Conventional tissue culture compared with rapid immunofluorescence for identifying *Chlamydia trachomatis* in specimens from patients attending a genitourinary clinic

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**SUMMARY** Specimens collected from 182 patients with histories suggesting chlamydial disease were examined by conventional culture and direct immunofluorescence techniques. *Chlamydia trachomatis* was identified by both methods in 57% of all patients. There was no significant difference between the two methods in detecting *C trachomatis*.

Where a tissue culture service is not already established, cost analysis in individual departments may justify the use of the immunofluorescence method.

**Introduction**

*Chlamydia trachomatis* is widely recognised as the most common sexually transmitted agent in the United Kingdom, with an incidence nearly three times that of *Neisseria gonorrhoeae*. *C trachomatis* is associated with urethritis, salpingitis, epididymitis, perirectal, conjunctivitis, and pneumonia. In addition, there is accumulating evidence of a major role for *C trachomatis* in the pathogenesis of infertility, which may be associated with asymptomatic infection.

Asymptomatic women in particular are an important reservoir of infection. Their sexual partners are likely to contract non-gonococcal urethritis and their infants conjunctivitis or pneumonia, or both. Infection with *C trachomatis*, whether clinical or subclinical, may persist for many months. The importance of this organism therefore led us to reconsider our own methods of identification, and we were stimulated by the report of Thomas *et al* and the potential applications of their findings in our clinical unit. These workers compared a conventional tissue culture technique with the use of a fluorescein labelled monoclonal antibody to detect *C trachomatis* elementary bodies in smears. They concluded that the immunofluorescence technique was highly specific and slightly more sensitive than tissue culture. In addition, they found it quicker and simpler.

The aims of the present study were: firstly, to assess the incidence of chlamydial infection at the Alexandra Clinic, King’s College Hospital, London (the genitourinary department for the Camberwell Health Authority, which serves a resident population of around 227,000). Secondly, we aimed to compare the tissue culture and immunofluorescence methods in the context of a busy clinic.

**Patients and methods**

**STUDY POPULATION**

The population studied consisted of consecutive patients attending the Alexandra Clinic who either had signs and symptoms of chlamydial infection or were known contacts of men with non-gonococcal urethritis (NGU). Presenting features in the women included cervicitis, mucopurulent discharge (with no Gram negative diplococci seen in Gram stained endocervical specimens), and lower abdominal pain with clinical pelvic inflammatory disease. All the men in the study were diagnosed as suffering from NGU on clinical grounds and had >5 pus cells per high power field (magnification ×1000) in Gram stained urethral smears.

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COLLECTION OF SPECIMENS

Men
We took urethral swabs for microscopy and culture for *N gonorrhoeae* with 1 μl inoculating loops (NUNC Products, Kamstrup, Denmark). Specimens for gonococcal culture were directly plated on to Thayer-Martin medium (Southern Group Laboratory, London, England). A sterile pernasal swab (Medical Wire & Equipment Co, Corsham, Wiltshire, England) was used for collecting specimens to identify *C trachomatis*. Swabs were inserted a few centimetres into the urethra and rotated several times. The swab was then rolled over a circular area (4 mm in diameter) of a teflon coated slide, which was checked for even coverage of material left on the slide. Finally, the swab was placed in a bijoux bottle containing 3 ml of chlamydia transport medium. The transport medium consisted of Eagle's minimum essential medium supplemented with 0·13% sodium bicarbonate, 10% fetal calf serum, 0·5% glucose, and additional amino acids, vitamins, and glutamine. It contained gentamicin (10 mg/l) and amphotericin B (2·5 mg/l).

Women
The cervical area was first cleared of excess mucus and exudate with a large cotton wool swab. We then used 10 μl inoculating loops (NUNC) to obtain urethral and cervical specimens for microscopy, wet preparations for *Trichomonas vaginalis*, and endocervical specimens for *N gonorrhoeae* culture, directly inoculated on to Thayer-Martin media. Finally, a cotton wool swab was inserted into the endocervical canal, rotated for five to 10 seconds, and withdrawn without touching the vaginal surface. This swab was rolled on to a teflon coated slide and placed in chlamydia transport medium as described for the men. Thayer-Martin plates were incubated in a candle jar with 2% carbon dioxide at 37°C until transported to the laboratory.

Slides were air dried and flooded with acetone, which was allowed to evaporate. When completely dried, the slides were placed in a slide box. All specimens were kept at 4°C for a maximum of 18 hours before transport to the laboratory. On receipt in the laboratory swabs were stored at 4°C if they were to be inoculated on the day of receipt or stored in liquid nitrogen (at −192°C) if inoculation was to occur subsequently. Slides were held at −70°C if not examined on the day of receipt.

CHLAMYDIAL ISOLATION
Isolation was attempted in McCoy cells grown on 13 mm coverslips in culture tubes, each coverslip being seeded with 5 × 10⁶ cells. The McCoy cells were seeded in growth medium (Eagle's minimum essential medium containing 10% fetal calf serum, 0·11% bicarbonate, 10 mg/l gentamicin, and additional amino acids, vitamins, and glutamine) containing 25 mg/l idoxuridine and were incubated for two days before use. For isolation, the growth medium was removed, replaced with 1 ml of the specimen, and centrifuged at 3000 × g for one hour at 35°C. After further incubation for two hours at 35°C, the supernatant was removed and replaced with fresh growth medium containing idoxuridine. Tubes were incubated for a further two to three days before the coverslips were fixed with methanol and stained with iodine. *C trachomatis* was considered to be present if characteristic intracytoplasmic inclusions were seen. All specimens were examined by the same observer (CS).

EXAMINATION OF SLIDES
Fixed slides were allowed to reach room temperature, and 15 μl of direct monoclonal antibody (MicroTrak, Syva, Palo Alto, California, United States of America) was spread on the smear. The slide was incubated at room temperature in a moist chamber for 15 minutes. Reagent was removed by immersing the slide in distilled water for 10 seconds, excess water being absorbed by blotting round the smear with filter paper. Finally, the slide was allowed to dry at room temperature. The smear was mounted under a coverslip with MicroTrak chlamydia direct specimen mounting fluid and examined with a polyvar immunofluorescence microscope (Reichert-Jung). We used a B1 filter block epi-illumination system with ×10 magnification eye pieces, a ×40 magnification aperture, and with ×1·25 intermediate magnification. All slides were examined by one observer (CS).

STATISTICAL COMPARISON
We used the following definitions: true positives (results positive by both methods), true negatives (results negative by both methods), false positives (results positive by test method and negative by standard method), and false negatives (results negative by test method and positive by standard method).

We defined sensitivity as:
true positives
true positives plus false negatives
and specificity as:
true negatives
true negatives plus false positives

We calculated the probability value using the χ² test.
Results

A total of 216 patients (93 men, 123 women) entered the study. Thirty four (19 men and 15 women) were excluded from the analysis; 24 because of insufficient material on the slides to perform the immunofluorescence tests, seven because of contaminated tissue culture cells, and three because specimens failed to reach the laboratory. The table summarises the presenting clinical features and may not return. With an ‘on site’ immunofluorescence service, a result could be available within 40 minutes. If there is sufficient clinical awareness for patients to be treated on clinical grounds, then a tissue culture method may suffice if that is deemed necessary. The avoidance of delay in diagnosis and effective treatment of patients and sexual contacts is, however, of paramount importance. A rapid diagnostic method will undoubtedly be more efficient in achieving this.

<table>
<thead>
<tr>
<th>Clinical diagnosis</th>
<th>No (%) positive by:</th>
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<tbody>
<tr>
<td></td>
<td>Both methods</td>
</tr>
<tr>
<td>Cervicitis and vaginal discharge (n = 17)</td>
<td>7 (41)</td>
</tr>
<tr>
<td>Pelvic inflammatory disease (n = 45)</td>
<td>28 (62)</td>
</tr>
<tr>
<td>Contact of men with NGU (n = 46)</td>
<td>20 (43)</td>
</tr>
<tr>
<td>Men with NGU (n = 74)</td>
<td>48 (63)</td>
</tr>
<tr>
<td>Total (n = 182)</td>
<td>103 (57)</td>
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</tbody>
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NGU = non-gonococcal urethritis.

The incidence of chlamydial infection in our study population justifies providing an identification service and, though local incidences may vary, we suspect that this is generally true. In our hands, there was no significant difference between the two methods used for identifying *C trachomatis*, but it should be pointed out that we already had a well established tissue culture service at the start of the study. Such a service requires considerable expenditure and technical expertise, and cost analysis in an individual unit may well justify the capital outlay for a fluorescence microscope. In such an analysis, consideration must be given to factors such as possible delays between collecting specimens and inoculating tissue cultures in the laboratory. Even if transport medium is used there may be loss of viability of *C trachomatis* and hence false negative results. None of the nursing or technical staff associated with this study found either the collection and transport of specimens or practical procedures difficult to learn effectively. The most common difficulty encountered was the finding of insufficient material on the slides for the immunofluorescence procedure. This was greatly reduced by careful instruction and explanation to those taking the specimens and occurred rarely towards the end of the study.

In this study we highlighted a need for clinical awareness of chlamydial infection and for a microbiological service to genitourinary clinics. There was no significant difference between tissue culture and immunofluorescence methods in detecting *C trachomatis*, and the choice of method must rest with...
an analysis of cost, expertise, and practicalities in individual departments.

References

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