Australian Gonococcal Surveillance Programme, 1 April to 30 June 2016

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Introduction

The Australian National Neisseria Network (NNN) comprises reference laboratories in each state and territory that report data on sensitivity to an agreed group of antimicrobial agents for the Australian Gonococcal Surveillance Programme (AGSP). The antibiotics are penicillin, ceftriaxone, azithromycin and ciprofloxacin, which are current or potential agents used for the treatment of gonorrhoea. Azithromycin combined with ceftriaxone is the recommended treatment regimen for gonorrhoea in the majority of Australia. However, there are substantial geographic differences in susceptibility patterns in Australia and in certain remote regions of the Northern Territory and Western Australia gonococcal antimicrobial resistance rates are low, and an oral treatment regimen comprising amoxycillin, probenecid and azithromycin is recommended for the treatment of gonorrhoea. When *in vitro* resistance to a recommended agent is demonstrated in 5% or more of isolates from a general population, it is usual to remove that agent from the list of recommended treatments.[1] Additional data on other antibiotics are reported in the AGSP annual report. The AGSP has a program-specific quality assurance process.

Results

A summary of the proportion of isolates with decreased susceptibility to ceftriaxone, and the proportion resistant to azithromycin, penicillin, and ciprofloxacin for the 2nd quarter of 2016 are shown in Table 1.

The category of ceftriaxone decreased susceptibility as reported by the AGSP includes the minimum inhibitory concentration (MIC) values 0.06 and 0.125 mg/L. A summary of the proportion of isolates with decreased susceptibility to ceftriaxone, for 2011 to 2015, and the first 2 quarters of 2016 is shown in Table 2.

Ceftriaxone

Ceftriaxone MIC values in the range 0.06–0.125 mg/L have been reported in the category decreased susceptibility since 2005.

The proportion of *Neisseria gonorrhoeae* isolates with decreased susceptibility to ceftriaxone in Australia for the 2nd quarter of 2016 was higher than the previous quarter, and was higher when compared with the same quarter in 2015 and with the annual data for 2015.

Table 1: Gonococcal isolates showing decreased susceptibility to ceftriaxone and resistance to azithromycin, penicillin, and ciprofloxacin, Australia, 1 April to 30 June 2016, by state or territory

State or territory	Number of isolates tested Q2, 2016	Decreased susceptibility		Resistance					
		Ceftriaxone		Azithromycin		Penicillin		Ciprofloxacin	
		n	%	n	%	n	%	n	%
Australian Capital Territory	35	0	0.0	7	20.0	1	2.9	10	28.6
New South Wales	586	38	6.5	21	3.6	275	46.9	196	33.4
Queensland	210	12	5.7	1	0.5	75	35.7	57	27.1
South Australia	110	1	0.9	25	22.7	45	40.9	38	34.5
Tasmania	8	1	12.5	0	0.0	4	50.0	2	25.0
Victoria	418	4	1.0	16	3.8	116	27.8	144	34.4
Northern Territory Urban & Rural	10	0	0.0	0	0.0	0	0.0	3	30.0
Northern Territory Remote	35	0	0.0	0	0.0	2	5.7	1	2.9
Western Australia Urban & Rural	186	1	0.5	4	2.2	33	17.7	43	23.1
Western Australia Remote	42	0	0.0	1	2.4	1	2.4	1	2.4
Australia	1,640	57	3.5	75	4.6	552	33.7	495	30.2

Table 2: Percentage of gonococcal isolates with decreased susceptibility to ceftriaxone MIC 0.06–0.125 mg/L, Australia, 2011 to 2015, 1 January to 31 March 2016, and 1 April to 30 June 2016

Ceftriaxone MIC mg/L	2011	2012	2013	2014	2015	2016 Q1	2016 Q2
0.06 (%)	3.2	4.1	8.2	4.8	1.7	1.5	3.4
0.125 (%)	0.1	0.3	0.6	0.6	0.1	0.0	0.1

In the 2nd quarter of 2016 the states that reported isolates with decreased susceptibility to ceftriaxone were New South Wales, Queensland, Victoria, South Australia, urban/rural Western Australia and Tasmania. There were no isolates with decreased susceptibility to ceftriaxone reported in the Northern Territory, the remote regions of Western Australia, or the Australian Capital Territory. New South Wales, Queensland, and Tasmania reported an increase in the proportion of *N. gonorrhoeae* isolates with decreased susceptibility to ceftriaxone when compared with the same quarter in 2015, and with the annual data for 2015. Victoria, urban and rural Western Australia, and South Australia reported a decrease in the proportion of *N. gonorrhoeae* isolates with decreased susceptibility to ceftriaxone when compared with the same quarter in 2015, and with the annual data for 2015. Other states reported similar results.[2]

From New South Wales, there were 38 of 586 strains with decreased susceptibility to ceftriaxone. Of those, 21 (55%) were multidrug-resistant (MDR); 33 (87%) were from males; and 13 (34%) were isolated from extragenital sites (rectal and pharyngeal). From Queensland, there were 12 of 210 strains with decreased susceptibility to ceftriaxone and of those, 8 (67%) were MDR, 8 (67%) were from males, and 42 (33%) were from extragenital sites. From Victoria, 4 of 418 strains had decreased susceptibility to ceftriaxone. All were MDR and from males; and 1 (25%) was isolated from an extragenital site. From South Australia there was 1 of 110 strains with decreased susceptibility to ceftriaxone, the strain was MDR, from a male, and from an extragenital site. From urban/rural Western Australia, 1 of 186 strains had decreased susceptibility to ceftriaxone, the strain was MDR, from a male, but not from an extragenital site. From Tasmania there was 1 of 8 strains with decreased susceptibility to ceftriaxone, the strain was MDR, from a male, and from an extragenital site.

In recent years the proportion of strains with decreased susceptibility to ceftriaxone has been of increasing concern in Australia and overseas, as this is phenotypic of the genotype with the key mutations that are the precursor to ceftriaxone resistance.[3] There are recent reports of ceftriaxone 500 mg treatment failures in patients from Victoria and New South Wales in patients with pharyngeal gonococcal infections. In these patients the infecting gonococcal strains had ceftriaxone MIC values in the range 0.03–0.06 mg/L.[4,5] Until 2013 there had not been an isolate reported in Australia with a ceftriaxone MIC value >0.125 mg/L.[2] In late December 2013, there was a new multidrug-resistant gonococcal strain (A8806) with a ceftriaxone MIC of 0.5 mg/L, the highest ever reported in Australia that was isolated from a female traveller from Central Europe. This infection was acquired in Sydney from another traveller, also from Europe. The patient was tested in the Northern Territory, but had travelled to north eastern Queensland before the results were available, and was treated there. To date there has been no evidence of spread of this strain.[6]

Azithromycin

Azithromycin resistance is defined as a MIC to azithromycin equal to, or greater than 1.0 mg/L.

In the 2nd quarter of 2016, all states, with the exception of Tasmania and the Northern Territory, reported isolates with resistance to azithromycin. Notably the reported proportion of *N. gonorrhoeae* isolates with resistance to azithromycin in South Australia for the 2nd quarter 2016 was 25/110 (22.7%). This proportion of resistance follows on from the 1st quarter of 2016, which was previously reported as 26/88 (29.5%); and compares with none (0/54) in the same quarter of 2015, and 7/251 (2.8%) for all of 2015. None of these strains had high level resistance, 24/25 (96%) were resistant to penicillin (beta-lactamase producing); and all were sensitive to ceftriaxone and ciprofloxacin. Enhanced surveillance, case reviews, and genotypic investigations are in process in South Australia with further results to follow.

In the Australian Capital Territory there were 7 of 35 (20%) isolates that were resistant to azithromycin compared with 2 of 22 (9.1%) in the previous quarter, and none (0/69) in 2015. The other states that reported an increase in the proportion of *N. gonorrhoeae* isolates with resistance to azithromycin when compared with the previous quarter, and when compared with 2015, were New South Wales (5/590, 0.8% in 1st quarter of 2016, and

43/1,905, 2.3% in 2015) and Victoria (7/445, 1.6% in the 1st quarter of 2016, and 30/1,695, 1.8% in 2015). Queensland and urban/rural Western Australia reported a decrease when compared with the previous quarter, and with 2015. The other states reported similar results when compared with the previous quarter, and with 2015.

Penicillin

Penicillin resistant *N. gonorrhoeae* are defined as those isolates with a MIC to penicillin equal to or greater than 1.0 mg/L. Penicillin resistance includes penicillinase producing *N. gonorrhoeae* (PPNG), and *N. gonorrhoeae* that have chromosomally mediated resistance to penicillin (CMRP). In certain areas of the Northern Territory and Western Australia, which are classified as remote, a treatment regimen based on oral amoxicillin, probenecid and azithromycin is used. Due to the distance specimens must travel in these remote regions to a laboratory, low numbers of cultures are collected, and thus, by necessity, nucleic acid amplification testing (NAAT) is used. In remote Western Australia the introduction of a targeted NAAT, developed by the NNN to detect PPNG, is in use to enhance surveillance.[7,8]

Ciprofloxacin

Ciprofloxacin resistance includes isolates with an MIC to ciprofloxacin equal to or greater than 1.0 mg/L.

Dual therapy of ceftriaxone plus azithromycin is the recommended treatment for gonorrhoea as a strategy to temper development of more widespread resistance.[8] Patients with infections in extragenital sites, where the isolate has decreased susceptibility to ceftriaxone, are recommended to have test of cure cultures collected. Continued surveillance to monitor *N. gonorrhoeae* with elevated MIC values, coupled with sentinel site surveillance in high risk populations remains important to inform therapeutic strategies, to identify incursion of resistant strains, and to detect instances of treatment failure.

References

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