Chitotriosidase in neonates with fungal and bacterial infections

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Increased plasma and/or urine chitotriosidase activity was observed in neonates with fungal and/or bacterial infections in parallel with their clinical condition. Increased levels were also found in neonates with bacterial infection. Chitotriosidase activity increase is not a response specific to fungi, but serial assays could monitor the course of neonatal fungal infection.

Human chitotriosidase is a fully active chitinase, specifically expressed by activated phagocytes. Observations support its possible role in the defence against chitin containing pathogens, such as fungi. The human gene is homologous to other chitinase genes found in nature. Approximately 6% of the general population cannot synthesise an active enzyme.1–3

Increased chitotriosidase activity was reported in a neonate with systemic Candida albicans infection.4 Here we report the levels of chitotriosidase in a number of neonates with fungal and bacterial infections.

METHODS

Eight neonates with fungal (group A) and 15 with bacterial infection (group B) were studied. Group A neonates I, II, and IV–VII had blood cultures positive for C albicans, also cultured post mortem from the peritoneal fluid, tracheal tube, and umbilical catheter of neonates II and IV. Neonate III gave a positive blood culture for fungus identified as Aspergillus niger through the detection of fungus DNA (PCR)5 and elevated antigen titre (Platelia Aspergillus, Sanofi Diagnostics Pasteur, Marnes La Coquette, France).

Antifungal treatment (amphotericin B liposome and flucytosine) was initiated following the diagnosis of fungal infection in all neonates except II, III, and IV who died around the time of diagnosis. Of the treated neonates, four (V–VIII) recovered and one (I) died in septic shock (table 1).

Group B comprised neonates with positive blood culture for Staphylococcus epidermidis, Klebsiella pneumonia, Enterobacter cloacae, Serratia marcescens, or Citrobacter sp.

Chitotriosidase was assayed in plasma and urine samples from all neonates as follows: group A, at least four times, at weekly intervals; group B once only, on diagnosis.

This study was approved by the Ethical Committee of the Institute of Child Health.

RESULTS

Increased activity of chitotriosidase in plasma and/or urine was observed in 7/8 of group A neonates on diagnosis of the fungal infection.

Serial assays showed changes in chitotriosidase activity, more evident in urine, in parallel with the clinical condition (fig 1 and table 2). One neonate (VIII) had zero activity in both biological fluids at all time points studied (table 1).

Increased chitotriosidase activity was observed on diagnosis of bacterial infection in group B neonates. Three had increased activity in plasma and 12 in urine (1.9–12.5 and 1.5–40 times the upper normal values, respectively).

DISCUSSION

Chitinases are ubiquitous chitin fragmenting enzymes, identified in various organisms and involved in several biological processes including defence against chitin containing pathogens, such as fungi.6

Despite detailed characterisation of human chitotriosidase, its biological role is still unclear. Evidence suggests that it also plays a role in defence against fungi. Macrophages, one of the primary defences against fungal intruders, are the main source of chitotriosidase, which degrades both colloidal chitin and chitin in the cell wall of C albicans.4 Increased activity has been reported in tissues and plasma of guinea

Figure 1 Chitotriosidase activity in urine of neonates with fungal infection (I–VII). Arrows indicate time of diagnosis of the infection.
of a neonate with pigs infected by F.532 Labadaridis, Dimitriou, Theodorakis, et al. www.archdischild.com

urine assays could be exploited for monitoring the response particularly in the absence of microbial infection. Alert the activity is not a response specific to fungal infection, it could, established post mortem.7

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response to fungal infections but rather reflects phagocyte indicating that increase in chitotriosidase activity is not a specific Gram-negative and Gram-positive bacterial infections, indi-

creased activity was also detected in neonates with infections. Improvement in their clinical condition was associated with a decline in chitotriosidase activity.

Fungal infections are an increasingly serious problem in neonatal intensive care units. Their diagnosis is often difficult, with a false negative culture rate of 20–50%. Early diagnosis is essential for survival, but often diagnosis is only established post mortem.7

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Our results show that although increased chitotriosidase activity is not a response specific to fungal infection, it could, particularly in the absence of microbial infection, alert the physician to possible fungal infection. Furthermore, serial urine assays could be exploited for monitoring the response of neonates to anti-fungal treatment. Studies of the behaviour of human chitotriosidase in relation to innate and acquired defence mechanisms are needed in order for its role to be elucidated.

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