The activity of rosoxacin, fosfomycin, cefotiam, and spectinomycin on \(\beta\)-lactamase producing \textit{Neisseria gonorrhoeae} \\

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SUMMARY We measured the activity of rosoxacin, fosfomycin, cefotiam, and spectinomycin against 51 isolates of \(\beta\)-lactamase producing \textit{Neisseria gonorrhoeae}, all of which were susceptible to each drug at sufficient concentrations. The development of strains of penicillinase producing \textit{N gonorrhoeae} (PPNG) which are resistant to spectinomycin can therefore be avoided, as there are alternative drugs.

\section*{Introduction} 
Penicillinase (\(\beta\)-lactamase) producing \textit{Neisseria gonorrhoeae} (PPNG) was first isolated in Liverpool in 1976,\(^1\) and these strains have since been isolated in many other countries of Europe, America, Asia, and Australia. A report from the Centers for Disease Control stated that worldwide in 1981 and 1982 there had been a twofold to sixfold increase in PPNG strains.\(^2\) These strains are clinically important as they are resistant to penicillin G, the most widely used treatment for gonorrhoea. The susceptibility of PPNG strains to several cephalosporins has been examined, and they have been shown to be sensitive, for example, to cefuroxime and cefoxitin.\(^3\) Nevertheless, in many countries the drug of choice for infections with PPNG strains is spectinomycin hydrochloride. As there may be a one step mutation of \textit{N gonorrhoeae} to spectinomycin resistance,\(^4\) it is of growing concern that spectinomycin has been used more frequently in the past years for the treatment of gonorrhoea. To prevent this resistance, spectino-myacin should be used only in special cases, and not as frequently as at present.

The purpose of this study was to examine alternative drugs to spectinomycin for the treatment of infections caused by PPNG strains. We tested the sensitivity to spectinomycin, cefotiam, fosfomycin, and rosoxacin of 51 PPNG strains isolated from different geographical areas.

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period was chosen as it gave more reproducible results than the usual 20 hours. MICs of rosoxacin, fosfomycin, and spectinomycin were the same after 45 hours as after 20 hours, while that of cefotiam was one dilution higher after 45 hours than after 20 hours.

Results

The figure shows cumulative data on the susceptibilities of PPNG strains to rosoxacin, cefotiam, fosfomycin, and spectinomycin, with the MIC of rosoxacin being the lowest. The table shows the ranges of MICs related to inoculum sizes.

![Antibiotic susceptibilities of 51 PPNG strains using 10^5 cfu/spot](image)

Discussion

Our data corresponded with susceptibility figures already published. MICs of fosfomycin of 8-32 mg/l for non-PPNG strains have been reported, but there are no data for PPNG strains. The reported MICs of cefotiam vary from 0.007 to 0.5 mg/l (PPNG strains) and 0.12 to 0.5 mg/l (non-PPNG strains); those in our study ranged from 0.03 to 8 mg/l depending on inoculum size. Reported MICs of rosoxacin vary from 0.007 to 0.06 mg/l (PPNG strains) and 0.007 to 0.5 mg/l (non-PPNG strains); those for our isolates were 0.015 to 0.5 mg/l. Resistance to spectinomycin of 4-16 mg/l (PPNG strains) and 0.5-31 mg/l (non-PPNG strains) has been reported; our results showed MICs of 8-32 mg/l.

Bacteria inhibited by concentrations of <16 mg/l fosfomycin were considered to be susceptible, and strains inhibited by concentrations of >64 mg/l were interpreted as being resistant. The half life of fosfomycin is 2.5 hours, and serum concentrations after administration of 5 g are between 157 mg/l after one hour and 39 mg/l after six hours. Acute gonorrhoeal infections have been cured successfully using a single dose of 4 g fosfomycin. The half life of cefotiam is 45 minutes, and serum concentrations after a single dose of 1 g are between 30 mg/l after 30 minutes and 0.7 mg/l after five hours. Strains inhibited by concentrations of <8 mg/l cefotiam are considered to be susceptible, and those inhibited by concentrations of >32 mg/l to be resistant, according to data given by the manufacturer. The half life of rosoxacin is 3.4 hours, and peak serum concentrations are between 4.6 and 4.9 mg/l. If it is administered orally as a single dose of 300 mg, serum concentrations are between 4.9 mg/l after two hours and 0.5 mg/l after 15 hours. Calabrian reported 100% cure rates of uncomplicated gonorrhoea using a single dose of 300 mg rosoxacin. Strains of N. gonorrhoeae inhibited by <32 mg/l spectinomycin are interpreted as being sensitive. We concluded, therefore, that the PPNG strains tested were susceptible to fosfomycin, cefotiam, rosoxacin, and spectinomycin provided there is sufficient diffusion of the drugs.

This report shows the possibility of treating infections caused by PPNG strains with rosoxacin, cefotiam, fosfomycin, or spectinomycin. An advantage of treatment with rosoxacin is that it can be administered orally. The development of mutant strains resistant to spectinomycin can therefore be avoided, as alternative drugs are available.

References

2. Centers for Disease Control. MMWR 1982; 31:1

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<th>Antibiotics</th>
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