



Mycobacteria & Tuberculosis

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Objectives

- Recognize that tuberculosis as a chronic disease mainly affecting the respiratory system.
- Recall the epidemiology of tuberculosis world wide and in the kingdom of Saudi Arabia.
- Describe the methods of transmission of tuberculosis and people at risk.

Objectives

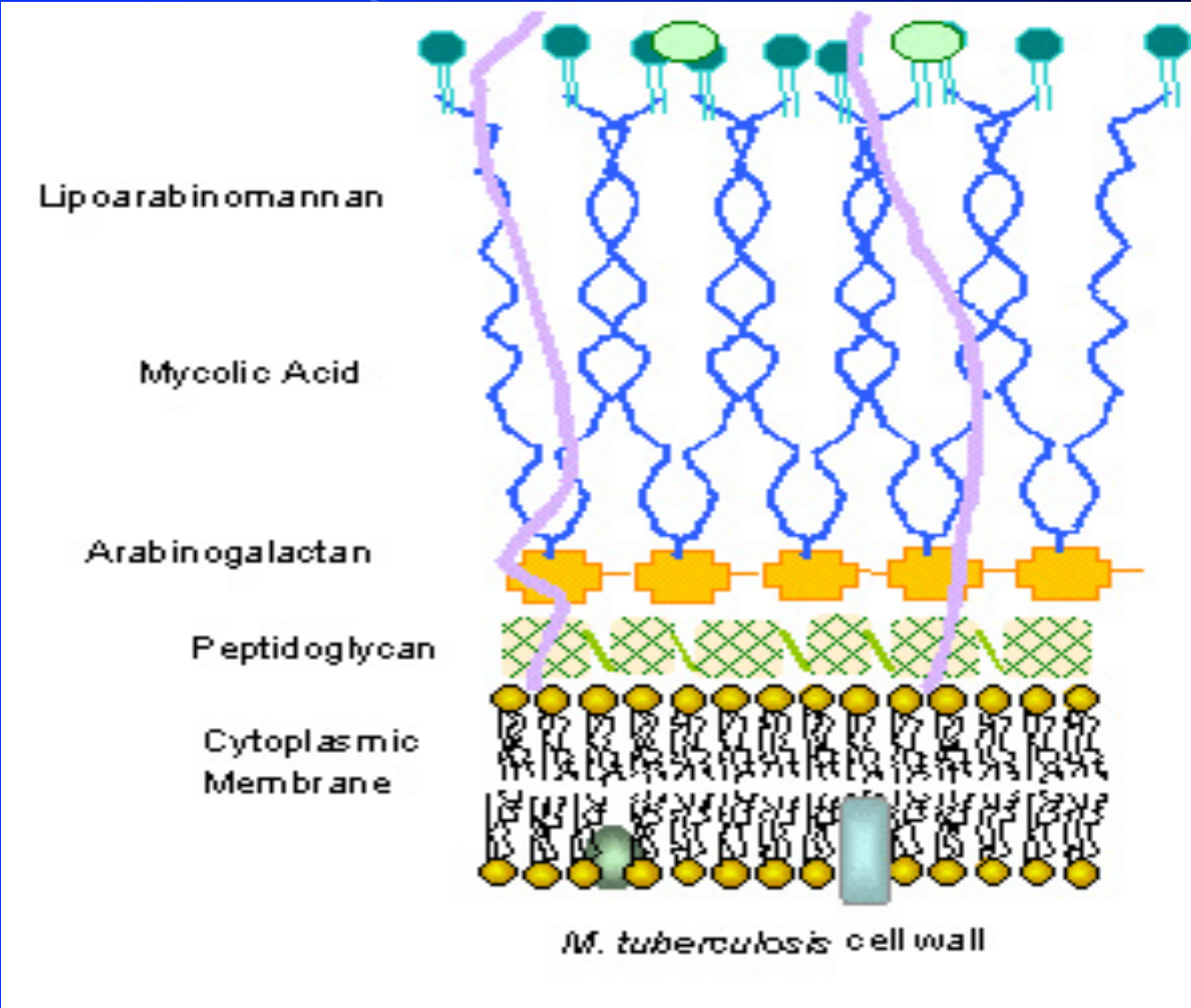
- Recall the causative agents , their characteristic and staining methods .
- Describe the pathogenesis of tuberculosis.
- Differentiate between primary and secondary tuberculosis and the clinical features of each.

Objectives

- Recall the laboratory diagnostic methods.
- Recall the chemotherapeutic agents and other methods of management .
- Describe the methods of prevention and control of tuberculosis

Characteristics of the Genus Mycobacteria

- Slim, rod shaped, non-motile, do not form spores.
- Do not stain by Gram stain . Why ?
- Cell wall contains high lipid concentration (**Mycolic acid**) which resists staining by Gram stain .
- **Acid- Alcohol Fast Bacilli (AFB)** : resist decolorization with up to 3% HCL, 5% ethanol or both.



Acid-Fast Bacilli (AFB)

- Stains used : **Ziehl-Neelsen** stain (ZN stain) and **Auramine Rhodamine** stain.
- Strict aerobes
- Multiply intracellularly
- Cause delayed hypersensitivity reaction type of immune response
- Slowly growing (2 - 8 weeks)

Ziehl-Neelson Stain Kinyoun Modification

Acid Fast
Organisms

Not Acid Fast
Organisms



A small amount of organism suspended in saline solution is fixed on a slide.



Slide is flooded with Carbol Fuchsin and phenol for 3 minutes, and gently rinsed with water.



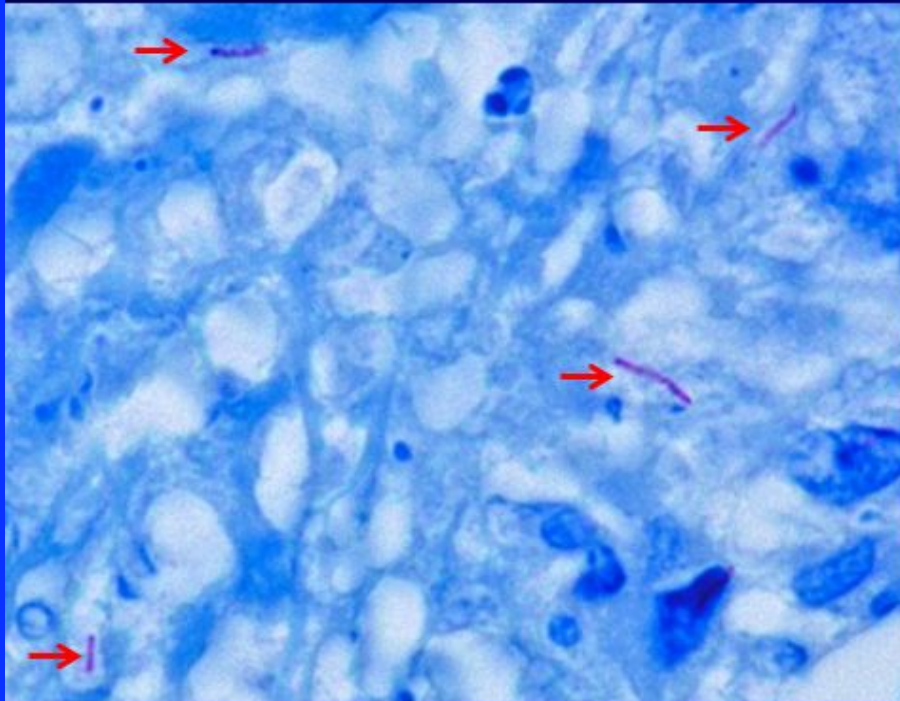
Slide is decolorized with 3% HCl in 70% alcohol until color appears to be removed (approx. 2 mins), and rinsed with water.



Slide is flooded with methylene blue counterstain for 30 secs, rinsed with water and air-dried.



ZN Stain vs. Auramine



Species of Mycobacteria

- *Mycobacterium tuberculosis* complex cause tuberculosis.
- *Mycobacterium leprae* causes leprosy.
- **Atypical Mycobacteria** / Mycobacteria other than tuberculosis (MOTT) cause infections in immunosuppressed patients.

Mycobacterium tuberculosis complex Include

1- *M.tuberculosis* (Human type)

2- *M. bovis* (Bovine type)

3- *M. Africanum*

4- *BCG strains*

All are called *Mycobacterium tuberculosis*
complex and cause tuberculosis in human

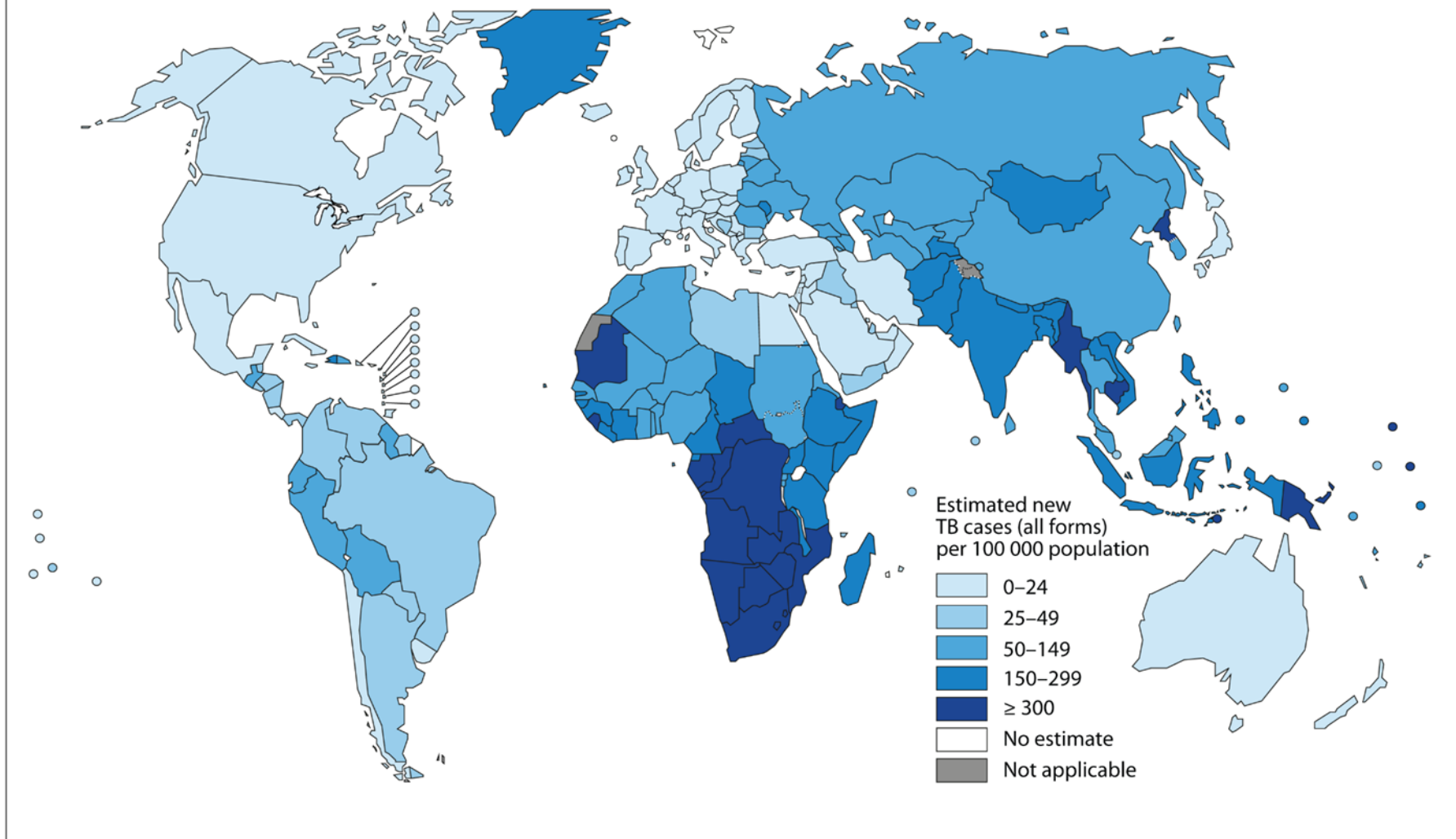
Tuberculosis

- Tuberculosis (TB) is an ancient chronic disease affects humans , caused by *Mycobacterium tuberculosis complex*.
- A major cause of death worldwide.
- Usually affects the lungs, other organs can be affected in one third of cases.
- If properly treated is curable, but fatal if untreated in most cases.

Epidemiology

- TB affects 1/3 of human race as a latent dormant tuberculosis.
- WHO estimated 8.9 million new cases and 2-4 million death in 2014
- **Incidence:** a world wide disease , more common in developing countries (see diagram).
- Affects all age groups who are subject to get the infection.
-

Estimated tuberculosis (TB) incidence rates, 2011



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.

Source: *Global Tuberculosis Report 2012*. WHO, 2012.





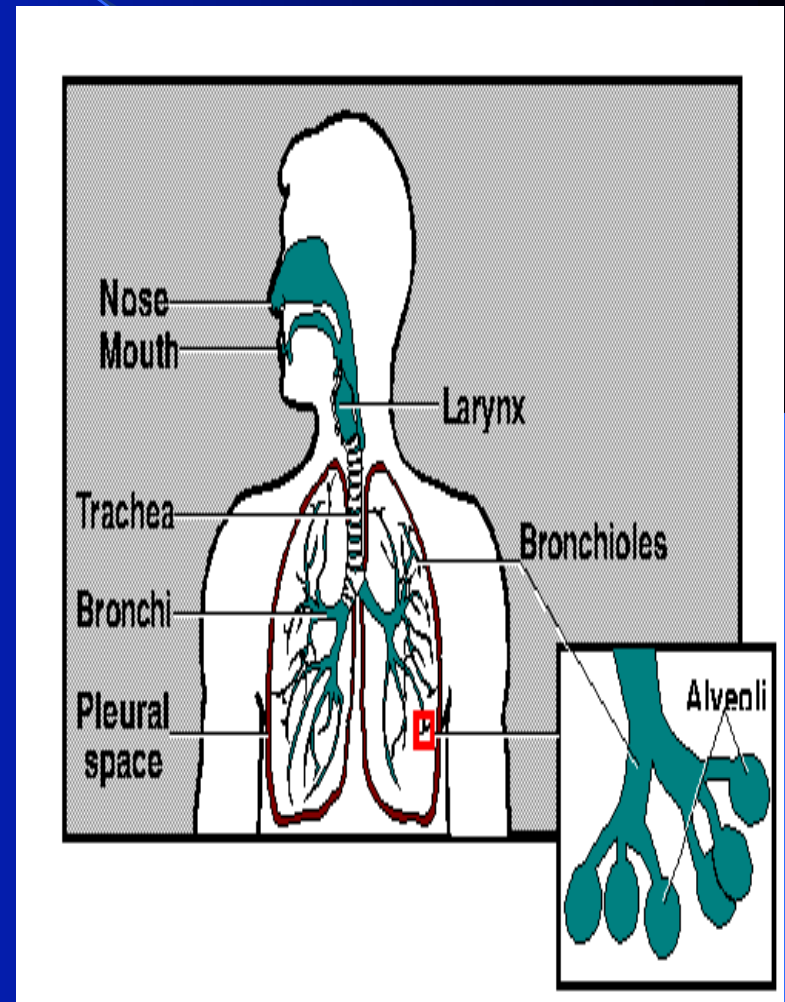
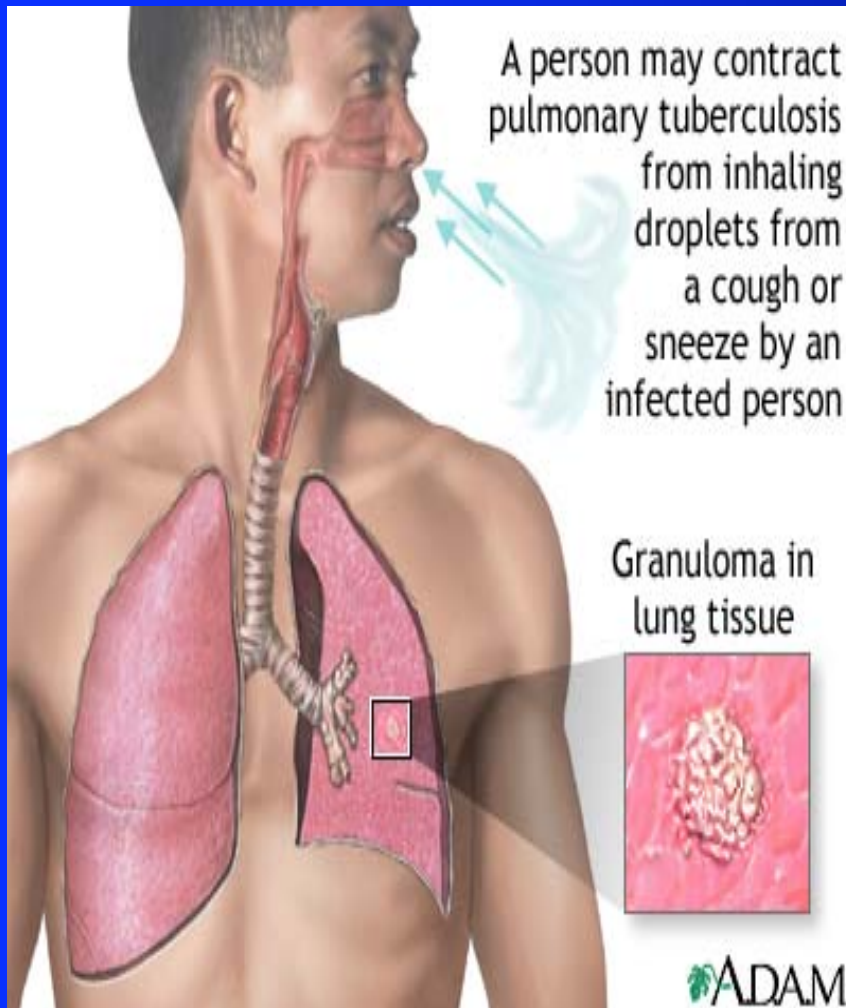
Epidemiology

- Transmission mainly through inhalation of airborne droplet nuclei ($< 5 \mu\text{m}$) in pulmonary diseases cases , rarely through GIT & skin
- **Reservoir:** patients with open TB.
- **Age:** young children & adults
- **People at risk :** include ;lab technicians, immunosuppressed patients ,workers in mines and contacts with index case.

Pathogenesis of Tuberculosis

- Mycobacteria is acquired by airborne droplet which reach the **alveolar macrophages** and are able to survive their (**main virulence factor**).
- Simulates cell mediated immune response which controls the multiplication of the organism but does not kill it.
- Granuloma formed and organism lives in dormant state (**latent tuberculosis infection**)

Pathogenesis of TB





Pathogenesis of Tuberculosis

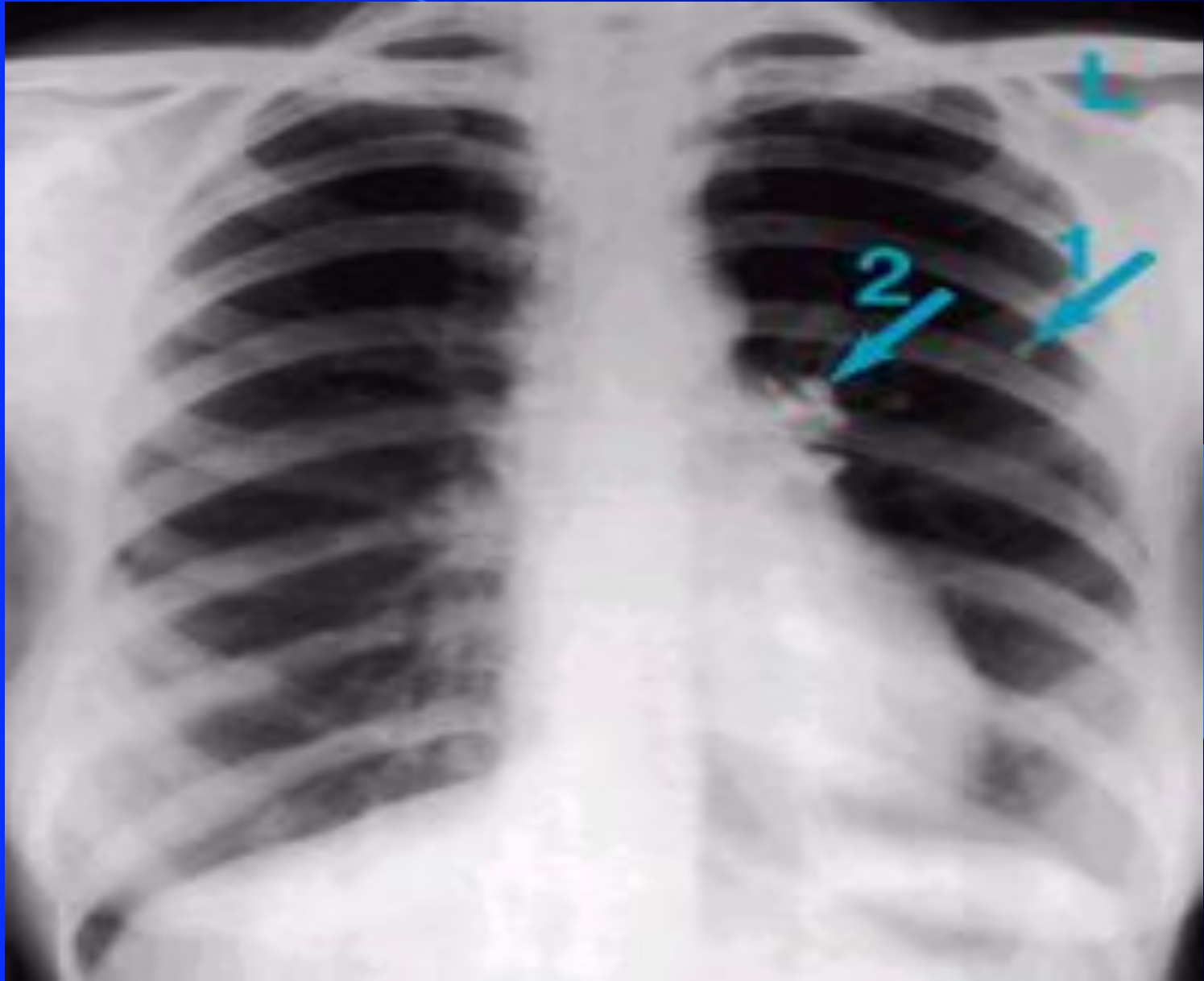
- Patient show evidence of delayed cell mediated immunity (**CMI**).
- Disease results due to destructive effect of **CMI** .
- Clinically the disease is divided into **primary** or **secondary** .

Pathogenesis of Tuberculosis

➤ Primary Tuberculosis

Occurs in patients not previously infected.


Inhalation of bacilli  Phagocytosis 
lymph nodes calcify to produce **GHON Focus**
(or **Primary Complex**) at the periphery of mid
zone of lung.




Primary Tuberculosis

- Microscopy of lesion shows **Granuloma**.
- **Clinically**: primary TB usually asymptomatic or / minor illness.
- **Non-pulmonary TB**: may spread from pulmonary infections to other organs eg.:
 - TB of lymph nodes (cervical, mesenteric).
 - TB meningitis
 - TB bone & joint

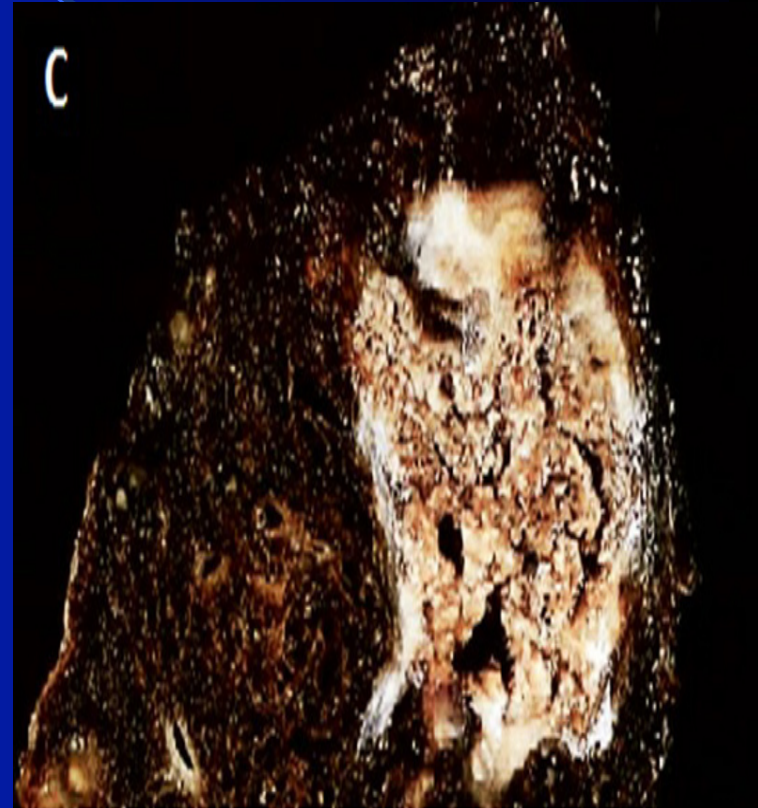
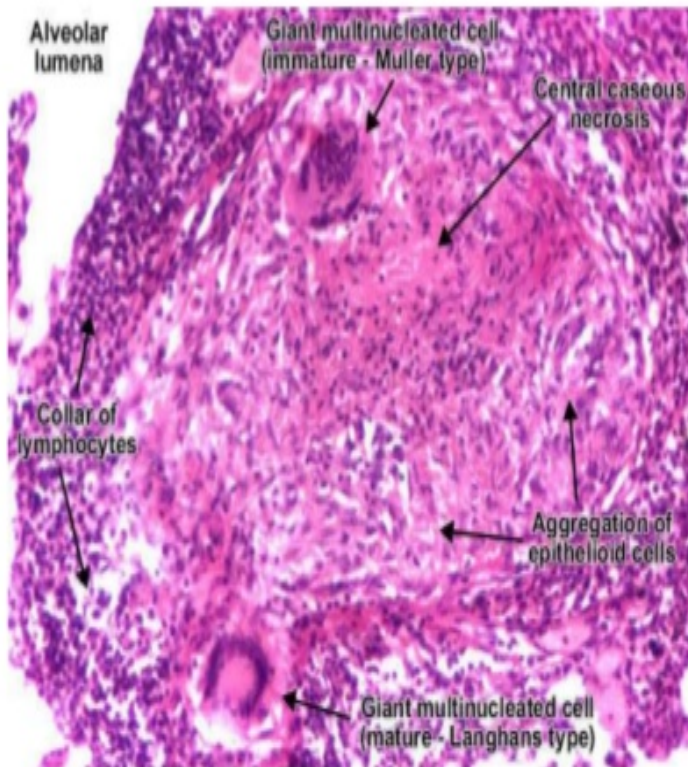
Primary Tuberculosis

- Genitourinary TB
- Miliary TB  (blood)
- Soft tissue (**cold abscess**): lack of inflammation with caseation.

Caseation: due to delayed hypersensitivity reaction. Contains many bacilli, enzymes, O_2 , N_2 intermediates,  necrotic center of granuloma (cheesy material).


CASEATION

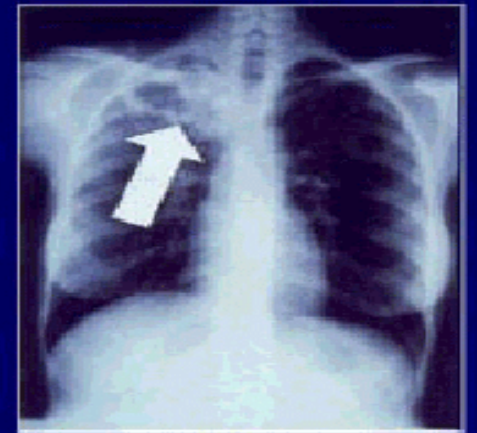
HISTOLOGY



Caseous necrosis in lung tissue

Secondary TB (reactivation)

- Occurs later in life
- Lung more common site
- Immunocompromised patients.
- Lesion localized in **apices**
- **Infectious & symptomatic**
- **Microscopy: many bacilli, large area of caseous necrosis**  **cavity (open TB) with granuloma and caseation.**



Arrow points to cavity in patient's right upper lobe.

CDC

Secondary TB

- Clinically: fever, cough, hemoptysis ,weight loss & weakness.

Sources of secondary TB :

- **Endogenous** (reactivation of an old TB) or
- **Exogenous** (re-infection with new strain)

Immunity to Tuberculosis

- **CMI** associated with delayed hypersensitivity reaction.
- Detected by **tuberculin skin test**.
- Tuberculin test takes 2-10 weeks to react to tuberculin and becomes positive.
- *To be discussed in immunology lecture.*

Laboratory Diagnosis of TB

specimens depend on affected organ:

- Pulmonary TB: **Three** sputum samples (at least one early morning), or bronchial lavage, or gastric washing (infants) .
 - TB meningitis: cerebrospinal fluid (CSF)
 - Urinary tract tuberculosis :**three early morning urine**
 - Bone , joint aspirate
 - Lymph nodes, pus or tissues **NOT** swab.
- Repeat sample as required.

Laboratory Diagnosis of TB

Direct microscopy of specimen :

Z-N or (Auramine) stain.

Culture is the **gold standard** . Important for identification and sensitivity.

- **Media used:** Lowenstein-Jensen media (L J).

Contains: eggs, asparagine, glycerol, pyruvate / malachite green.

Laboratory Diagnosis of TB

- Colonies appear in **LJ media** after 2-8 weeks as eugenic, raised, buff, adherent growth enhanced by glycerol (*MTB*) or by pyruvate (*M.bovis*).
- Other media and methods **plus** LJ media used ,eg:
 - **Automated methods** : Bactec MGIT (Mycobacterium Growth Indicator Test).
 - **Molecular methods** : eg. **ProbTech** detects nucleic acid directly from respiratory samples. **Xpert MTB/RIF** detects nucleic acid and resistance to rifampicin

Mycobacterium

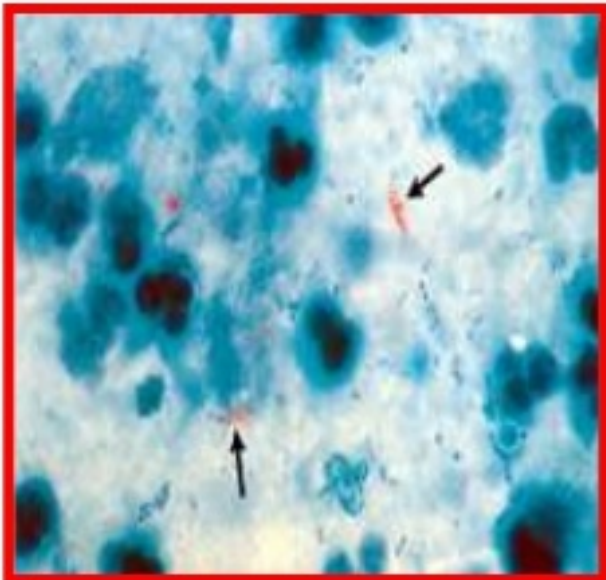


Fig. 5.3: **Myc. TB in Sputum, Z.N stain**

(few thin pink bacilli with blue background)



Fig. 5.1: **Selective media**

for **Myc. T.B.**



Fig. 5.2: **Culture of Myc. TB on L.J. media**

- Grow after 6-8 week

Growth of MTB on LJ media

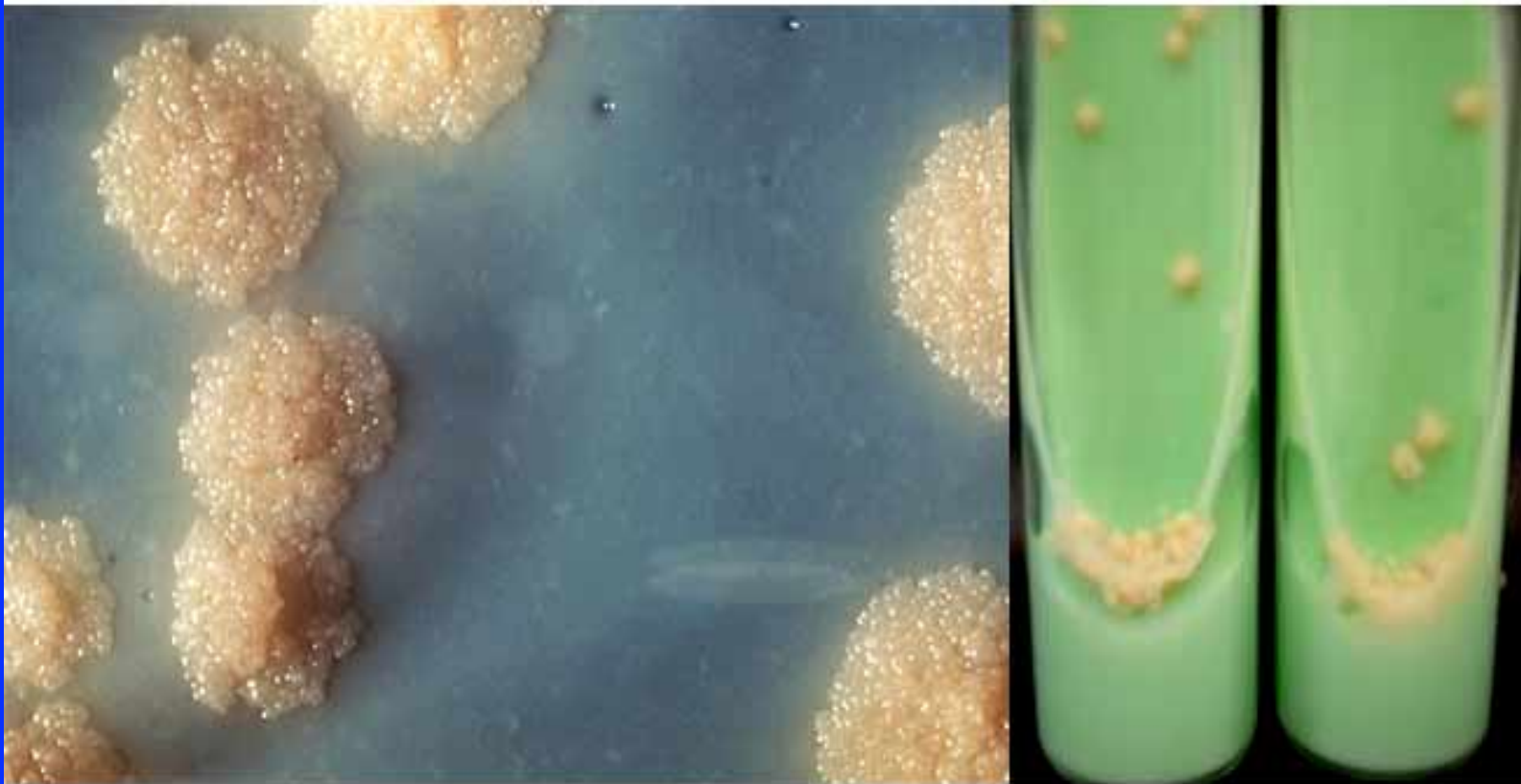


Fig: Cultural Characteristics of *Mycobacterium tuberculosis*

Identification & antimicrobial susceptibility testing

- Morphological characteristics , growth at 37C + 5 -10 % CO₂
- **Biochemical tests** : Niacin production & Nitrate test.
- **Antimicrobial susceptibility testing**: to detect resistance to anti-tuberculosis agents.

Management of a TB case

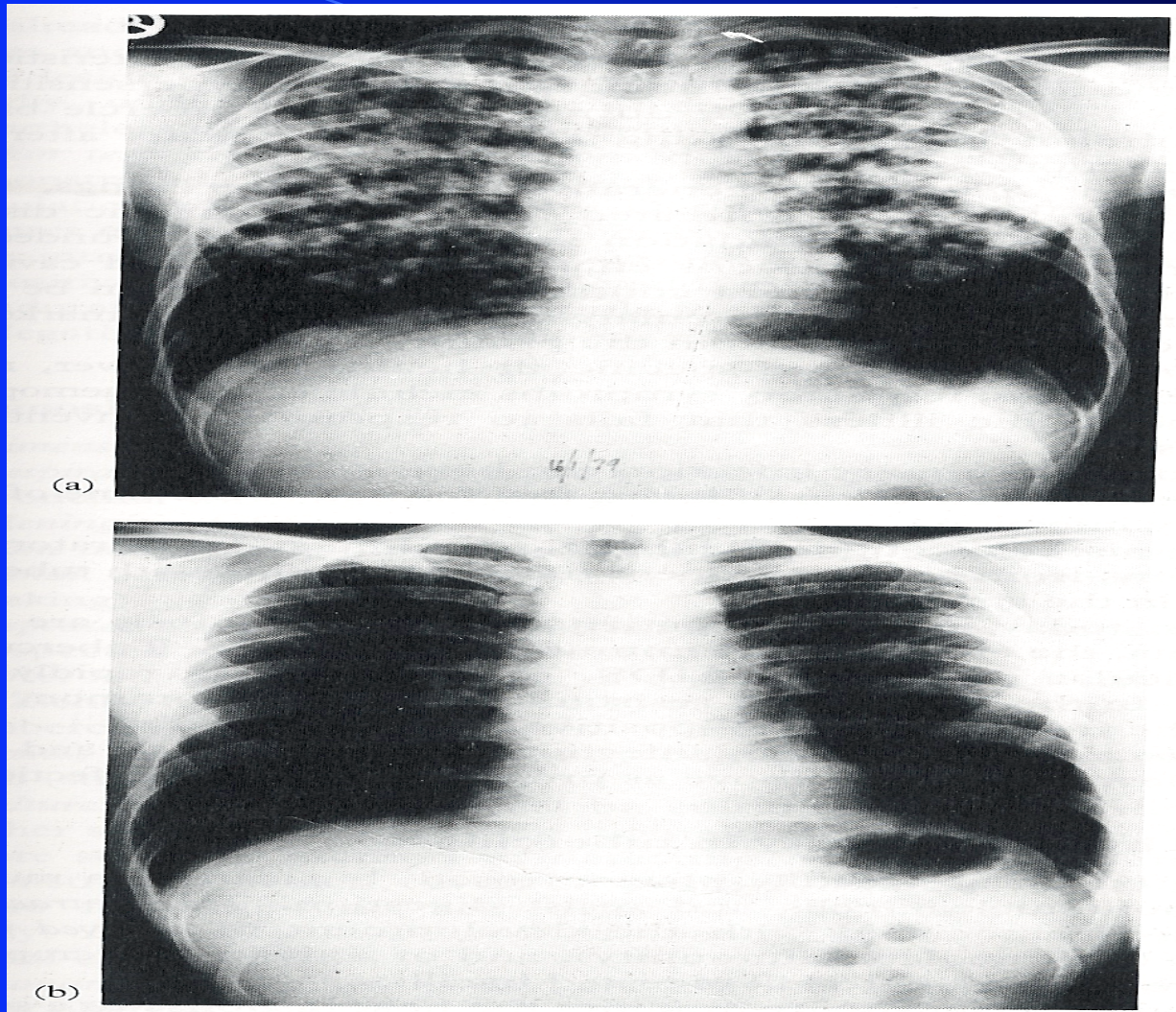
- **Isolation** of the patient for 10-14 days (smear positive cases contain > 1000 organisms / ml of sputum and considered infectious).
- **Triple regimen of therapy** .Why ?
 - To prevent resistant mutants
 - To prevent relapse
- Treatment must be guided by sensitivity testing.

First Line Treatment

- Isoniazide (INH)
- Rifampicin (RIF)
- Ethambutol (E)
- Pyrazinamide (P)

Combination therapy : All 4 first line or INH+ RIF +P for 2 months then continue with INH+RIF for **4-6 months.**

- **Directly Observed Therapy (DOT).**



Tuberculosis: (a) Chest X-ray of a patient with tuberculosis bronchopneumonia. (b) Chest X-ray of the same patient 10 months after antituberculous therapy. (Courtesy of Dr. R.S.Kennedy)

Second Line

Used for the bacteria resistant to first line drugs. More toxic than the first line drugs.

- PAS (Para-Amino Salicylic acid)
- Ethionamide
- Cycloserine,
- Kanamycin,
- Fluroquiolones

Diagnosis of Latent TB

- Measurement of interferon -gamma release (IGRA) :
- Tuberculin Skin testing
 - See *immunology lecture*.

Prevention of TB

- Tuberculin testing of herds.
- Slaughter of infected animals.
- Pasteurization of milk to prevent bovine TB
- Recognition of new cases.
- Prophylaxis with INH of infected contacts.
- Follow up cases .
- Immunization with **BCG** (live attenuated) to all new borne.

Reference book

Ryan, Kenneth J.. Sherris Medical
Microbiology, Latest Edition.
McGraw-Hill Education.