Recurrent Infections and Chronic Colonization by an *Escherichia coli* Clone in the Respiratory Tract of a Patient with Severe Cystic Bronchiectasis

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A 39-year-old woman with cystic bronchiectasis had repeated pulmonary infections from 1996 to 1999, and 6 of a total of 28 isolates of *Escherichia coli* from sputum specimens were studied. Their identical antibiotype and randomly amplified polymorphic DNA patterns indicated a single clone of *E. coli*, which persistently colonized the respiratory tract, causing recurrent infections.

*Escherichia coli* is the most abundant facultative anaerobic bacterium in the normal human intestine. Its presence is clearly associated with infections of the gastrointestinal tract, urogenital tract, and peritoneum and occasionally with infections at distant loci after bacteremia. However, it is rarely associated with pulmonary infections (2).

In March 1987, a 39-year-old woman who suffered from fever, a productive cough with copious purulent sputum, and progressive dyspnea was admitted to National Taiwan University Hospital. She had survived measles complicated with pneumonia when she was 4 years old and had had a chronic cough, purulent expectoration, and chronic dyspnea with episodic exacerbation accompanied by fever thereafter. She did not smoke cigarettes or drink alcohol. Physical examination revealed an emaciated woman with fever, respiratory distress, and cyanosis. She had engorged jugular veins, coarse crackles over bilateral lung fields, and marked clubbing of all digits. Her breath and sputum both produced a putrid odor. Chest roentgenography revealed diffuse cystic bronchiectasis of bilateral lungs with multiple air-fluid levels, pulmonary hypertension, and localized right pneumothorax. From March 1996 to February 1999, she was readmitted seven times with similar manifestations. High-resolution computed tomography of the chest done in December 1998 showed diffuse severe cystic bronchiectasis with multiple air-fluid levels and right pneumothorax. Microbiological studies (Gram and acid-fast stains and aerobic bacterial cultures) of multiple sputum specimens were performed during each hospital stay. Microscopic examinations of the sputum specimens all revealed numerous polymorphonuclear cells and predominant gram-negative bacilli. Cultures of a total of 28 sputum specimens over this 3-year period all yielded heavy growth of *E. coli*. Each organism was isolated either as a sole pathogen (21 occasions) or as one of mixed pathogens (with *Haemophilus parainfluenzae* on three occasions, *Pseudomonas aeruginosa* on three occasions, and *Klebsiella pneumoniae* on one occasion). All of these *E. coli* isolates had nearly identical antibiotic types, as determined by disk diffusion testing against 12 antimicrobial agents. The isolates were resistant to ampicillin, intermediate susceptibility or susceptible to amoxicillin-clavulanic acid, and susceptible to cefotaxim, cefotaxime, aztreonam, gentamicin, netilmicin, amikacin, imipenem, and ciprofloxacin. Blood and urine cultures of specimens collected during this period were all negative for *E. coli*. In July 1996, arterial blood gas collected while the patient was breathing room air showed a pH of 7.407, pCO₂ of 6.78 kPa, pO₂ of 9.30 kPa, and a bicarbonate level of 31.7 mmol/liter. Intravenous antibiotic therapy including amoxicillin-clavulanic acid, cefazolin, cefmetazole, or ciprofloxacin had been given and continued for 21 to 28 days during each hospitalization. Fever usually declined within 3 to 7 days, while decreases in sputum amount and purulence took 2 to 4 weeks. Even between hospital stays her sputum remained copious and purulent. Her pulmonary function deteriorated rapidly, and arterial blood gas when the patient was on a 40%, 10-liter/min O₂ mask in February 1999 showed a pH of 7.445, pCO₂ of 7.45 kPa, pO₂ of 9.06 kPa, and a bicarbonate level of 37.8 mmol/liter. She had remained bedridden since 1997.

Of the 28 *E. coli* isolates, six were subjected to further investigations: one was isolated in 1996, two were isolated in 1997, two were isolated in 1998, and one was isolated in 1999. MICs of six antimicrobial agents were determined for these isolates using the Etest (AB Biodisk, Solna, Sweden) as described previously (6). All of the isolates had identical antibiotype types: MICs of >256 μg/ml for ampicillin, 48 μg/ml for cefazolin, 24 μg/ml for amoxicillin-clavulanic acid, 0.75 μg/ml for ciprofloxacin, 4 μg/ml for minocycline, and 32 μg/ml for trimethoprim-sulfamethoxazole. Analysis of randomly amplified polymorphic DNA (RAPD) patterns generated by arbitrarily primed PCR was performed as reported previously (7). In addition to the six isolates from our patient, three isolates (as control strains) from blood samples of three other patients were also typed. Two oligonucleotide primers were used: M13 (5′-TTATGTAACGACGAGCCAGT-3′) and ERI1 (5′-GTGAATCCCCAGGCTTACAT-3′) (Operon Technologies Inc., Alameda, Calif.). Figure 1 shows the RAPD patterns of the nine isolates obtained with the two primers. The six patient isolates had identical RAPD patterns, which were different from those of the three control strains. Pulmonary infection due to *E. coli* is rare in clinical settings. Tillotson and Lerner reported that *E. coli* accounted for only 0.7% of 1,882 cases of pneumonia at Detroit Receiving Hospital (15). *E. coli* infection usually induces bronchopneumonia with interstitial infiltration of mononuclear cells (8, 11, 15, 16).


FIG. 1. RAPD patterns generated by arbitrarily primed PCR of the nine isolates of E. coli with two primers: M13 (A) and ERIC1 (B). Lanes M, molecular marker; lanes 1 to 6, six E. coli isolates from the patient with cystic bronchiectasis; lanes 7 to 9, the three control strains.

REFERENCES