Q Fever in the Greek Island of Crete: Detection, Isolation, and Molecular Identification of Eight Strains of *Coxiella burnetii* from Clinical Samples

IOANNA SPYRIDAKI, ACILHEAS GIKAS,* DIAMANTIS KOFTERIDIS, ANNA PSAROULAKI, AND YANNIS TSELENTIS

Clinical Bacteriology, Parasitology, and Geographical Medicine, University Hospital of Heraklion, Voutes-Heraklion
TK 71110 Crete, Greece

Received 13 October 1997/Returned for modification 10 November 1997/Accepted 26 March 1998

Over a period of 6 years (1989 to 1995), serum samples from 3,300 patients suspected to be infected by *Coxiella burnetii* were assayed for the presence of antibodies against antigen phase II of the microorganism by the indirect immunofluorescence antibody technique (IFAT). One hundred fifty-two cases were recorded, and blood samples from 17 patients were cultured for the isolation of the pathogen. By a centrifugation shell vial technique, eight strains were isolated from patients suffering from acute Q fever. The microorganism was detected in the cultures by IFAT, by Gimenez staining, and by the cytopathogenic effect on Vero and human embryonic lung (HEL) cells. PCR followed by restriction fragment length polymorphism analysis was used to confirm the diagnosis and identify the *Coxiella burnetii* strains within the cell cultures as well as to compare them with reference strains. In order to avoid time-consuming cultures, to achieve direct detection of *Coxiella burnetii* in clinical samples (blood, buffy coat, etc.), and to improve the specificity and sensitivity of the detection, nested PCR was performed. The first step of DNA extraction was performed with the QiAamp blood kit 250. For the second step of the PCR assays, the conditions of temperature and times of recycling were properly modified, and the microorganism was detected within 4 h. Our study demonstrates that Q fever is an endemic disease in Crete and that the diagnosis of *Coxiella burnetii* infection can be rapidly achieved by the detection of the microorganism in buffy coat samples by nested PCR. Although the presenting symptoms of the disease in this study differed from those in other studies, the Cretan strains do not differ genotypically from the reference strains (Nine Mile and Q212).

*Coxiella burnetii*, an obligate intracellular parasite with a worldwide distribution, is the causative agent of Q fever in humans and animals (1, 25).

The bacterium exists as a strict intracellular parasite when infecting its host but can also survive in the environment (1). Early assessments of the epidemiology of Q fever suggested that the diseases can be transmitted through contact with infected animals, blood transfusions, inhalation of infectious aerosols, the digestive tract, skin trauma, and sexual contact and, rarely, by a mother to the fetus (21, 24).

In humans, the infection has two forms, acute and chronic. The acute form is manifested by pneumonia, prolonged fever, granulomatous hepatitis, and, rarely, meningoencephalitis (23). The main clinical manifestation of chronic Q fever is endocarditis (1, 23, 24, 34).

In Greece in 1946, Caminopetros detected the microorganism in sera of German soldiers (2). Since 1950, only sporadic cases have been reported, and the microorganism was never cultured.

In a previous study on the Greek island of Crete, Tselentis et al. reported that the predominant clinical manifestations of the infection were fever and respiratory disease, whereas hepatitis occurred in only a minority of the infected patients (34). Reports from Australia (4), Great Britain (3, 8), the United States (10), Spain (17), France (5), and Canada (35) indicate that epidemiological and clinical features of the disease may vary from one area of the world to another. For example, in two Australian studies the prevailing clinical presentation was fever of unknown origin (16); in two studies from Nova Scotia (15) and Switzerland (6), the prevailing clinical presentation was pneumonia, while in a French study, hepatitis was the prevailing feature (5).

Since the reason for this clinical diversity between acute cases of Q fever is not known, the causative roles of strain differences cannot be excluded. However, no firm conclusions can be drawn because of the small number of *C. burnetii* strains isolated from patients suffering from acute Q fever (18–20, 36). Thus, isolation of *C. burnetii* strains from different geographic areas is needed.

Laboratory diagnosis of Q fever is mainly based on serological tests (29). The isolation of *C. burnetii* in cultures is time-consuming and hazardous and may give false-negative results. To overcome these problems, PCR and nested PCR techniques were developed (12, 29, 36). A number of *C. burnetii* strains originating from patients suffering from either chronic or acute Q fever have been isolated by a shell vial culture method. The method was successfully applied on valves, arterial prostheses, bone, skin biopsies, bone marrow, and blood (11, 18, 20, 29, 30).

The purpose of this study was (i) the isolation and molecular identification of clinical strains of *C. burnetii* in Greece, (ii) the comparison of our isolates with the reference strains by PCR-restriction fragment length polymorphism (RFLP), and the improvement of the methodology of rapid detection of *C. burnetii* in patient samples.
noglobulin G (IgG) of antibodies against antigen phase II of the microorganism. Using the indirect patients suspected to be infected by Organization. Over a period of 6 years (1989 to 1995), serum samples from 3,300 and Geographical Medicine and a collaborating center of the World Health increase of the titers between two assays as a strong indication of acute infection. C. burnetii from Greek patients, the identification of these at 72°C.

denaturation (at 94°C for 30 min), annealing (at 55°C for 30 min), and extension

Hin mutase gene, and primers G4131 and G4132 were derived from a shotgun

QpH11..............5'-GAATTTCTTCCAGATCATGAATG-3' (363 bp)

Plasmidic
OprRS01............5'-GGTTTCAAGGATCAGTTGACCTTACT-3' (183 bp)

OprRS02............5'-GCATATATATGCAATGTGACCTTACT-3' (183 bp)

Hragl.............5'-ATTGGAATACGCAGTCAAAG-3' (183 bp)

Hragl2.............5'-ACGACAGTCAAAG-3' (183 bp)

HFF1..............5'-GACAGTCAAAG-3' (183 bp)

HFF2..............5'-GACAGTCAAAG-3' (183 bp)

In this study, we report the isolation of eight strains of C. burnetii from Greek patients, the identification of these strains by PCR-RFLP with material from cell cultures, and the direct detection of the pathogen by nested PCR in buffy coat samples within 4 h.

MATERIALS AND METHODS

Our laboratory is the National Reference Centre of Parasitology, Zoosanitaria, and Geographical Medicine and a collaborating center of the World Health Organization. Over a period of 6 years (1989 to 1995), serum samples from 3,300 patients suspected to be infected by C. burnetii were assayed for the presence of antibodies against antigen phase II of the microorganism. Using the indirect immuno- fluorescence antibody technique (IFAT), we considered titers of immuno-globulin G (IgG) of ≥1/960 or titers of IgM of ≥1/400 and/or a fourfold increase of the titers between two assays as a strong indication of acute infection. A fever of ≥38°C, respiratory disease (dyspnea, expectoration, cough, and chest pain with associated X-ray abnormalities), hepatitis (a higher-than-twofold increase in serum glutamic oxaloacetic transaminase and/or serum glutamic pyruvic transaminase levels), central nervous system involvement (neurological symptoms associated with normal or abnormal cerebrospinal fluid findings), and skin rash were considered cardinal manifestations of Q fever. The diagnosis was made according to clinical and serological criteria of the disease. One hundred fifty-two cases of Q fever were recorded.

Physicians were asked to provide buffy coat samples from patients who had not received C. burnetii-specific antibiotics at admission.

Samples. Samples from 17 patients were assayed for the detection and identification of the microorganism. For blood cultures, a 5-ml sample of heparinized blood was obtained, and after sedimentation for 40 min, the supernatant mono-layer was inoculated into the shell vials.

Isolation of C. burnetii. Human embryonic lung (HEL) fibroblasts were grown in minimum essential medium with 10% fetal calf serum and then 1% glutamine. Shell vials (3 and 7 ml; Sterilin, Felthan, England) with 12-mm-diameter coverslips were seeded with 1 ml of medium containing 50,000 cells and incubated in a 5% CO2 incubator for 3 days to obtain a confluent monolayer. A portion of the buffy coat fraction of each sample (0.5 ml) was diluted with 1 volume of growth medium.

One milliliter of the mixture was placed in each shell vial. The shell vials were centrifuged at 700 × g for 1 h at 22°C. The inoculum was then removed, and 1 ml of growth medium was added to the cells. The shell vials were incubated in a 5% CO2 incubator at 37°C. At least three shell vials were inoculated per sample. The cytotoxic effect of C. burnetii in HEL and Vero cells was also observed (20).

Immunofluorescence detection of C. burnetii. The cell monolayers in the shell vials were examined for C. burnetii by IFAT on day 6 and again on day 12 if the first test was negative. For detection of C. burnetii, human serum samples collected in our laboratory (which display a high titer of immunofluorescent antibodies to C. burnetii of ≥1/10,000), at a dilution of 1/100, and fluorescein-conju-gated goat antiserum to human IgG (dilution, 1/200) (Kallestad, Austin, Tex.) were used. Specificity was evaluated by simultaneous staining of uninoculated cell monolayers and inoculated cultures with human serum negative for antibod- ies to C. burnetii.

Detection by PCR and nested PCR. The DNA extraction from buffy coat was performed with the QIAamp blood kit 250 (Qiagen, Hilden, Germany) according to the instructions of the manufacturer. Infected cells were used for PCR detection and RFLP identification of C. burnetii. Two hundred microliters of the cell suspension was incubated in the presence of 400 ng of proteinase K per ml (stock solution, 20 mg/ml in H2O) overnight at 56°C. Subsequently, proteinase K was inactivated by boiling for 10 min, and the solution was centrifuged at 2,000 rpm for 5 min at 22°C in a Beckman GS-4R centrifuge. The supernatant was kept at −20°C.

DNA amplification. In order to perform DNA amplification of the Greek strains and compare them with the reference strains, Nine Mile and Q212, three different genomic primers were used. Additionally, in order to ascertain whether the Greek isolates contained plasmids, two additional types of primers which have been described to indicate acute or chronic Q fever were used (Table 1) (36). Primers OprHI1 and OprHI2 detect plasmids present during acute Q fever, whereas primers OprRS01 and OprRS02 detect plasmids present in chronic infec-tion due to C. burnetii (36).

PCR was performed with 10 μl of supernatant from the proteinase-K-treated cell suspension in a total volume of 100 μl. The PCR mixture contained 1 μM of each primer, 200 μM of each deoxynucleoside triphosphate, 2.0 mM MgCl2, and 0.5 U of Taq polymerase (GIBCO BRL Life Technologies, Gaithersburg, Md.). The primers used, as well as the cycling conditions, are listed in Table 1.

For the direct PCR detection of C. burnetii in the buffy coat, a nested PCR assay was performed with primers Hrag1 and Hrag2 in the first PCR and primers HFI1 and HFF2 in the nested PCR. The conditions used are described in

<table>
<thead>
<tr>
<th>Primer</th>
<th>Sequence (length [bp])</th>
</tr>
</thead>
<tbody>
<tr>
<td>OprRS01</td>
<td>5'-CTGACCACAAGCTACTGAATATCC-3' (363 bp)</td>
</tr>
<tr>
<td>OprRS02</td>
<td>5'-CAGATTGGATCTGACTTGCTCCCT-3' (363 bp)</td>
</tr>
<tr>
<td>OprHI1</td>
<td>5'-GAATTTCTTCCAGATCATGAATG-3' (183 bp)</td>
</tr>
<tr>
<td>OprHI2</td>
<td>5'-GAATTTCTTCCAGATCATGAATG-3' (183 bp)</td>
</tr>
<tr>
<td>Hrag1</td>
<td>5'-ATTGGAATACGCAGTCAAAG-3' (183 bp)</td>
</tr>
<tr>
<td>Hrag2</td>
<td>5'-ACGACAGTCAAAG-3' (183 bp)</td>
</tr>
<tr>
<td>HFF1</td>
<td>5'-GACAGTCAAAG-3' (183 bp)</td>
</tr>
<tr>
<td>HFF2</td>
<td>5'-GACAGTCAAAG-3' (183 bp)</td>
</tr>
</tbody>
</table>

* Cycling conditions were as follows: 94°C for 5 min with 35 (total) cycles of denaturation (at 94°C for 30 min), annealing (at 55°C for 30 min), and extension (at 72°C for 30 min). After the 35 cycles, the PCR product was held for 10 min at 72°C.
* Primers CB1 and CB2 were derived from the C. burnetii superoxide dismutase gene, and primers G4131 and G4132 were derived from a shotgun HindIII subcloning fragment (297 bp).

TABLE 1. Primer sequences used in this study

<table>
<thead>
<tr>
<th>Primer</th>
<th>Sequence (length [bp])</th>
</tr>
</thead>
<tbody>
<tr>
<td>G4131</td>
<td>5'-CTG ACC ACA GGC ACT GGA ACC GC-3'</td>
</tr>
<tr>
<td>G4132</td>
<td>5'-GTT CAT GGT TAT GAT TCT GCG-3' (183 bp)</td>
</tr>
<tr>
<td>16S1</td>
<td>5'-GTT AGT TCA GTA AGG TCG G-3'</td>
</tr>
<tr>
<td>16S2N</td>
<td>5'-GTT AGT TCA GTA AGG TCG G-3' (77 bp)</td>
</tr>
</tbody>
</table>

In Table 2, the clinical, serological, therapeutic, and culture data for eight Q fever patients with blood cultures positive for C. burnetii are presented.

<table>
<thead>
<tr>
<th>Patient no.</th>
<th>Diagnosis at admission (duration of fever [days])</th>
<th>Treatment</th>
<th>Phase II antibody titer for:</th>
<th>Blood culture (day)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>CB1</td>
<td>Fever + (10)</td>
<td>Vibramycin</td>
<td>IgM 3,200 IgG 3,840 IgA 200</td>
<td>+ (10)</td>
</tr>
<tr>
<td>CB2</td>
<td>Pneumonia + fever (8)</td>
<td>Vibramycin</td>
<td>800 IgM 7,680 IgG 800 IgA 600</td>
<td>+ (12)</td>
</tr>
<tr>
<td>CB3</td>
<td>Pneumonia + fever (6)</td>
<td>Vibramycin</td>
<td>6,400 IgM 30,700 IgG 6,900 IgA 1,200</td>
<td>+ (11)</td>
</tr>
<tr>
<td>CB4</td>
<td>Pneumonia + fever (9)</td>
<td>Vibramycin</td>
<td>51,200 IgM 61,440 IgG 12,800 IgA 6,900</td>
<td>+ (8)</td>
</tr>
<tr>
<td>CB5</td>
<td>Pneumonia + fever (10)</td>
<td>Macrolide</td>
<td>102,400 IgM 122,880 IgG 12,800 IgA 6,900</td>
<td>+ (6)</td>
</tr>
<tr>
<td>CB6</td>
<td>Pneumonia + fever (6)</td>
<td>Macrolide</td>
<td>6,400 IgM 30,700 IgG 6,900 IgA 1,200</td>
<td>+ (10)</td>
</tr>
<tr>
<td>CB7</td>
<td>Pneumonia + fever (8)</td>
<td>Macrolide</td>
<td>3,200 IgM 7,680 IgG 800 IgA 600</td>
<td>+ (10)</td>
</tr>
<tr>
<td>CB8</td>
<td>Pneumonia + fever (5)</td>
<td>Macrolide</td>
<td>800 IgM 3,840 IgG 200 IgA 600</td>
<td>+ (12)</td>
</tr>
</tbody>
</table>

* Body temperature greater than or equal to 38°C.
* Dyspnea, cough, expectoration, hemoptysis, or chest pain associated with chest radiographic abnormalities.
* +, positive shell vial cultures.

Downloaded from http://jcm.asm.org on August 22, 2017 by guest.
Table 1. The PCR products were separated on a 2% agarose gel and visualized by UV illumination.

Restriction endonuclease digestion. The specificity of the amplification was evaluated by restriction analysis of the PCR products. The CB1 and CB2 and Hfrag1 and Hfrag2 products from infected cells were digested with the enzymes TaqI and AluI (New England Biolabs) as previously described (29, 36). The restriction fragments were examined by electrophoresis on a 3% low-melting-point agarose gel (GIBCO BRL), stained with ethidium bromide, and viewed by UV illumination. The restriction fragments were compared with those obtained with the reference strains, Nine Mile and Q212.

RESULTS

Isolation of C. burnetii. Three cultures were obtained from each patient prior to any administration of antibiotics. We were able to isolate C. burnetii in blood cultures from eight of 17 patients suffering from Q fever. All patients except one presented with fever and pneumonia. The last patient had had fever for 10 days upon admission. Clinical, serological, therapeutic, and culture data from these eight patients are presented in Table 2.

The microorganism was detected between days 6 and 12 by IFAT, Gimenez staining, and PCR (7). The subcultures derived from the initial shell vial were considered heavily infected after 15 to 21 days of incubation. At this point, the voluminous vacuolar formations in the cell cytoplasm, due to the cytopathic effect of C. burnetii, were prominent (20).

PCR identification. C. burnetii-specific sequences were amplified by PCR from DNA derived from infected Vero or HEL cells. For further characterization of the isolates, PCR was carried out with infected cells with the genomic primers CB1 and CB2 and the plasmidic primers QpH11 and QpH12, which were initially designed as primers specific for acute infection (29, 36). Our results showed clearly that the specific PCR product appeared in all our samples and the Nine Mile strain but not in the Q212 strain (36). On the other hand, the primers QpRS01 and QpRS02, which were referred to as amplifying only chronic infection from specific sequences, did not give any amplification with our samples and the Nine Mile strain but produced a PCR-specific product with the Q212 strain (36).

The PCR methods were not sensitive enough to detect C. burnetii directly in the clinical samples (buffy coat, blood, etc.).

The assay specificity has been previously evaluated by restricted digestion of the PCR products (29). PCR products obtained (with primers CB1 and CB2) from our samples and the reference strains were subsequently digested with AluI, resulting in the generation of fragments of 186, 68, and 3 bp (Fig. 1), whereas cleavage with TaqI gave fragments of 118, 57, 43, and 39 bp (Fig. 2). The product of amplification with primers Hfrag1 and Hfrag2 in infected cells was digested with TaqI, and the sizes of the generated fragments were identical to those of the fragments derived from the reference strains, Nine Mile and Q212 (36).

Nested PCR detection. Detection of C. burnetii by nested PCR (Fig. 3 and 4) succeeded only with buffy coat samples by the DNA extraction method with the QIAamp blood kit. When whole blood was used, we were unable to detect a positive signal, even in the samples from which C. burnetii had been...
previously isolated. The nested PCR test for the detection of
C. burnetii was modified from the one previously described (36)
in three ways. (i) Extraction of DNA was done by us with the
QIAamp blood kit instead of by the traditional boiling method
(36), (ii) the temperatures were changed, and (iii) the times of
recycling were modified (Table 1). Thus, the overall duration
of nested PCR was 4 h.

C. burnetii was also isolated from the same samples by cul-
ture. The product obtained by the nested PCR had a size of
183 bp (Fig. 3).

DISCUSSION

C. burnetii is an obligate intracellular parasite that was iso-
lated initially in animals (guinea pigs) and embryonated chick-
en eggs and later in cell cultures (Vero and L929). These modes
of isolation are time-consuming, hazardous, and restricted to
specialized laboratories. A less-hazardous technique for the
isolation of C. burnetii was proposed by Raoult et al., who used
a simplified shell vial culture system (20). Although this rapid
culture radically accelerates the identification of C. burnetii,
the process is still too lengthy to be employed in everyday
clinical practice. The shell vial technique proved to be very
efficient and able to yield large quantities of C. burnetii for
further studies of strain identification and antibiotic suscepti-
bility (22, 26). Although the genome of C. burnetii is still
thought to be highly conserved, previous studies have shown
that C. burnetii isolates can be differentiated by RFLP (9, 32)
and/or plasmid DNA content (27, 36). The first C. burnetii
plasmid, QpH1, was isolated and described by Samuel et al.
(28). This low-copy-number plasmid (13) was obtained from
tick isolate Nine Mile, the prototype strain of acute Q fever.
Another plasmid, QpRS, also described by Samuel et al. (27),
was obtained from a goat placenta C. burnetii isolate and found
to be common to most of the chronic Q fever isolates (14).

PCR-RFLP is useful for detection and identification of
C. burnetii in early shell vial cultures, for diagnosis of both
acute and chronic infections, and for detection of the bacteria
in certain clinical specimens (heart valves) (29).

The classification of C. burnetii strains into acute and chronic
isolates by PCR is still preliminary. It is not yet known whether
the virulence potential of C. burnetii is encoded by plasmids or
genomic sequences or dependent on host factors as well (31,
33). We used both primers (genomic and plasmidic) in order to confirm the above differentiation.

All our patients presented the clinical manifestations of acute Q fever infection. Follow-up analysis of IgM and IgG showed a decline in antibody titers. No other clinical manifestations (e.g., cardiac or chronic hepatic involvement, etc.) were present during a 2- to 3-year follow-up period.

Our strains were detected with the primers OphH11 and OphH12, derived from plasmids of strains associated with acute Q fever, but not with primers derived from strains associated with chronic Q fever.

Recently, a nested PCR approach was used for the highly sensitive and specific direct detection of C. burnetii in clinical samples collected from animals and humans, with primers based on conserved plasmidic sequences (33, 36).

However, this technique also proved inconvenient, since the procedure times are not yet appropriate for the everyday clinical practice and inhibitors of the reaction can falsify the results. Our method, which involved changing the DNA extraction procedures and optimizing the temperature and time conditions, improved the time required for the PCR procedure, making results available within 4 h.

This study presents the first successful attempt to isolate C. burnetii in Greece from patients suffering from the acute form of the infection.

In conclusion, we have successfully isolated C. burnetii in Greece from eight Greek patients by the shell vial assay. Isolates were detected and identified by molecular biology techniques. Optimization of nested PCR conditions allowed direct detection of C. burnetii within 4 h. The strains isolated did not differ from the standard reference strains.

REFERENCES