Haemophilus infection in cystic fibrosis

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Abstract
Twenty seven patients with cystic fibrosis under the age of 12 years and 27 matched patients with asthma were followed up in a prospective study for one year. The isolation rate of non-capsulated strains of *Haemophilus influenzae* from cough swabs and sputum specimens taken at routine clinic visits every two months was significantly greater in cystic fibrosis than in asthma. *Haemophilus parainfluenzae* was equally common in both groups. During exacerbations the isolation rate of *H influenzae* in cystic fibrosis was significantly greater than at other times, whereas in asthma there was no significant difference.

The distribution of biotypes of *H influenzae* and *H parainfluenzae* was similar in the two groups. In cystic fibrosis, biotype I was associated with exacerbations. Biotype V was more common than in previous studies, but was not associated with exacerbations.

In recent years, non-capsulated *Haemophilus influenzae* has become well established as an important human pathogen in both adults and children.1-3 Non-capsulated strains of *H influenzae* and *Haemophilus parainfluenzae* colonise the lower respiratory tracts of patients with cystic fibrosis but may also be found in the upper respiratory tracts of normal children.4 Some cystic fibrosis centres adopt a policy of treating all patients from whom *Haemophilus* spp have been isolated, irrespective of the clinical state of the patient.5 *H influenzae* and *H parainfluenzae* have been subdivided by Kilian on the basis of three biochemical characteristics (ornithine decarboxylation, indole production, and urea hydrolysis) into several biotypes.6 Biotype I of *H influenzae*, which is known to be associated with acute otitis media in normal children,7 was isolated significantly more often from patients with cystic fibrosis than from healthy controls.7 To assess the importance of *H influenzae* and *H parainfluenzae* in cystic fibrosis and the value of biotyping, we conducted a prospective study to determine the rates of isolation and the distribution of biotypes from the respiratory tracts of children with cystic fibrosis. Children with asthma were used as controls because they were likely to have increased respiratory secretions without significant bacterial infection.

Patients and methods

PATIENTS
All patients with cystic fibrosis under the age of 12 years who lived within easy reach of the hospital were invited to take part in the study. The next suitable patient seen in the asthma clinic, matched for age and sex, was invited to act as a control. Consent was obtained from the parents and the study was approved by the hospital ethical committee. Patients were seen routinely every two months and weekly during acute respiratory exacerbations. At each visit weight and height were recorded and where possible lung function tests were performed using a Wright peak flow meter and an electronic spirometer. The best of three readings was recorded in each case and was expressed as a percentage of the predicted value for height. Pulse, respiratory rate, and physical signs were scored by one of us (RJR) and the parents were asked to score symptoms of cough, wheeze, and breathlessness on a scale of 0 (none) to 4 (severe). The two scores were added together for analysis. At the start of the study, peak flow records and symptom charts were kept for two weeks to assess baseline variability during a period when the child was well. The parents contacted the hospital at any time when the child was unwell with increased cough, wheezing, or breathlessness and peak flow records and symptom scores were recorded until symptoms had resolved.

During acute exacerbations, patients with cystic fibrosis received a two week course of amoxycillin. Those aged less than 1 year, between 1 and 8 years, and over 8 years received 125, 250, and 500 mg of amoxycillin respectively every eight hours. If *Staphylococcus aureus* had been isolated recently amoxycillin was combined with flucloxacillin or occasionally erythromycin was prescribed. If the child was allergic to amoxycillin or the *Haemophilus* spp was resistant to ampicillin, co-trimoxazole was prescribed. Patients who were chronically infected with *Pseudomonas aeruginosa* were treated with intravenous antibiotics when necessary. In contrast, asthma patients did not receive antimicrobial treatment but inhaled therapy was adjusted and, if necessary, courses of oral steroids were prescribed for acute exacerbations. Cough swabs were repeated after one and two weeks of treatment in both groups.

Cough swabs were taken by a standard method either by the outpatient sister or by one of us (RJR). The swab was held at the back of the child’s throat and he or she was asked to cough. In the case of young children it was sometimes necessary to induce gag reflex. The swabs were placed in Stuart’s transport medium and labelled sequentially with a number so that the microbiologists were unaware of the identity
of the patient. In addition, whenever possible a sputum specimen was sent for culture in the usual way. A throat swab was placed in viral transport medium and sent for viral culture at the start of each exacerbation.

METHODS

Each cough swab was broken off into a bijoux bottle containing 0.5 ml of 2% N-acetylcysteine. It was shaken briefly in a Whirlmixer (Fisons) to distribute the swab contents. Using a Pasteur pipette a drop was placed on to plates containing heated blood agar, chocolate agar, crystal violet agar, and a selective chocolate agar (containing cefsulodin 8 mg/l, which inhibited Pseudomonas spp but allowed Haemophilus spp to grow). The drops were spread in the usual way and the plates were incubated at 37°C in 5% carbon dioxide for 18 hours. Isolates were identified as belonging to Haemophilus spp by typical colonial morphology, microscopic appearance, and growth requirement for ‘X’ and ‘V’ factors. All isolates of H influenzae were designated non-capsulated if they failed to agglutinate with type specific H influenzae type b (Public Health Laboratory Service) and polyclonal (Difco, types a–f) antisera or if they autoagglutinated. Other organisms were identified by standard methods. The biotypes of isolates were determined using the RapID/NH system (Merica Diagnostics). All isolates of H influenzae and H parainfluenzae were tested for β-lactamase production by the technique of Escamilla9 and additional disc diffusion sensitivity tests were carried out by Stokes’ method10 with discs containing ampicillin 2 and 10 μg. Discs containing sulphamethoxazole 50 μg, trimethoprim 2.5 μg, chloramphenicol 10 μg, and cefotaxime 30 μg were used to test isolates which were resistant to ampicillin.

Data were analysed by χ² tests, one way analysis of variance, and paired t tests using SPSSX programmes.

Results

There were 27 patients in each group with a predominance of boys in both groups (cystic fibrosis, n=18 and asthma, n=17). The median ages in the cystic fibrosis and asthma groups were 7.5 and 7.1 years respectively. The median Shwachman score11 in the group with cystic fibrosis was 82 (range 43–94), and the median Chrispin-Norman x ray score12 was 6 (range 2–20). Five patients with cystic fibrosis were chronically infected with P aeruginosa. In the asthma group, 19 patients were taking inhaled steroids and six were taking inhaled sodium cromoglycate. Twenty one patients in each group were able to perform reliable respiratory function tests.

There were 80 exacerbations in the group with cystic fibrosis and 34 in the group with asthma. Exacerbations were associated with a fall in mean peak expiratory flow rate (PEFR) and forced expiratory volume in one second (FEV₁) in both groups (p<0.05) and a rise in mean clinical score. There was an improvement in mean PEFR and FEV₁ by the second week of antibiotic treatment (p<0.05) in the group with cystic fibrosis (figure).

Four hundred and ninety cough swabs or sputum specimens (cystic fibrosis, n=303 and asthma, n=187) were examined between January and December 1988. H influenzae was isolated on at least one occasion from 21 patients with cystic fibrosis and eight with asthma (p<0.001), and in three or more occasions from six cystic fibrosis patients but no asthmatics. All strains of H influenzae isolated were non-capsulated. H parainfluenzae was isolated on at least one occasion from six patients with cystic fibrosis and two with asthma. Table 1 shows the isolation rates of H influenzae, H parainfluenzae, and other pathogens from specimens obtained at routine clinic visits, in the month preceding an acute exacerbation, during exacerbation, and after starting treatment (after exacerbation). At routine clinic visits, before and during exacer-
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Table 1 Number (%) of isolates of H influenzae and H parainfluenzae and other pathogens in the two groups according to type of visit

<table>
<thead>
<tr>
<th>Type of visit</th>
<th>Cystic fibrosis</th>
<th>Asthma</th>
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<tbody>
<tr>
<td></td>
<td>No of specimens</td>
<td>H influenzae</td>
</tr>
<tr>
<td>Routine Before exacerbation</td>
<td>94</td>
<td>24 (25-5)</td>
</tr>
<tr>
<td>Exacerbation</td>
<td>40</td>
<td>15 (37-5)</td>
</tr>
<tr>
<td>After exacerbation</td>
<td>80</td>
<td>31 (38-8)</td>
</tr>
<tr>
<td>Total</td>
<td>303</td>
<td>77 (25-4)</td>
</tr>
</tbody>
</table>

bations, H influenzae was isolated more frequently from patients with cystic fibrosis than from asthma patients (p<0.01). After antibiotic treatment, the rate of isolation of H influenzae from patients with cystic fibrosis was similar to the isolation rate from asthma patients. The isolation rate of H influenzae in the cystic fibrosis group increased from 25-6% at routine visits to 38-8% during exacerbations (p<0.05). In contrast, the isolation rate of H parainfluenzae remained low at all visits and was equal in the two groups. Of those specimens from which other pathogens only were isolated, P aeruginosa, S aureus, and group A haemolytic streptococci accounted for 30, 14, and 1 isolates respectively in cystic fibrosis, whereas in asthma the two isolates were both group A haemolytic streptococci.

Viral cultures performed during exacerbations yielded coxsackievirus, rhinovirus, and Herpes simplex virus in three patients with cystic fibrosis and cytomegalovirus in one patient with asthma.

Seventy nine strains of H influenzae and 14 strains of H parainfluenzae were biotyped. All but one strain of H parainfluenzae were biotype III. The distribution of biotypes of H influenzae was not significantly different in the two groups (table 2). Biotype V was more common than biotype I in both groups and occurred with equal frequency at routine clinic visits and during exacerbations. Biotype I was isolated more frequently around the time of an exacerbation (11 isolates) than at other times (four isolates). Patients with cystic fibrosis frequently harboured a particular biotype for several months, but some showed a change in biotype before an exacerbation.

Nine isolates of H influenzae (cystic fibrosis, n=8 and asthma, n=1) were ampicillin resistant and all except one produced β lactamase. Five of eight β lactamase producing strains were biotype V. Two strains of H parainfluenzae were ampicillin resistant.

In patients with cystic fibrosis from whom H influenzae only was isolated during an exacerbation, a 14 day course of oral amoxycillin was always associated with a clinical response. Eradication of H influenzae was achieved on 15 out of 22 (70%) occasions. It is our practice to treat all patients with cystic fibrosis from whom S aureus is isolated, irrespective of symptoms.

Discussion

The role of non-capsulated H influenzae in adults with lower respiratory tract infections is now widely recognised, but in children its role remains unresolved. This is because it is frequently isolated from the upper respiratory tract in normal children and it is known that invasive infections in children are almost always due to capsulated type b strains of H influenzae. Nevertheless, non-capsulated strains are undisputed pathogens of otitis media and sinusitis in children,3 and in a large study of community acquired pneumonia in children, more than half the strains of H influenzae producing pneumonia were non-capsulated.13

The results of this study suggest that H influenzae is a significant pathogen in children with cystic fibrosis. H influenzae was more frequently isolated from the lower respiratory tract in cystic fibrosis than in asthma. Furthermore, a rise in the isolation rate of H influenzae preceded the development of acute exacerbations in the patients with cystic fibrosis and clinical improvement coincided with a reduction in the isolation rate after antimicrobial treatment (table 1). In this age group H influenzae may be a more frequent pathogen than P aeruginosa. S aureus has been less frequently isolated in recent years because it is usually eradicated by elective antimicrobial treatment. Placebo controlled double blind trials would be needed to establish whether elective treatment of H influenzae isolates in young cystic fibrosis patients reduces the frequency of acute exacerbations.

In adults with chronic bronchitis the symptoms produced by infection with H influenzae and H parainfluenzae are indistinguishable,14 but no similar study has been carried out in children. This study has not found any difference between the groups in the isolation rate of H parainfluenzae or in the distribution of its

Table 2 Distribution of biotypes of H influenzae from patients with cystic fibrosis and asthma

<table>
<thead>
<tr>
<th>Biotype</th>
<th>No (%) of strains</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>I</td>
<td>15 (24-2)</td>
</tr>
<tr>
<td>II</td>
<td>10 (16-1)</td>
</tr>
<tr>
<td>III</td>
<td>4 (6-4)</td>
</tr>
<tr>
<td>IV</td>
<td>2 (3-2)</td>
</tr>
<tr>
<td>V</td>
<td>21 (34-0)</td>
</tr>
<tr>
<td>VI</td>
<td>3 (4-8)</td>
</tr>
<tr>
<td>VII</td>
<td>3 (4-8)</td>
</tr>
<tr>
<td>Non-typal</td>
<td>4 (6-4)</td>
</tr>
<tr>
<td>Total</td>
<td>62 (100)</td>
</tr>
</tbody>
</table>
biotypes. As *H. parainfluenzae* was much less frequently isolated than *H. influenzae*, a larger study would be needed to rule out the possibility that it may be associated with exacerbations in cystic fibrosis.

In this study the biotype distribution of *H. influenzae* isolates from children with cystic fibrosis and asthma was similar. Previous studies have suggested that biotype I may be more common and biotype II less common in cystic fibrosis than in normal children. The value of biotyping strains of *H. influenzae* in determining pathogenicity lies mainly in the detection of biotype I. As in this study less than one third of isolates during exacerbations were biotype I, biotyping may be of limited value in clinical practice. Other methods of typing non-capsulated *H. influenzae*, for example based on outer membrane proteins, may be more useful. Temporal changes in the biotype distribution of *H. influenzae* have been described. Therefore, the finding that biotype V was more common than in previous studies may merely reflect the passage of time, geographical differences, or selection of ampicillin resistant strains. Even when strains of *H. influenzae* are apparently sensitive to ampicillin, only 70% of courses of amoxycillin eradicate *H. influenzae* from the lower respiratory tract, as previously reported by Pressler et al. This may be due to inadequate penetration of the antibiotic into the sputum. The use of very high doses of amoxycillin has been advocated in adults with bronchiectasis and may be effective in children.

The isolation rate of viruses in this study was low, but nasopharyngeal cultures taken on the first day of illness and paired blood samples for viral serology might have yielded more positive results. Secondary bacterial infection may occur in cystic fibrosis as a result of damage to the respiratory epithelium during viral infection. *H. influenzae* may colonise the upper respiratory tract initially and then migrate to cause lower respiratory tract infections in the damaged bronchi of cystic fibrosis patients. *H. influenzae* is capable of producing histamine in vitro, which might contribute to inflammation and airflow obstruction in cystic fibrosis. This study has shown that antibiotic treatment for *H. influenzae* was associated with clinical improvement and with the eradication of the organism in most cases. Therefore, we feel that antimicrobial treatment should be considered seriously in patients with cystic fibrosis from whom non-capsulated *H. influenzae* is isolated, particularly during exacerbations.

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