Failure of Azithromycin in Treatment of Brill-Zinsser Disease

DRAGO TURČINOV,* ILIJA KUZMAN, AND BORIS HERENDIĆ

University Hospital for Infectious Diseases, Zagreb, Croatia

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Two patients suffering from Brill-Zinsser disease were treated with azithromycin, which did not prove effective. *Rickettsia prowazekii*, the agent causing Brill-Zinsser disease, cannot be treated with azithromycin. Both patients had epidemiological features consistent with and a clinical course typical of the disease. The diagnosis of Brill-Zinsser disease was serologically confirmed.

Brill-Zinsser disease occurs as a late recrudescence of epidemic typhus. The clinical effect of a newly developed azalide, called azithromycin, against *Rickettsia prowazekii* has not yet been determined. No clinical studies have been published regarding the effect of this treatment.

Two patients were admitted to the University Hospital for Infectious Diseases, Zagreb, Croatia, because they were suffering from a high fever. This man was a refugee from Brcˇko in Bosnia, which he had fled during the Bosnian War in 1992. In his childhood during World War II, he had been infested with lice. He told us that, although he had suffered from some type of febrile illness of unknown cause, some of his neighbors had been diagnosed with epidemic typhus. This led us to suspect that he had also suffered a mild form of typhus in his childhood, which gave us a starting point. In this case, we also had reason to believe that he had suffered a mild form of typhus during his childhood.

A physical examination revealed a fever of 39°C, chills, shivering, headache, pharyngitis, enlarged and painful cervical lymph nodes, and pain in the muscles and joints. A papular rash appeared on his legs and back. Physical and radiographic examination of the chest revealed atypical pneumonia. Despite treatment with azithromycin at doses of 500 mg a day for 3 days, the patient continued to suffer from high fevers for 6 more days, showing the ineffectiveness of azithromycin therapy. On the 10th day of hospitalization, a spinal tap was performed that revealed a pleocytosis of 45/mm³, predominantly mononuclear cells and 900 mg of protein per liter. Upon performance of the Weil-Felix test, the titer count of 1:80 remained unchanged. However, the CFR test showed a titer count change of 1:8 to 1:128, thus revealing Brill-Zinsser disease. On the 12th day of hospitalization, doxycycline therapy was administered at doses of 100 mg twice a day. The patient became afebrile and symptom free within 24 h of starting therapy.

Epidemic typhus has been a serious problem in Croatia, Bosnia, and Herzegovina in the past. In Croatia, large outbreaks occurred during and immediately after World War II, but epidemic typhus was never endemic.

The Weil-Felix test of patients who are suffering from Brill-Zinsser disease may show a negative or low titer count (7) or a change. This test is not always accurate for such a diagnosis. However, the CFR tests, developed later to obtain more accurate titer counts, help to establish and confirm the diagnosis of Brill-Zinsser disease. Our research team is aware that other tests have been developed, but in the aforementioned cases, we had only the CFR test at our disposal.

Tetracycline and chloramphenicol are effective antibiotics against *R. prowazekii* infection but not suitable for children and pregnant women. A single dose of doxycycline, 100 mg orally, is curative (2, 4, 6). Azithromycin is efficient in the treatment of intracellular bacterial infections and can be a potential alternative to tetracycline and chloramphenicol in the treatment of *Rickettsia* infections (5). Some authors agree that azithromycin shows good activity against *Rickettsia akari, Rickettsia conori, R. prowazekii, Rickettsia rickettsii*, and *Rickettsia typhi* in vitro (3). Azithromycin proved more efficient than doxycycline against some *Rickettsia tsutsugamushi* isolates (9).

Our clinical experience, based on only two cases, demonstrates the failure of standard-dose azithromycin in the treatment of Brill-Zinsser disease. The azithromycin (Sumamed) was locally made (Pliva d.d., Zagreb, Croatia). Both cases were diagnosed as rickettsial meningitis, which

* Corresponding author. Mailing address: University Hospital for Infectious Diseases, Mirogojska 8, 10 000 Zagreb, Croatia. Phone: 385 1 4603 142. Fax: 385 1 4678 235. E-mail: dturcinov@bfm.hr.
resulted from an infection of the endothelial cells that caused vasculitis and thrombosis of capillaries, small arteries, and veins (5, 7). Meningitis shows an increase in permeability across the blood-brain barrier and an influx of mononuclear cells. Very low concentrations of azithromycin are found in the cerebrospinal fluid in patients without meningitis (8), but very high concentrations are found in macrophages (1). This could account for the failure of the drug in the above-mentioned two cases. Studies show that doxycycline is also present in only small amounts in the cerebrospinal fluid (10) after therapy.

Azithromycin is given in doses of 500 mg a day for 3 days because significant antibacterial activity against many intracellular pathogens persists in the tissues for more than 5 days after completion of the therapy.

Both patients were effectively cured with doxycycline, although the second patient could have recovered without specific therapy. Therefore, our results need to be reproduced by other investigators, in order to clarify the potential of azithromycin in the treatment of Brill-Zinsser disease.

REFERENCES