- 3 Malamud D. Saliva as a diagnostic fluid. Dent Clin North Am 2011; 55 (1): 159–78.
- 4 Pant Pai N. Oral fluid-based rapid HIV testing: issues, challenges and research directions. Expert Rev Mol Diagn 2007; 7 (4): 325–8.
- 5 Debattista J, Bryson G, Roudenko N *et al.* Pilot of non-invasive (oral fluid) testing for HIV within a clinical setting. *Sex Health* 2007; **4** (2): 105–9.
- 6 Holm-Hansen C, Tong G, Davis C, Abrams WR, Malamud D. Comparison of oral fluid collectors for use in a rapid point-ofcare diagnostic device. Clin Diag Lab Immunol 2004; 11 (5): 909–12.
- 7 Segal A, Wong DT. Salivary diagnostics: enhancing disease detection and making medicine better. Eur J Dent Educ 2008; 12 (Suppl 1): 22–9.
- 8 Granade TC, Phillips SK, Parekh B, Pau CP, George JR. Oral fluid as a specimen for detection and confirmation of antibodies to HIV type 1. *Clin Diagn Lab Immunol* 1995; **2** (4): 395–9.
- 9 Soto-Ramírez LE, Hernández-Gómez L, Sifuentes-Osornio J et al. Detection of specific antibodies in gingival crevicular transudate by ELISA for diagnosis of HIV type 1 infection. J Clin Microbiol 1992; 30 (11): 2780–3.
- 10 Martínez PM, Torres AR, Ortiz de Lejarazu R, Montoya A, Martin JF, Eiros JM. Human HIV antobody testing by enzyme linked fluoresecent and Western blot assays using serum, gingival-crevicular transudate and urine samples. *J Clin Microbiol* 1999; 37 (4): 1100–6.
- 11 Hunt AJ, Connell J, Christofinis G *et al*. The testing of saliva samples for HIV-1 antibodies: reliability in a non-clinic setting. *Genitourin Med* 1993; **69** (1): 29–30.
- 12 Pasquier C, Bello PY, Gourney P, Puel J, Izopet J. A new generation of serum anti-HIV antibody immunocapture assay for saliva testing. *Clin Diagn Virol* 1997; 8 (3): 195–7.
- 13 Granade TC, Phillips SK, Parekh B *et al*. Detection of antibodies to HIV type 1 in oral fluids: a large-scale evaluation of immunoassay performance. *Clin Diagn Lab Immunol* 1998; **5** (2): 171–5.
- 14 Wesolowski LG, Sanchz T, MacKellar DA *et al*. Evaluation of oral fluid enzyme immuinoassay for confirmation of a positive rapid HIV test result. *Clin Vaccine Immunol* 2009; **16** (7): 1091–2.
- 15 Chamnanpunt J, Phanuphak P. Value of saliva collection device, Omnisal, in preserving the anti-HIV activities of stored saliva. *Int Conf AIDS* 1993; 9: 539 (www.aegis.org/search/ Default.aspx?key=Omnisal).
- 16 Chohan BH, Lavryes L, Kishorchandra N et al. Validation of a modified commercial enzyme-linked immunoassay for detection of human immunodeficiency virus type 1 immunoglobulin G antibodies from oral fluid. Clin Diagn Lab Immunol 2001; 8 (2): 346–8.
- 17 Louie B, Lei J, Liska S, Dowling T, Pandori MW. Assessment of sensitivity and specificity of first, second and third generation EIA for the detection of antibodies to HIV-1 in oral fluid. *J Virol Methods* 2009; **159** (1): 119–21.
- 18 Health Protection Agency. Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas. London: HPA, 2012
- 19 Spencer DV, Nolte FS, Zhu Y. Heterophilic antibody interference causing false-positive rapid human immunodeficiency virus antibody testing. Clin Chim Acta 2009; 399 (1–2): 121–2.
- 20 Fernando SA, Wilson GS. Multiple epitope interactions in the two-step sandwich immunoassay. *J Immunol Methods* 1992; **151** (1–2): 67–86.
- 21 Malamud D, Abrams WR, Barber CA, Weissman D, Rehtanz M, Golub E. Antiviral activities in human saliva. *Adv Dent Res* 2011; 23 (1): 34–7.

Identification of *Clostridium difficile*: evaluation of genotypic, phenotypic and proteomic methods

A. JAIN*, C. POPE*, M. WILKS† and T. PLANCHE*

*Department of Medical Microbiology, St George's Healthcare NHS Trust; and †Department of Medical Microbiology, Barts Health NHS Trust, London, UK

Clostridium difficile infection (CDI) is an important cause of nosocomial diarrhoea. Stool culture, a sensitive method for the detection of *C. difficile*, is necessary for epidemiological investigation, for monitoring antibiotic resistance, and for providing a reference standard against which to validate assays. It is, however, expensive, time-consuming, requires toxin testing and also technical expertise.¹

The clinical significance of culture remains unclear as carriage may occur.² Although the UK national standard operating procedure (SOP)³ provides guidance for culture and identification of *C. difficile*, wide variations in methods of identification were reported in a survey of eight European countries.⁴ The aim of this study is to compare phenotypic identification using the UK national SOP³ with identification by 16S ribosomal DNA (rDNA) sequencing and matrix-assisted laser desorption ionisation-time of flight mass spectrometry (MALDI-TOF MS).

The local research ethics committee confirmed that, as the study represented a service evaluation of recognised diagnostic methodologies performed on anonymised excess diagnostic materials, further formal ethical approval was not required. Consecutive anonymised faeces samples from patients aged ≥18 years submitted to pathology laboratories at St George's Hospital, London, for faecal occult blood (FOB) or Helicobacter pylori antigen detection between 4 January 2010 and 9 February 2010 were analysed. Additionally, cytotoxin enzyme immunoassay (EIA)-positive faeces samples from patients suspected of CDI, and stored C. difficile-positive samples (collected between August and December 2009) were also included. Repeat samples received ≤ 28 days after the first sample were excluded. Samples (stored at 4°C) were analysed within five days of collection.

The samples were cultured for *C. difficile* after alcohol shock³ for spore selection. The alcohol-faeces suspension (50 µL) was streaked on cycloserine cefoxitin fructose agar (CCFA; Oxoid, Basingstoke, UK) and Brazier's cycloserine cefoxitin egg yolk plate (CCEY; E&O Laboratories, Bonnybridge, Scotland). Plates were incubated anaerobically at 37°C for 48 h and examined by two readers (blinded). Positive controls for both selective media were used daily.

The colonies were identified by typical morphology (CCFA: ~2–4 mm in diameter, non-haemolytic, grey/white with rhizoid edge; CCEY: ~1.5–3 mm in size, grey, flat growth, no opacity around colonies). Suspected colonies were identified further after anaerobic subculture for up to

Correspondence to: Dr Anu Jain Reference Microbiology Services, Public Health England 61 Colindale Avenue, London NW9 5EQ. Email: dranujain@doctors.org.uk

Table 1. Differential tests for recognition of C. difficile colonies.3

	C. bifermentans	C. sordellii	C. glycolicum	C. innocuum	C. difficile
Fluorescence at 365 nm	No	No	No	Yes	Yes
Lecithinase on Brazier's CCEY medium	Yes	Yes	No	No	No
Latex agglutination	Yes	Yes	Yes	No	Yes

48 h on Columbia blood agar (CBA; Table 1). As CCFA medium lacks egg yolk, lecithinase production was not observed. The growth of *C. difficile* and other bacteria were quantified as scanty (<10 colonies), light (present in the first streak), moderate (present in the second streak) and heavy (present in the last streak).

The *C. difficile* isolates were tested for cytotoxin production by a cell cytotoxicity assay (CCTA) using a previously described method⁵ and were saved in cooked meat medium (bioMerieux, UK) at room temperature.

Presumptive saved *C. difficile* isolates were identified by 16S rDNA sequencing and MALDI-TOF MS after anaerobic incubation at 37°C for 48 h on CBA. A boil extraction method was used to extract DNA from colonies and the supernatant was added to the polymerase chain reaction (PCR) tube. Primers previously described⁶ were used to amplify a 1380 bp region of the 16S ribosomal RNA (rRNA) gene, and the products were quantified and then sequenced (Source Bioscience, Nottingham, UK).

The MALDI-TOF MS method was performed using a Bruker Microflex LT (Bruker Daltonik, Bremen, Germany). An *in situ* formic acid lysis method was used, which represented a minor modification of the direct analysis method. For samples with no reliable identification (scores <1.7), a full ethanol/formic acid extraction method was performed following the manufacturer's instructions. A culture (<48 h) of *Escherichia coli* (ACTC 25922) was used as a control.

A total of 163 samples were processed (120 *H. pylori* samples, 24 FOB samples, six cytotoxin EIA-positive samples, and 13 stored *C. difficile*-positive samples). *C. difficile*, phenotypically identified in 11.6% (19/163) samples, was confirmed both by sequencing and MALDI-TOF MS in 84.2% (16/19) isolates with full consensus. All 16 isolates grew on both culture media and were positive for toxin production by CCTA. The remaining three were identified as *C. bifermentans* (2/3) and *C. butyricum* (1/3) by sequencing. The MALDI-TOF MS method gave no reliable identification for one (1/2) isolate of *C. bifermentans* and *C. butyricum* (1/1). *C. butyricum* (1/1) and *C. bifermentans* (1/2) grew on CCFA and CCYA; the other isolate of *C. bifermentans* (1/2) grew only on CCFA.

Sensitivity of CCFA and CCEY was 16/16 (100%, 95% confidence interval [CI] 79.4–100%) and specificity was 144/147 (98.0% [CI 94.2–99.6%]) and 145/147 (98.6% [95.2-99.8%]), respectively. *C. difficile* growth on CCFA was moderate or abundant in 93.7% (15/16) and 100% (16/16) on CCEY, mixed with other flora in 81.2% (13/16) samples and 56.2% (9/16) on CCFA and CCEY, respectively. There was consensus in the observations by both readers except for two samples, where a third reader was consulted.

Identification of *C. difficile* from 16/163 specimens (9.8%) reflects the method of sample selection. Patients in the FOB and *H. pylori* groups were likely to have low prevalence of *C. difficile* and hence provided a challenge to the sensitivity

of different culture media. The specimens from patients with known or suspected *C. difficile* were chosen to provide a comparison of positive samples and to confirm the specificity of two different culture media.

Phenotypic methods may misidentify other *Clostridium* species as *C. difficile*, as illustrated above. Apart from colonial morphology, these methods rely on ultraviolet (UV) fluorescence, latex agglutination and lecithinase production (on CCEY, Table 1). Ultraviolet fluorescence, which varies with the type of medium and incubation conditions, may be exhibited by other anaerobes. The latex agglutination is also not specific for *C. difficile* (Table 1). Although the CCEY medium was more selective, no difference was observed in the sensitivity of the two media.

As correlation between 16S rDNA sequencing and MALDI-TOF MS proved to be excellent, MALDI-TOF MS can be considered a useful, rapid method to confirm phenotypic identification. However, larger studies would be required to confirm some of these findings.

The authors wish to thank Marcus Pond and John Haigh for their contribution to this work.

References

- Delmée M, Van Broeck J, Simon A, Janssens M, Avesani V. Laboratory diagnosis of *Clostridium difficile*-associated diarrhoea: a plea for culture. *J Med Microbiol* 2005; 54 (Pt 2): 187–91.
- 2 Wilcox MH, Planche T, Fang FC, Gilligan P. What is the current role of algorithmic approaches for diagnosis of *Clostridium difficile* infection? *J Clin Microbiol* 2010; **48** (12): 4347–53.
- 3 Health Protection Agency. Processing of faeces for Clostridium difficile. UK Standards for Microbiology Investigations. B 10, Issue 1.4 (www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/ 1317132856426).
- 4 Barbut F, Delmée M, Brazier JS et al.; ESCMID Study Group on Clostridium difficile (ESGCD). A European survey of diagnostic methods and testing protocols for Clostridium difficile. Clin Microbiol Infect 2003; 9 (10): 989–96.
- 5 Arnold A, Pope C, Bray S et al. Prospective assessment of two-stage testing for Clostridium difficile. J Hosp Infect 2010; 76 (1): 18–22.
- 6 Woo PC, Cheung EY, Leung K, Yuen K. Identification by 16S ribosomal RNA gene sequencing of an Enterobacteriaceae species with ambiguous biochemical profile from a renal transplant recipient. *Diagn Microbiol Infect Dis* 2001; 39 (2): 85–93.
- 7 Haigh J, Degun A, Eydmann M, Millar M, Wilks M. Improved performance of bacterium and yeast identification by a commercial matrix-assisted laser desorption ionization-time of flight mass spectrometry system in the clinical microbiology laboratory. J Clin Microbiol 2011; 49 (9): 3441.
- 8 Summanen P, Baron E, Citron D, Strong C, Wexler H, Finegold S. *Wadsworth Anaerobic Bacteriology Manual* 5th edn. Belmont, California: Star Publishing, 1993.