**Bacteremic Pneumococcal Pneumonia: a Longitudinal Study in 279 Adult Patients from a Single Center**

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**Abstract**

**Background:** Bacteremic pneumococcal pneumonia (BPP) is the most common clinical presentation of invasive pneumococcal disease (IPD). Although it has been extensively studied, there is little knowledge in our region in relation to burden of disease, demographic and outcome features.

**Methods:** We conducted a prospective, longitudinal, observational study from 1989 to 2015 in adult patients with BPP, in order to deepen our knowledge of the characteristics of this disease in our community hospital in Tandil, Argentina.

**Results:** 279 patients were included. The mean incidence was 2.8/1000 admissions with a sharp decrease in the last two years, reaching 0.8/1000 admissions. Mean patient age was 60 years. Comorbidities were found in 65% of the cases. Non-respiratory symptoms occurred in 50% of cases. Infiltrates on chest x ray were predominantly unilateral (75%) and lobar (57%). Regarding severity, a low PSI score I-II-II was found in 178 patients (64%); 60 (22%) were admitted to ICU, 40 (14%) required mechanical ventilation, and 21 (8%) developed empyema. Penicillin resistance was not found. Mortality was 18% (49/279), and by a multivariate analysis it was associated with confusion (OR= 5.44), age>80 years (OR =5.72), leukopenia (OR =5.73) and dyspnea (OR=7.87).

**Conclusions:** In this study of 279 bacteremic pneumococcal pneumonia we reinforce previous knowledge on this disease regarding incidence and clinical features and confirm a considerable early mortality associated to age and severity of disease at onset. Recent changes in incidence of BPP in adults could be secondary to herd effect of PVC 13 a vaccine that is mandatory in children in our community since 2012.

**Introduction**

*Streptococcus pneumoniae* (S. pneumoniae) is the most common cause of community acquired pneumonia (CAP) in adults accounting for most cases of pneumonia hospitalizations and deaths [1-2]. Bacteremic pneumonia is the most frequent invasive pneumococcal disease (IPD) in adults and remains a major cause of morbidity and mortality despite improvements in medical care [2-3]. From older and recent studies, it is estimated that approximately 20% of patients with pneumococcal pneumonia develop bacteremia [3-4], with a mortality rate ranging between 15-35%.

More than 50% of *S. pneumoniae* bacteremia cases occur in elderly patients and most studies show increased pneumococcal-related deaths in this population [1-3-5]. Variations between reported fatality rates might be explained by differences between studied populations including demographic factors, underlying health conditions, severity of illness at the time of admission, and bacterial factors. Also, geographical and temporal situations should be considered. On the other hand, drug resistance does not appear to contribute to mortality or ICU admission rates [5].

Despite the fact that BPP is a frequent and severe disease, there is minimal information regarding BPP in our city. We report here the result of 26-year prospective study in patients with BPP treated in our hospital, to assess local disease incidence, clinical, radiographic and microbiological features, as well as to evaluate factors related to mortality.

**Methods**

**Study Design and Study Population**

This was a longitudinal, prospective observational study of adult patients with BPP evaluated at the Santamarina Hospital in the city of Tandil. The hospital is a 130-bed primary care community hospital. Tandil is a city with a population of 130,000 inhabitants located in the province of Buenos Aires, Argentina.

**Inclusion/exclusion criteria**

Inclusion criteria: Patients 18 years or older with BPP that were assisted in the emergency room and admitted to the hospital or
treated in ambulatory setting between 1989 and 2015. Exclusion criteria: having been hospitalized in the last 30 days, or presented with any other evidence suggestive of nosocomial pneumonia, severe immunosuppression such in transplantation, AIDS or receiving chemotherapy or other immunosuppressive drugs.

**Study definitions/variables**

Pneumonia was defined as the presence of a new infiltrate on chest radiograph plus two or more of the following clinical manifestations including: fever (axillary temperature >37.8°C), cough, production of purulent sputum, pleuritic chest pain and dyspnoea. BPP was defined as a diagnosis of pneumonia with one or more positive blood cultures for *S. pneumoniae*.

Identification of patients with BPP: one of the authors of this manuscript, (CH or JG), or a resident, reviewed admissions to the hospital daily, including holidays. The laboratory informed as soon as possible, when *S. pneumoniae* was isolated from blood culture. Data of chart was reviewed and a form was completed within 48-72h of admission. All patients were questioned, examined and followed exclusively by the authors. (JG or CH). When a patient with criteria of BPP was not admitted and sent home we strived to contact him in order to assist and include him in the study.

Hospital based incidence was calculated dividing number of BPP/adult patients admitted annually to the hospital x 1000. Seasonal distribution was registered. Population incidence, was calculated during the period 2010-2015, adding to our series of patients with BPP admitted to the other two centres of the city, and considering population variations in the period.

The following variables were recorded on admission directly from the subject, or from documentation in chart or interview with relatives: age, sex, duration of illness before consult, underlying chronic conditions such as diabetes, chronic renal failure, congestive heart failure, chronic lung disease, neurologic disease, malignancies, HIV infection, alcoholism, hepatic disease, smoking, prior antimicrobial therapy as well as clinical signs and symptoms. Living in nursing home or homelessness was registered too.

Patients with dull percussion and bronchial breathing sounds on auscultation were considered as having clinical consolidation. Hypotension was defined as systolic arterial tension below 90mmHg. Abdominal pain, vomiting, hypotension, and confusion were considered nonpulmonary symptoms.

Classical pneumococcal infection was considered if patients had all four of the following features: fever, pleuritic chest pain, lobar consolidation on chest X ray and leucocytosis. Pleural fluid examination was performed in all patients with pleural effusion. Empyema was considered when macroscopic pus or bacteria were identified in pleural fluid.

History of pneumococcal vaccination was recorded in all cases and considered positive in patients who had received at least a single dose of 23-valent pneumococcal polysaccharide vaccine within the last 5 years. On admission, patients were stratified into risk classes I to V based on Pneumonia Severity Index (PSI) score [6].

### Laboratory

Leukocytosis was considered when white blood cells were more than 12,000/ml and leukopenia when WBC <4,000/ml

**Microbiological Testing**

*S. pneumoniae* was identified using standard microbiology procedures. One set of blood cultures were collected from each patient at entry, which is considered standard of care for patients with CAP admitted to the hospital.

Conventional broth culture using nutritionally enriched media was used until 1997, after which fully automated, continuous blood culture monitoring equipment (BacT/ALERT® 3D BioMérieux, Inc. 100 Rodulphe Street, Durham, NC) became available. High quality sputum specimens (containing <10 squamous epithelial cells and >25 Polymorph Nuclear cells per low power field) were processed for bacterial diagnosis. Briefly, sputum was homogenized in 1.2 ml of sterile saline, spread onto a glass slide, air dried and heat fixed. Strains were identified based on Gram stains and morphology: gram-positive cocci found in singles, in pairs or in short chains were indicative of pneumococci infection. Sputum samples were inoculated on blood agar and chocolate agar plates and incubated at 35°C with 5-10% CO₂ for 72 hours. All *S. pneumoniae* isolates were tested for penicillin susceptibility by diffusion, using 1 μg oxacillin disks and by broth micro-dilution test. Isolates were also screened for susceptibility to erythromycin, tetracycline, and levofloxacin using disk diffusion method. In addition, minimum inhibitory concentration (MIC) tests were used to determine susceptibility to erythromycin, extended spectrum cephalosporins, fluoroquinolones, tetracycline, trimethoprim sulfametoxazol, clindamycin, cefuroxime and vancomycin, in accordance to Clinical and Laboratory Standards Institute (CLSI, 2012) established guidelines [7].

**Radiology**

Images on chest radiograph were classified by one of the investigators (JG) according to pattern (lobar consolidation, interstitial infiltrate, bronchopneumonia, pleural effusion) and extension (number of lobes affected, bilateral involvement)

**Outcome**

Patient were followed for 30 days after diagnosis, and complications were recorded, namely: pleural effusion, empyema, admission to ICU and need of mechanical ventilation. Overall case fatality rate was defined as death due to any cause within 30 days of hospitalization. Overall case fatality rate was defined as death due to any cause within 30 days of hospitalization.

**Statistical Analysis**

Qualitative variables are presented as the mean and range(min-max), while categorical variables are presented as frequency and percent. Contingency tables were used to measure associations with calculation of the chi-squared or Fisher’s exact test, and odds ratio (OR) were estimated. Multiple logistic regression analyses was performed to evaluate those factors found to be significant by univariate analysis and previously hypothesized to affect mortality. Two-tailed p-values are reported, with statistical significance when p<0.05. SAS V9.3 statistical software was used for calculations (SAS, Institute Inc. Cary, NC, USA).
Results

Epidemiology: 279 patients were included. Distribution of cases showed a sporadic pattern along the study ranging from 3 to 30 cases per year Figure 1. A decrease of 50% was observed in the last two years of the study. Hospital-based incidence of BPP was 2.1 cases/1,000 admissions and population-based incidence was 11.8 per 100,000 person-years (95% CI, 11.65-12.01), while 38% of episodes occurred in winter. The mean time from onset of illness to hospital admission was 2.9 days (1.15).

Two patients, the only individuals who had received antipneumococcal vaccine, both with humoral immunodeficiency multiple myeloma and hypogammaglobulinemia, had recurrent episodes of BPP.

The main demographic, comorbidities, clinical findings, radiographic, laboratory, severity and outcome features of patients are showed in Table 1A and Table 1B.

Table 1B Patient characteristics of study population. Differences between survivors and mortalities by univariate analysis.

<table>
<thead>
<tr>
<th>Total number of patients</th>
<th>Study Population</th>
<th>Survivors</th>
<th>Mortalities</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unilateral infiltrate</td>
<td>209 (74.91)</td>
<td>178 (77.39)</td>
<td>31 (63.26)</td>
<td>0.0184</td>
</tr>
<tr>
<td>Bilateral infiltrate</td>
<td>56 (21.35)</td>
<td>40 (17.39)</td>
<td>16 (31.02)</td>
<td>0.0154</td>
</tr>
<tr>
<td>Lobar</td>
<td>160 (57.34)</td>
<td>143 (62.17)</td>
<td>17 (34.69)</td>
<td>0.0006</td>
</tr>
<tr>
<td>Diffuse</td>
<td>102 (36.53)</td>
<td>70 (30.04)</td>
<td>32 (63.8)</td>
<td>0.0057</td>
</tr>
<tr>
<td>Pleural effusion</td>
<td>48 (17.56)</td>
<td>42 (17.79)</td>
<td>6 (11.86)</td>
<td>0.7705</td>
</tr>
<tr>
<td>Laboratory</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Hematocrit</td>
<td>37.716±3.92</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White blood cells</td>
<td>1680 (790-44700)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leukocytosis</td>
<td>177 (63.44)</td>
<td>150 (67.82)</td>
<td>27 (42.85)</td>
<td>0.0010</td>
</tr>
<tr>
<td>Leukopenia</td>
<td>28 (10.03)</td>
<td>14 (6.08)</td>
<td>14 (22.8)</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

Severity

PSI Score I                | 47 (16.84)       |            |             |         |
PSI Score II               | 72 (25.44)       |            |             |         |
PSI Score III              | 60 (21.5)        |            |             |         |
PSI Score IV               | 94 (33.69)       |            |             |         |
PSI Score V                | 72 (25.44)       |            |             |         |
PSI Score I-II-III         | 178 (63.7)       | 16 (71.26)  | 11 (22.4)   | 0.0001  |
PSI Score IV/V             | 101 (36.2)       | 52 (22.60)  | 49 (97.73)  | 0.0001  |
Complications

CCU admission            | 60 (21.5)        | 32 (12.3)   | 28 (57.14)  | <0.0001 |
Mechanical Ventilation     | 40 (14.33)       | 14 (6.08)   | 26 (53.06)  | <0.001  |
Empyema                   | 217 (77.53)      | 122 (77.72) | 95 (52.12)  | 0.470   |

The classic association of fever, chest pain, leukocytosis and lobar consolidation was present in 35 patients (14%), all of whom survived.

Non-pulmonary symptoms as abdominal pain, confusion and hypotension were present in 50% of cases. In 3 cases there was associated meningitis, and in one case purulent pericarditis.

Antibiotic treatment: Ninety five percent of BPP cases admitted to the hospital received monotherapy and 5% combined therapy. Fifteen patients were managed as outpatients, and treated with oral antibiotics as amoxicillin, clarithromycin, and fluoroquinolones, or intramuscular ceftriaxone. βeta-lactam antibiotics (cefotaxime, ceftriaxone, ampicillin, ampicil/ sulbactam) were used in 93% of patients.

Mortality: 49 patients died, resulting in an overall mortality rate of 16.7%: 27 deaths (5%) occurred within the first 3 days of hospitalization. Mean time elapsed between hospital admission and death was 5.2 days (median time 3 days) and there was an increment of death with age. Factors found to be significantly associated with mortality in univariate analyses were: age >80 years, dyspnea, hypotension, confusion, nonpulmonary symptoms, bilateral and diffuse infiltrates on chest radiograph, leukopenia, and high PSI score. Conversely, fever, chest pain and lobar infiltrates were significant predictors of survival. Multivariate analysis is shown in Table 2.
Microbiology: All pneumococcal strains were found to be susceptible to penicillin (MIC=0.006-2 µg/ml) and ceftriaxone (MIC =0.012 to 0.019 µg/ml). Percentages of resistance to other antibiotics were: erythromycin 8.1% (MIC =0.064 – 256 µg/ml), clindamycin 6.4% (MIC= 0.024-128 µg/ml), doxycycline 6.9% (MIC=0.5-64.0 µg/ml). Resistance rate to fluoroquinolones (levofloxacin) remained low 2.8% (MIC=0.38-8.00 µg/ml). Only 4 patients had S. pneumoniae isolated simultaneously in sputum and blood. One case of BPP and simultaneous pulmonary tuberculosis was detected.

Discussion

In this study of 279 patients with bacteremic pneumococcal pneumonia we confirm a considerable early mortality associated to increased age and increased severity of disease at time of presentation.

Overall annual rate of BPP in this study population was 11.8 cases/100,000 person-years, which is in agreement with other published results [8-10]. The reduction in the last two years could be secondary to herd effect of PVC 13, a vaccine that is mandatory in children in our city since 2012. The average age of 60 years found for the patients in our study is comparable to the mean age in other studies (range between 52 and 64 years old)[5,8,11].

Regarding underlying conditions and in agreement with previous published results, cigarette smoking, was the most prevalent risk factor, followed by chronic obstructive lung disease and congestive heart failure [10,12,13]. In fact, current cigarette smoking was predictive of BPP in one study [8] and was associated to septic shock in another [14].

Interestingly, one third of the patients had no evidence of any predisposing condition for BPP. We believe that this group deserves to be exhaustively evaluated in order to gain knowledge in the prevention of IPD.

Clinical manifestations were similar to those reported in the literature [12,15], except for sputum production which was less frequent: only 30% of the patients with BPP presented this symptom and this fact has been observed by others [16,17]. Isolation of S. pneumoniae from sputum specimens was very uncommon in our population. This can be related to early hospital admission or to differences in BPP and non-BPP pathophysiology [18].

Classical presentation with fever, chest pain, leukocytosis and lobar pattern on chest radiograph, although uncommon, showed significant correlation to better outcome.

Almost half of the patients had nonpulmonary symptoms from onset, so it is important to consider hemodynamic, abdominal or neurological manifestations in patients at risk for IPD in order to ensure prompt diagnosis and treatment [19].

As has been previously described most patients with BPP presented marked leukocytosis and neutrophilia. Leukopenia, although less frequent, was significantly related to worst outcome, as others investigators have observed [18,20].

In agreement with already published large series of patients [5,21,22] the presence of bacteremia was not associated with severity of illness, since most patients presented low PSI score (classes I-III). Even though the PSI score was not originally designed as a prognostic tool for BPP, it can be used to define illness severity because, although less specific, it is still more sensitive than other scores for BPP-related risk of death [23]. Surprisingly, patients in the low score risk group had higher than expected mortality rate. These were mainly young individuals, with specific comorbidities not identified by the PSI score such as asthma, COPD; HIV infection, obesity, alcohol and tobacco use. As some experts have reported, mortality within a certain score stratum may differ depending on the patient group [23].

It is possible that pneumococcal disease by itself may differ in previously healthy patients compared to those who present an underlying condition.

Main complications overlapped with those frequently observed in patients with CAP admitted to hospital, namely: ICU stay, presence of pleural effusion, empyema and need for mechanical ventilation [5].

Mortality rate was 17%, similar to the results obtained by others in larger series [5,11,13] and most deaths (55%) occurred within the first 3 days after hospital admission as already has been described [4,5]. In our study, severity of disease at onset was the most important factor associated with death. The presence of severe symptoms such as dyspnea, hypotension or altered mental status, may suggest organ dysfunction, indicating early signs of sepsis. As others have observed, age was found to be an important marker of poor prognosis, mostly in patients over 80 years of age [5,24].

Penicillin resistance is not a problem in our region, so we can continue using βeta-lactams, alone or combined for treatment of BPP.

This study has several limitations. The study was performed in a single center, in a small city then generalizibility of this data may be limited. Since the study was performed during a prolonged period of time, the local practice for therapy of BPP may have changed and affected the clinical outcomes. In this study S. pneumoniae serotyping was not performed.

In conclusion we found that BPP is a common infection with a considerable mortality, mostly after the first days of onset of the disease. Deaths were associated with increased age, increased severity of disease at onset and leukopenia.

We believe that a large-scale collaborative epidemiological study is needed in the region to gain further insight related to circulating pneumococcal strains. This knowledge would allow...
us to improve the use of available pneumococcal vaccines. We must not forget that surveillance strategies focusing on BPP, underestimate pneumococcal disease burden and hence the true benefits of pneumococcal immunization in adults.

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References


