Use of in-house PCR for identification of *Mycobacterium tuberculosis* in BACTEC broth cultures of respiratory specimens

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We evaluated the ability of a PCR assay to identify Mycobacterium tuberculosis complex (MTBC) from positive BACTEC® 12B broth cultures. A total of 107 sputum samples were processed and inoculated into Ogawa slants and BACTEC® 12B vials. At a growth index (GI) ≥ 30, 1.0 ml of the 12B broth was removed, stored, and assayed with PCR. Molecular results were compared to those obtained by phenotypic identification methods, including the BACTEC® NAP method. The average times required to perform PCR and NAP were compared. Of the 107 broth cultures evaluated, 90 were NAP positive, while 91 were PCR positive for MTBC. Of particular interest were three contaminated BACTEC® 12B broth cultures yielding microorganisms other than acid-fast bacilli growth with a MTBC that were successfully identified by PCR, resulting in a mean time of 14 days to identify MTBC before NAP identification. These results suggest that PCR could be used as an alternative to the NAP test for the rapid identification of MTBC in BACTEC® 12B cultures, particularly in those that contained both MTBC and nontuberculous mycobacteria.

Key words: Mycobacterium tuberculosis - identification - PCR - BACTEC® 12B - culture - diagnosis

The rapid and specific detection of *Mycobacterium tuberculosis* in clinical samples remains difficult despite years of research. The introduction of the BACTEC® 460 and, more recently, the BACTEC® MGIT 960 (Becton Dickinson Diagnostic Instruments, Sparks, USA) have made possible major improvements in mycobacterial cultures by providing more rapid detection of mycobacteria (Cruciani et al. 2004, Rishi et al. 2007). In our setting, the BACTEC® systems, in conjunction with the NAP (p-nitro-α-acetylamino-β-hydroxy-propiophenone), are very specific for distinguishing *M. tuberculosis* complex (MTBC) from non-tuberculous mycobacteria (NTM), but they may require approximately six days for interpretable results (Laszlo & Siddiqi 1984, Siddiqi 1989, Giampaglia et al. 2007). DNA probes have significantly decreased the length of time required for the identification of *M. tuberculosis* and other mycobacterial species (Rusch-Gerdes & Richter 2004, Spada et al. 2005). A few studies have evaluated molecular techniques, such as the Gen-Probe MTB Accuprobe (Ellner et al. 1988) and Gen-Probe Amplified Mycobacterium Tuberculosis Direct Test (Bergmann & Woods 1999, Desmond & Lo-reitz 2001), for their ability to identify the MTBC directly from BACTEC® 12B broth cultures in attempts to further decrease turnaround time. These commercial tests offer several advantages over conventional biochemical identification methods for rapid detection and identification, such as turnaround time for results, reliability, reproducibility, and the possibility of improving patient management (Woods 2002). However, most of these tests have not yet provided easy access to the routine procedures performed in the clinical mycobacteriology laboratory, especially in low-income countries where tuberculosis is an important public health problem (CRPHF 2002, Dowdy et al. 2003, Kivihya-Ndugga et al. 2004, Ducati et al. 2006). In-house PCR might be attractive alternatives for these commercial molecular methods, assuming that in-house PCR is cheaper, faster, and relatively easy to perform (Cleef et al. 2005, Muhamuza et al. 2006). In this study, we aimed to determine the ability of an in-house PCR assay for earlier identification of MTBC on BACTEC® 12B broth cultures using a pair of *IS6110*-derived primers. Although many laboratories have replaced the BACTEC® 460 radiometric system with non-radiometric culture systems, we assume that this in-house PCR assay can also be applied to the BACTEC® MGIT960 system, which uses non-radiometric fluorescence technology.

**PATIENTS, MATERIALS AND METHODS**

**Clinical specimens** - This study included a total of 107 respiratory specimens (sputum) from 95 patients being screened or under treatment for tuberculosis at the Hospital Universitário Cassiano Antônio Moraes (Espírito Santo, Brazil) between March 2004 and March 2005. A Fisher’s exact test with a 0.05 one-sided significance level was used to measure this sample size.
**Sample processing** - Sputum samples were digested with dithiothreitol (DTT) to a final concentration of 0.1% for 5 min on a shaker, decontaminated with an equal volume of N-acetyl-cysteine-NaOH to a final concentration, and mixed thoroughly for 5 min before being left to stand for 15 min at room temperature. After decontamination, phosphate buffer (pH 6.8) was added to all the specimens for a final volume of 50 ml and then mixed thoroughly. The mixture was centrifuged at 4000 g at 4°C/15 min, and sediment was adjusted to 2.0 ml with phosphate buffer (Kent & Kubica 1985). The sediment was subjected to microscopic examination for acid-fast bacilli (AFB) by standard procedures with fluorescent stain (Collins et al. 1997).

**Culture and identification** - The sediment was inoculated in the culture media: 0.2 ml onto Ogawa medium, and 0.5 ml into BACTEC® 12B vials, to which 0.1 ml of an antimicrobial supplement (PANTA™) had previously been added. Cultures were then incubated at 37°C for a maximum of six weeks. The solid media were examined weekly for visible growth, and the BACTEC®12B broth was analyzed by the BACTEC®460 TB instrument according to the manufacturer’s instructions (Kent & Kubica 1985, Siddiqi 1989). When the GI of a bottle reached ≥ 30, aliquots of broth were aseptically removed for (i) smears stained by the Ziehl-Neelsen (ZN) method, (ii) inoculation onto a 5% sheep blood agar plate to test the purity of broth cultures, and (iii) analysis by the PCR. The remainder was monitored daily to GI ≥ 50, at which time a BACTEC® NAP TB differentiation test was set up. All isolates were identified as MTBC according to their growth characteristics as colony morphology, resistance to thiophen-2-carboxylic acid hydrazide (Giampaglia et al. 2005), and susceptibility to NAP (Fig. 1).

**BACTEC® NAP TB differentiation test** - At GI ≥ 50, a NAP test was set up following the manufacturer’s instructions in the BACTEC® 460 manual. Both the control and NAP vials were monitored daily, and the results were interpreted according to the manual (Siddiqi 1989).

**PCR assay** - In preparation for PCR, 1.0 ml 12B aliquots were heat-killed at 90°C for 90 min and concentrated by centrifuging at 13,000 g for 2 min. The supernatant was discarded, and the sediment was re-suspended in about 5 μl of water. This was the cell sample that was used for the amplification. Aliquots from 12B vials were frozen at -20°C until use. Oligonucleotides of 18 bp homologous for sequences in the insertion sequence IS6110 specific for MTBC were used as primers for PCR. The forward primer (5’GGCTGTTGGTAGACAGACC3’) and reverse primer (5’CGGGTCAGATGGCTTGC3’) generated a 123 bp product of IS6110. The amplification was performed with a final volume of 25 μl using a LCx Thermal Cycler (Abbott Diagnostic Division, Abbott Park, IL, USA). Each reaction tube contained 2 μl of the heat-killed suspension, 5 pmol of IS6110 primers, 4 mM MgCl₂, 2.5 μl 10X buffer (Gibco-BRL, Gaithersburg, MD, USA), 0.1 mg/ml BSA, 200 μM each of dATP, dGTP, dCTP, dTTP, and 1.25 U of Taq DNA polymerase (Cenbiot, Porto Alegre, Brazil).

Positive controls were provided by reactions containing *M. tuberculosis* H37Ra (ATCC 25177), and negative controls by using *Escherichia coli* (ATCC 29522) and sterile distilled water. The thermal cycler was programmed to promote a first denaturation at 94°C for 5 min, and then 34 cycles of denaturation at 94°C/30 s, annealing at 65°C/30 s, and extension at 72°C/ 45 s followed by a final extension at 72°C/ 10 min. The products were held at 4°C. A 10 μl portion of the PCR products was analyzed by 4% polyacrylamide gel electrophoresis and stained with ethidium bromide. The gels were visualized and photographed on an ultraviolet transilluminator (Eagle eye II, Stratagene, CA, USA). The presence of the 123 bp IS6110 product was considered a positive PCR result for MTBC.

**Initial evaluation** - During the first phase of our study, the sensitivity and specificity of the PCR primers were evaluated. Specificity was determined by testing DNA extracted from six mycobacterial 12B broth cultures: *M. chelonae* (ATCC 35752), *M. kansasi* (ATCC 12478), *M. marinum* (ATCC 927), *M. tuberculosis* H37Ra (ATCC 25177), *M. africanum* (ATCC 25420), and *M. bovis* (ATCC 35721). One *E. coli* (ATCC 29522) strain was also included as a negative control. To assess the sensitivity and competition at various levels of mycobacterial growth, DNA extracted from *M. tuberculosis* H37Ra 12B broth cultures presenting different GIs (68, 88, 105, 121, and 552) were tested. All of these cultures were handled as previously described.

**Cross-contamination** - To minimize cross-contamination, aerosol resistant tips were used and changed for each sample. Separate rooms were used for (i) culture

![Image](https://example.com/image.png)

**Fig. 1:** algorithm for identify *M. tuberculosis* complex from BACTEC® 12B vials. AFB: acid fast bacilli; BAP: blood agar plate; GI: growth index; MTB: *M. tuberculosis*; MTBC: *M. tuberculosis* complex; NAP: α-nitro-α-acetylamino-β-hydroxy-propiophenone test; NTM: non-tuberculous mycobacteria; PCR: polymerase chain reaction; TCH: thiophen-2-carboxylic acid hydrazide; ZN: Ziehl Neelsen; -: negative; +: positive. Asterisk indicates mycobacterial cultures contaminated with other microorganisms; such cultures were decontaminated and retested.
and sample preparation (heat killing and sedimentation), (ii) preparation of the master mix, and (iii) amplification and detection. To detect possible cross-contamination, negative controls were included in each batch.

RESULTS

The results of our preliminary study demonstrated that the primers used were specific for MTBC species (Fig. 2). None of the DNA isolated from the three mycobacteria other than MTBC were amplified. With respect to sensitivity, PCR was able to detect MTBC at all GIs tested, with no noticeable differences in the strength of the bands (Fig. 3).

A total of 107 BACTEC® culture positive sputum specimens that attained a GI ≥ 30 were assayed by PCR and subsequently tested by NAP at GI ≥ 50. Of these, 90 were culture positive for MTBC (84.1%), eight cultures (7.5%) grew NTM, and 7 (6.5%) were contaminated by microorganisms other than mycobacteria. These results are summarized in Table I. All of the 90 cultures positive for MTBC were PCR positive. Except for one, all cultures which grew NTM were PCR negative. The remaining seven cultures that did not grow any mycobacteria were PCR negative. In two cultures that grew both mycobacteria and other organisms than AFB, a phenotypic identification was not possible, and both of them were PCR negative. These samples were obtained from patients under treatment for M. tuberculosis infection. Of the 91 cultures which were PCR positive, 30.8% (28/91) were assayed by PCR with GIs of ≤ 50 while 35.2% (32/91) were assayed with GIs between 51 and 100; the remaining vials were assayed with GIs of > 100. In this study, three of the 90 cultures positive for MTBC were contaminated with other microorganisms, which was demonstrated by the ZN result and the subculture onto blood agar. PCR was able to further detect MTBC in these three mixed cultures, including one positive 12B vial that was ZN-negative for AFB (Table II).

To determine the impact of PCR on decreasing the time to reporting of M. tuberculosis, we compared the time elapsed from specimen submission to identification of MTBC by the PCR and BACTEC® NAP methods. Although PCR can be performed in a few hours, it is more feasible to test all the positive 12B cultures detected in a day in one batch, which may mean performing PCR the following day. In BACTEC® broth inoculated with sputum samples, the average number of days required for identification of MTBC by PCR and NAP was 16.4 (10 to 27) and 26.1 (15.5 to 34), respectively (Table II). Of particular interest were the three contaminated BACTEC® 12B broth cultures yielding MTBC growth with organisms other than AFB, which were successfully identified by PCR, resulting in a mean time to identify M. tuberculosis complex of 14 days before NAP identification.

DISCUSSION

Timely laboratory reporting of tuberculosis is important for prompt initiation of appropriate medical therapy for TB patients and rapid public health response (Drobniowski et al. 2003, Pascopella et al. 2004, WHO 2006). Molecular methods show promise for rapid and reliable detection of M. tuberculosis in sputum and other samples (Woods 2002, Ducati et al. 2006, Pinto et al. 2007). Theoretically, the PCR method, in which nucleic acid is multiplied many times, could be more sensitive than the DNA probe method for identification of M. tuberculosis (Eisenach et al. 1990, Wolk et al. 2001).

Data from several studies evaluating commercial PCR kits for direct detection of M. tuberculosis in clinical specimens have been extensively published, but studies that have investigated the ability of the assay to detect M. tuberculosis in broth culture systems have been rarely

### TABLE I

Comparison of PCR results with that of final identification of *Mycobacterium tuberculosis* by culture

<table>
<thead>
<tr>
<th>Phenotypic identification</th>
<th>PCR result</th>
<th>M. tuberculosis</th>
<th>Non-tuberculous mycobacteria</th>
<th>Other microorganisms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>90</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>90</td>
<td>8</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

a: two mycobacterial cultures contaminated with other microorganisms which phenotypic identification was not possible were not included.
TABLE II
Comparison of the median time to identify Mycobacterium tuberculosis by PCR and NAP methods

<table>
<thead>
<tr>
<th>AFB* smears and subculture results from 12B broth with GI ≥ 30</th>
<th>Number of cultures positive for Mycobacterium tuberculosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PCR</td>
</tr>
<tr>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>AFB positive</td>
<td>87</td>
</tr>
<tr>
<td>AFB positive + non-mycobacteria</td>
<td>2</td>
</tr>
<tr>
<td>non-mycobacteria</td>
<td>1</td>
</tr>
<tr>
<td>AFB negative</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
</tr>
</tbody>
</table>

* PCR: polymerase chain reaction; NAP*: nitropropholate test

| a: acid-fast bacilli; b: ρ-nitro-α-acetylamino-β-hydroxy-propiophenone test; c: two mycobacterial cultures contaminated with other microorganisms which phenotypic identification was not possible were not included.

The time advantage that the radiometric method of detection and molecular technology for identification has given to the area of clinical mycobacteriology has been clearly documented (Bergmann & Woods 1999, Desmond & Loretz 2001). In this study, the time required to detect and identify mycobacteria in BACTEC® 12B cultures by the PCR method was compared with that of identification by the NAP method. The median time saving for identification of mycobacteria with the PCR was about nine days compared to that of NAP identification. This observation is similar to those of earlier researchers (Forbes & Hicks 1994, Ryang et al. 1996). In the report by Muhumuza et al. (2006), in-house PCR also identified MTBC six days earlier than the NAP results.

In addition to the long time necessary for M. tuberculosis growth, non-fastidious microorganisms eventually contaminate a small percentage of cultures. This may lead to errors in the diagnosis, and delays in the administration of appropriate treatment (Buijlets & Petit 2005, Lima et al. 2005). In our study, PCR was able to provide the correct identification weeks earlier than when NAP test results became available. These results demonstrate that the presence of contaminating organisms did not interfere with MTBC detection in broth cultures by the PCR.

The phenotypic tests did not allow us to arrive at a definite diagnosis for two mixed-cultures presenting negative PCR. Unfortunately, the PCR results could not be confirmed because these samples had been discarded. Both of these samples were obtained from patients who had cultured positive for MTBC within the past five months, and all had been started on tuberculosis treatment. These possible false negative results could be explained by the presence of low numbers of organisms in the specimen or the inhibition of PCR by interfering substances in the sample, as reported by several investigators (Wolk et al. 2001). The elimination of inhibitory factors continues to be a challenge in the use and acceptance of PCR assays in a clinical diagnostic setting. The use of an internal control is of paramount importance, allowing for the evaluation of each individual reaction as to whether the reaction was inhibited by interfering substances (Wolk et al. 2001, Hoorfar et al. 2004).

Since mycobacterial DNA can be detected by amplification tests for a long time after the start of treatment and in the absence of positive cultures of tuberculosis (Yuen et al. 1993), the PCR positive results may not necessarily reflect an active disease by M. tuberculosis. Some studies have found PCR positive results from patients with only a tuberculosis infection or a past history of tuberculosis (Yuen et al. 1993, Rajalahti et al. 2001). In the present study, there was only one BACTEC® 12B vial that was PCR positive for MTBC but culture positive for NTM. This specimen was obtained from one patient with a past history of treated tuberculosis. Although considered a false positive in our analysis, we feel that the PCR result cannot be totally ruled out as a possible true positive.
To achieve better sensitivity than direct testing and better turnaround time than current culture and identification methods, mycobacteriology laboratories have been using commercially available nucleic acid amplification test kits to detect *M. tuberculosis* in BACTEC™ 12B medium cultures (Desmond & Loretz 2001). Despite considerable improvement of commercially available assays and their advantage in shortened turnaround times for diagnosis, these tests require a frequent supply of expensive commercial reagents or chips and are not expected to supplant culture for the definitive diagnosis of clinically significant mycobacterial infections (Bayram et al. 2006).

This study demonstrated a reliable and rapid assay that could be easily incorporated into a clinical laboratory routine. The conventional tests for detection of *M. tuberculosis*, culture, and microscopy are undoubtedly much cheaper than the PCR systems. However, none of these conventional methods combine a reasonable sensitivity with a reasonable test time, as in-house PCR does. Even though these methodologies might be expensive for developing countries, the cost-benefit of this test must be considered. It is less expensive than a prolonged patient stay in the hospital wards, which is common for tuberculosis patients; in many cases, these patients are waiting only for confirmation of the diagnosis. Based on the findings from our study, in-house PCR proved to be a useful and rapid means for the detection and identification of MTBC in 12B broth cultures. In addition, PCR has the potential to detect MTBC at an earlier phase of growth than those needed for the NAP method, even in the context of contaminated cultures.

REFERENCES


Use of PCR to identify \textit{M. tuberculosis} • Ana Cláudia C Gouveia et al.

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