Penicillinase-producing Neisseria gonorrhoeae in Riyadh, Saudi Arabia

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SUMMARY Of 83 strains of Neisseria gonorrhoeae isolated in Riyadh, Saudi Arabia, between April 1979 and August 1980, 10 produced β-lactamase and had minimum inhibitory concentrations (MICs) of penicillin between 1 and >4 μg/ml. Of the 73 (88%) non-penicillinase-producing strains, 55% had diminished sensitivity to penicillin (MIC = 0·06 μg/ml) and 11 (15%) were highly resistant (MICs ranging from 0·5-2 μg/ml). This high incidence of resistance may be due to widespread abuse of antibiotics; it also confirms that two mechanisms of resistance to penicillin exist in this species.

Introduction
Relative resistance of Neisseria gonorrhoeae to penicillin has been reported from all over the world.1,2 Although penicillin still remains the drug of choice in the treatment of gonorrhoea, treatment failures are becoming more common. Recently, the problem of antibiotic resistance in strains of N. gonorrhoeae has been aggravated by the appearance of penicillinase-producing strains (PPNG). The first two PPNG strains were isolated in the USA in 1976,3 4 and at the end of the same year a national surveillance programme was initiated to detect infections due to PPNG in the USA. In 1977, 191 cases of PPNG infection were confirmed at the Center for Disease Control (Atlanta, Georgia, USA).5 PPNG strains were also isolated for the first time in Britain in 1976; most of these reports were of single sporadic cases.6 7 There was, however, an outbreak of gonorrhoea due to PPNG strains in 76 patients in Liverpool, England, between February and November of that year.8 Since then, there have been several reports on their appearance in South Africa,9 some parts of the USA,10 Singapore,11 Hong Kong,12 West Germany,13 and the Netherlands.14 15

As far as we know there are no published data on the incidence of strains of N. gonorrhoeae resistant to penicillin in Saudi Arabia. We have, therefore, studied the penicillin sensitivity and β-lactamase production of strains of N. gonorrhoeae isolated in Riyadh, with particular reference to their epidemiology.

Patients and methods

ISOLATION AND IDENTIFICATION Strains of N gonorrhoeae were obtained from 83 patients (79 men and four women) with acute purulent gonococcal urethritis attending the dermatovenerological clinic, King Abdul Aziz Teaching Hospital, Riyadh, between April 1979 and August 1980. Specimens of genital discharge were sent to the laboratory in a Stuart’s transport medium and cultured on Thayer-Martin medium (Oxoid) and chocolate blood agar; the plates were incubated in candle extinction jars at 37°C for 24-48 hours. Gonococci were identified by their morphological characteristics, the oxidase reaction, and sugar fermentation tests.

PENICILLIN SENSITIVITIES
Doubling dilutions of penicillin G were incorporated in chocolate blood agar to give concentrations from 0·0075 μg/ml to 4 μg/ml. A standard loop (0·005 ml) was used to inoculate the plates with 10⁵ colony-forming units (cfu). The inoculum was prepared by making a suspension of N gonorrhoeae taken from an overnight culture on chocolate blood agar to match a Browne’s opacity tube number 4, which is equivalent to 1·4 × 10⁹ organisms/ml. The suspension was then diluted to give a final concentration equivalent to 10³ organisms/ml. A control chocolate blood agar plate without any antibiotic was included in each batch of tests and the Oxford strain of Staphylococcus aureus (MIC = 0·03 μg/ml) was used as control.
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β-LACTAMASE PRODUCTION

All strains of N gonorrhoeae were tested for β-lactamase production by both intralactam strips and a plate method. The intralactam strips were obtained from Mast Laboratories (Liverpool, England), and tests were carried out according to the method of Whelden and Slack. In the plate method a chocolate agar plate was flooded with a suspension of the Oxford strain of Staph aureus, which is sensitive to ampicillin. When the plate was dry, an ampicillin disc (10 μg) was placed in the centre of the plate and the test organism was streaked radially out from the disc. Known positive and negative controls were included on each plate. If β-lactamase is produced, the ampicillin will be denatured and the indicator Oxford Staph aureus will grow along the line of the streak up to the ampicillin disc.

Discussion

Reports on the antibiotic resistance of strains of N gonorrhoeae to penicillin started to appear in 1944. Since then the impression of a progressive increase of resistance to penicillin has been confirmed. Fifty-five per cent of our strains (excluding PPNG strains) showed diminished sensitivity to penicillin. This figure is comparable to those in Bombay (56%) and Rotterdam (48%). However, it is lower than those in Greenland (86%), Toronto (80%), Ethiopia (66%), USA (70%), and Nigeria (82.5%). The incidence of resistance may be high because antibiotics are easily available and are abused by the general public. Self-medication with inadequate doses and the frequent use of inappropriate antibiotics are common among prostitutes as well as among patients. Olsen and Lomholt showed that improving the results of treatment of gonorrhoea by increasing the dosage of penicillin lowers the prevalence of partially resistant strains.

In this study 10 (12%) strains of N gonorrhoeae were resistant to penicillin owing to β-lactamase production. This figure is higher than in other countries, for example, England (Liverpool) 99% and the Netherlands 2-4%. It is, however, much lower than in some parts of the USA (40%) and in Singapore (53%).

We found that 15% of non-PPNG strains were highly resistant, with MICs for penicillin ranging from 0.5 to 2 μg/ml. This confirms that two mechanisms may cause penicillin resistance in strains of N gonorrhoeae—namely, penicillinase production and some intrinsic interference in the passive diffusion of penicillin into the bacterial cell. Similar mechanisms of resistance were recently described in strains of Haemophilus influenzae.

In one of our strains of PPNG a mixture of enzyme-negative and enzyme-positive colonies was found in the primary culture. This finding is similar to that of Percival et al, who detected enzyme-negative colonies in 1-30% of colonies obtained from the primary clinical specimens. In addition, they pointed out that infections due to PPNG strains may be missed unless several anatomical sites are sampled since some patients harbour these strains in only some of the infected sites.

TABLE Minimum inhibitory concentrations of penicillin for 83 isolates of Neisseria gonorrhoeae

<table>
<thead>
<tr>
<th>Strains</th>
<th>No (%) of strains showing MICs (μg/ml)</th>
<th>0.0075</th>
<th>0.015</th>
<th>0.03</th>
<th>0.06</th>
<th>0.12</th>
<th>0.25</th>
<th>0.5</th>
<th>1.0</th>
<th>2.0</th>
<th>4.0</th>
<th>&gt;4.0</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-PPNG</td>
<td>6 (8)</td>
<td>14 (19)</td>
<td>13 (18)</td>
<td>11 (15)</td>
<td>14 (19)</td>
<td>4 (5)</td>
<td>8 (11)</td>
<td>2 (3)</td>
<td>1 (1)</td>
<td>0</td>
<td>0</td>
<td>73 (88)</td>
<td></td>
</tr>
<tr>
<td>PPNG</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1 (1)</td>
<td>4 (5)</td>
<td>1 (1)</td>
<td>4 (5)</td>
<td>10 (12)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It was not possible to detect the relative resistance to penicillin by a disc diffusion method. The MIC should, therefore, be routinely determined by a plate dilution technique in areas where the incidence of relative resistance is high and also in cases of treatment failure.

Because of the high prevalence of PPNG strains in Riyadh, we recommend that all gonococcal isolates should be screened for $\beta$-lactamase production, as stated by Sng et al. All strains should be screened firstly by a quick strip method; all positive and dubious results should then be confirmed by a plate or other methods.

References