for inhibition). The relatively heavy inoculum on the plate (about $10^9$ cfu) compared with the $10^4$ cfu/spot used for MIC determination may partly explain the phenomenon.

Despite wide recognition of the problems and many published recommendations supporting the use of low value discs and careful control of inoculum size, the information gathered during the course of this survey suggests that many United Kingdom laboratories have not adapted their methods for susceptibility testing of $H$ influenzae. During the collection period, $H$ influenzae isolates were collected consecutively and underwent laboratory susceptibility testing as part of the routine clinical workload without any special

<table>
<thead>
<tr>
<th>Medium and disc</th>
<th>No of laboratories</th>
<th>Reported sensitive by external laboratory</th>
<th>Reported to agree with London Hospital results</th>
<th>Reported as $\beta$ lactamase positive by external laboratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chocolate agar (2 $\mu$g)</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Chocolate agar (10 $\mu$g)</td>
<td>3</td>
<td>20</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>IsoSensitest agar with choklicated blood or lysed blood $\pm$ NAD (2 $\mu$g)</td>
<td>3*</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>IsoSensitest agar with choklicated blood or lysed blood $\pm$ NAD (5 or 10 $\mu$g)</td>
<td>3</td>
<td>7</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sensitest agar with 5% lysed blood and 10 mg/l NAD (2$\mu$g)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>DST with choklicated blood or lysed blood (5–10%) and 10 mg/l NAD (2$\mu$g)</td>
<td>5*</td>
<td>11</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DST with choklicated blood or lysed blood (5–10%) and 10 mg/l NAD (10 $\mu$g)</td>
<td>2</td>
<td>11</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>MAST SAT with isovitalex and haemin (2 $\mu$g)</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\beta$ lactamase test without disc test on non-invasive isolates</td>
<td>2</td>
<td>26</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

*Number includes one laboratory incubating plates in air. All others used an atmosphere of 5% carbon dioxide and 95% air.
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M Powell was supported by ICI (Pharmaceuticals). We thank Miss A Seymour for her technical help and the following laboratories for their participation in the survey: City Hospital, Aberdeen; North Ayrshire DGH, Kilmarnock; Barking Hospital, Barking; Dudley Road Hospital, Birmingham; Southmead Hospital, Bristol; Western General Hospital, Edinburgh; Princess Alexandra Hospital, Harlow; Ruchill Hospital, Glasgow; Wycombe General Hospital, High Wycombe; Raigmore Hospital, Inverness; Royal Liverpool Hospital, Liverpool; Guy's Hospital, St Thomas's Hospital, The London Hospital and University College Hospital, London; Manchester Royal Infirmary, Manchester; General Hospital, Newcastle upon Tyne; University Hospital, Nottingham; Deniford Hospital, Plymouth; St Mary's General Hospital, Portsmouth; Hope Hospital, Salford; Stepping Hill Hospital, Stockport; York District Hospital, York.

References


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*J Clin Pathol* 1988 41: 716-719
doi: 10.1136/jcp.41.7.716

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