Prevalence of antibodies to *Chlamydia pneumoniae* in an Israeli population without clinical evidence of respiratory infection

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Aims: To estimate the occurrence of recent, past, and "persistent" infections with *Chlamydia pneumoniae*—as indicated by serology—in an Israeli population without clinical evidence of respiratory infection.

Methods: Serum samples from 402 subjects (172 children and 230 adults), without known respiratory symptoms, were collected. Antibodies to *C pneumoniae* (IgG, IgA, and IgM) were evaluated using the microimmunofluorescence (MIF) assay. Antibody prevalence and indication of recent, past, and persistent infections were calculated and their distribution determined according to age, sex, and season.

Results: Antibodies to *C pneumoniae* were detected in 53 children (31%) and 171 adults (74%). Recent infection was indicated in only one of 50 children under 5 years of age, in nine of 122 older children, and in 19 of 230 adults. IgM antibodies were detected in nine children, but only in three adults. Past infection was indicated in six of 96 young children (aged 1–10 years), in 28 of 76 teenagers, and in 128 of 230 adults. Persistent infection was indicated in three young children, in six teenagers, and in 24 adults, with a significantly higher frequency (p = 0.012) in men (18 of 117) than in women (six of 113). No seasonal differences could be detected.

Conclusions: Infection with *C pneumoniae* was detected serologically in children and adults without clinical signs of respiratory disease. These results should serve as a basis for studies on the role of *C pneumoniae* infections and their sequelae in Israel and contribute to the general understanding of asymptomatic infection with *C pneumoniae*.

*Chlamydia pneumoniae* has recently been recognised as a common and important intracellular bacterium, implicated in upper and lower respiratory tract infections in humans worldwide.

*Chlamydia pneumoniae* can cause severe clinical disease, but only symptoms are mild or even subclinical. A seemingly healthy population will include individuals with low antibody prevalence during childhood, which increases during the teenage years, and relatively high values in middle age and old age.

"Because *C pneumoniae* often persists in the body after acute infection, it may be involved in chronic respiratory diseases, such as chronic obstructive pulmonary disease and asthma"

The microimmunofluorescence (MIF) test is the serological testing method of choice for the diagnosis of acute *C pneumoniae* infection. The specificity of the test can be attributed to the use of purified elementary bodies of *C pneumoniae* that can detect species specific antibodies.

Because of the lack of standardisation of the test, the interpretation of published data is difficult. Interlaboratory and regional variations exist. Although there is extensive variation in the numerical titre values, the overall percentage agreement with the reference standard titre from the university of Washington is 80%.

The prevalence and titre of antibodies to *C pneumoniae* in children and adults in our region, without clinical evidence of respiratory infection, has not yet been reported. It is therefore important to evaluate these criteria as a basis for further considerations on the role of *C pneumoniae* in infection and thereby contribute to the general understanding of asymptomatic respiratory infection with *C pneumoniae*.

**MATERIALS AND METHODS**

Our study included 172 children of both sexes, age range 1–19 years, visiting the emergency room and the paediatric surgery...
was considered indicative of past infection. Chlamydia antibody titre of 1/16 to 1/256 in the IgG fraction was considered indicative of recent infection. For each conjugate the optimal dilution was determined by titration of washings from a single glass slide using fluorescein isothiocyanate conjugated goat anti-human immunoglobulins (Jackson Immuno Research, West Grove, USA) in 0.5% yolk sac, as an antigen. The slides were fixed with acetone. IgG, IgA, and IgM antibodies were measured using fluorescein isothiocyanate conjugated goat antihuman immunoglobulins (Jackson Immuno Research, West Grove, USA) with evans blue (0.05%) as a counterstain. Sera were stored at -20°C until tested.

Antibodies to Chlamydia pneumoniae were detected by the micro-immunofluorescence assay using self prepared slides with purified dotted formalinised C. pneumoniae elementary bodies, 10^7 particles/ml (AR39; Washington Research Foundation, Seattle, USA) in 0.5% yolk sac, as an antigen. The slides were fixed with acetone. IgG, IgA, and IgM antibodies were measured using fluorescein isothiocyanate conjugated goat antihuman immunoglobulins (Jackson Immuno Research, West Grove, USA) with evans blue (0.05%) as a counterstain. For each conjugate the optimal dilution was determined by titration with a hightitre serum. Positive and negative control serum samples were included in each run and reproducibility between runs was checked by the titration of positive control serum. All the tests were performed blinded by the same very experienced staff member (BYM).

Sera were diluted from 1/16 to endpoint for IgG determination. IgA and IgM were tested at a dilution of 1/20, after IgG neutralisation by Gullisorb (Gull Lab, Utah, USA)1 10 18 and positive sera were further diluted to endpoint.

The antibody titre for each serum was recorded and for each study group antibody prevalence and indication of recent, past, or persistent infections were calculated.

A titre of ≥ 1/20 in the IgM fraction and/or ≥ 1/512 in the IgG fraction was considered indicative of recent infection. A chlamydia antibody titre of 1/16 to 1/256 in the IgG fraction was considered indicative of past infection.

Because there is as yet no standardisation of serological criteria for persistent infection, we considered antibody titres of ≥ 1/20 in the IgA fraction, together with IgG titres of 1/64 to 1/256, to be indicative of persistent infection.

Age, sex, and seasonal distribution were noted.

The significance of the data was determined by Fisher’s exact test or by the χ² test for numbers larger than five in all cells. A p value < 0.05 was considered significant.

| Table 1 Chlamydia pneumoniae (CP) infection and antibody prevalence in children according to age and sex |
| --- | --- | --- | --- | --- | --- |
| Age group (years) | Bays | Girls |
| 1–5 | 5–10 | 10–18 | 1–5 | 5–10 | 10–18 |
| 1–5 | 2.5 | 2.4–9 | 10.3–16 | 1–5 | 2.6 | 7.9 |
| Mean (years) | 17 | 25 | 34 | 33 | 21 | 42 |
| No. tested | 19 | 20 | 21 | 22 | 23 | 24 |
| No. with | | | | | | |
| CP antibodies | 2 | 3 | 19* | 3 | 6 | 20** |
| Past infection | 1 | 2 | 1 | 1 | 2 | 1 |
| “Persistent” infection | 0 | 0 | 3 | 2 | 1 | 3 |

Recent infection categorised as IgM titre ≥ 1/20 and/or IgG titre ≥ 1/512 with or without IgA titre ≥ 1/20. Past infection categorised as IgG titre 1/16–1/256. Persistent infection categorised as IgA titre ≥ 1/20 with IgG titre 1/64–1/256.

*p<0.05 compared with children under the age of 10 years (Fisher’s exact test); **p<0.05 compared with children under the age of 10 years (χ² test).

Orthopaedic clinic of the Assaf Harofeh Medical Centre, from October 1996 to March 1997. Exclusion criteria were positive physical findings relating to present respiratory infection or any symptoms of respiratory tract infection or complaints during the previous three months.

Our study also included 230 healthy adults of both sexes, visiting outpatient clinics from January to August 1997 for annual check ups, or healthy hospital personnel without respiratory symptoms three months before the study. Blood samples were obtained for necessary routine laboratory tests, and aliquots were used for our study according to the guidelines for human experimentation (Helsinki committee). A single blind specimen was drawn from each individual. Sera were stored at -20°C until tested.

| Table 2 Chlamydia pneumoniae (CP) infection and antibody prevalence in adults according to age and sex |
| --- | --- | --- |
| Age group (years) | Men | Women |
| No. tested | 46 | 41 | 30 | 39 | 44 | 30 |
| No. with | | | | | | |
| CP antibodies | 32 | 32 | 26 | 28 | 32 | 21 |
| Past infection | 20 | 23 | 19 | 24 | 27 | 15 |
| “Persistent” infection | 8 | 5 | 5 | 2 | 2 | 2 |
| IgG: mean geometric titre | 1/160 | 1/152 | 1/126 | 1/110 | 1/108 | 1/146 |

Recent infection categorised as IgM titre ≥ 1/20 and/or IgG titre ≥ 1/512 with or without IgA titre ≥ 1/20. Past infection categorised as IgG titre 1/16–1/256. Persistent infection categorised as IgA titre ≥ 1/20 with IgG titre 1/64–1/256.

No significant difference according to season was recorded for C. pneumoniae recent infections. Five of 51 children showed an indication of recent infection from October to December.
Prevalence of antibodies to *Chlamydia pneumoniae*

compared with five of 121 from January to March (p = 0.27). An indication of recent infection was detected in 11 of 168 adults during January to April compared with eight of 62 during May to August (p = 0.2).

**DISCUSSION**

A group of children and adults, without clinical evidence of respiratory infection, was evaluated for the presence of *C pneumoniae* antibodies. The recommended serological test for the diagnosis of *C pneumoniae* infection—the MIF assay—was used. The frequency of past infection was significantly higher in young adults (age 19–30), compared with teenagers, but higher than that seen in teenagers. If we were to calculate the results according to higher cut off values—IgA titres > 1/40, with IgG titres of 1/128—only four adults (two men and two women) would have been included in this category. Prevalence was significantly higher in men (18 of 117) than in women (six of 113), p = 0.0012.

We feel that the importance of our study goes beyond establishing a background for our further studies by contributing to the worldwide trials to standardise this method. Serological testing of *C pneumoniae* remains problematical because of difficulties in obtaining paired serum samples, discrepancies in the antibody values of a healthy population from different geographical locations, and the lack of standardised tests and reagents. It is therefore of crucial importance to establish a background for the particular population which a laboratory intends to diagnose.

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**REFERENCES**