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Clinical chorioamnionitis at term I: microbiology of the amniotic cavity using cultivation and molecular techniques

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Abstract

Introduction—The objectives of this study were: 1) to determine the amniotic fluid (AF) microbiology of patients with the diagnosis of clinical chorioamnionitis at term using both cultivation and molecular techniques; and 2) to examine the relationship between intra-amniotic

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inflammation with and without microorganisms and placental lesions consistent with acute AF infection.

Methods—The AF samples obtained by transabdominal amniocentesis from 46 women with clinical signs of chorioamnionitis at term were analyzed using cultivation techniques (for aerobic and anaerobic bacteria as well as genital mycoplasmas) and broad-range polymerase chain reaction (PCR) coupled with electrospray ionization mass spectrometry (PCR/ESI-MS). The frequency of microbial invasion of the amniotic cavity (MIAC), intra-amniotic inflammation [defined as an AF interleukin 6 (IL-6) concentration ≥ 2.6 ng/mL], and placental lesions consistent with acute AF infection (acute histologic chorioamnionitis and/or acute funisitis) were examined according to the results of AF cultivation and PCR/ESI-MS as well as AF IL-6 concentrations.

Results—1) Culture identified bacteria in AF from 46% (21/46) of the participants, whereas PCR/ESI-MS was positive for microorganisms in 59% (27/46) – combining these two tests, microorganisms were detected in 61% (28/46) of patients with clinical chorioamnionitis at term. Eight patients had discordant test results; one had a positive culture and negative PCR/ESI-MS result, whereas seven patients had positive PCR/ESI-MS results and negative cultures. 2) *Ureaplasma urealyticum* (n = 8) and *Gardnerella vaginalis* (n = 10) were the microorganisms most frequently identified by cultivation and PCR/ESI-MS, respectively. 3) When combining the results of AF culture, PCR/ESI-MS and AF IL-6 concentrations, 15% (7/46) of patients did not have intra-amniotic inflammation or infection, 6.5% (3/46) had only MIAC, 54% (25/46) had microbial-associated intra-amniotic inflammation, and 24% (11/46) had intra-amniotic inflammation without detectable microorganisms. 4) Placental lesions consistent with acute AF infection were significantly more frequent in patients with microbial-associated intra-amniotic inflammation than in those without intra-amniotic inflammation [70.8% (17/24) vs. 28.6% (2/7); P = 0.04].

Conclusion—Microorganisms in the AF were identified in 61% of patients with clinical chorioamnionitis at term; 54% had microbial-associated intra-amniotic inflammation, whereas 24% had intra-amniotic inflammation without detectable microorganisms.

Keywords

funisitis; *Gardnerella vaginalis*; histologic chorioamnionitis; intra-amniotic infection/inflammation; microbial invasion of the amniotic cavity (MIAC); PCR/ESI-MS; pregnancy; sterile inflammation; *Ureaplasma urealyticum*

Introduction

Clinical chorioamnionitis is the most common infection-related diagnosis made in labor and delivery units worldwide [1–4]. The standard clinical definition is based on the studies of Gibbs et al. [5, 6], and refers to the presence of maternal fever associated with clinical signs (i.e., foul-smelling discharge, uterine tenderness, maternal and fetal tachycardia) as well as laboratory abnormalities (i.e., leukocytosis). These signs are thought to be manifestations of both local and systemic maternofetal inflammatory processes initiated in response to microbial invasion of the amniotic cavity (MIAC) [7–13].

The prevalence of clinical chorioamnionitis in term gestations is 5%–12% [3], whereas in preterm gestations with premature rupture of membranes (PROM) it is approximately 20% [2, 14, 15]. Clinical chorioamnionitis at term is associated with a 2- to 4-fold increase in endometritis [16], wound infection [16], septic pelvic thrombophlebitis [3, 16], pelvic abscess [3, 16], maternal admission to the intensive care unit [3, 17], and postpartum hemorrhage [3, 18]. Neonates born to mothers with clinical chorioamnionitis have a high risk of neonatal mortality [1], short-and-long term complications such as neonatal sepsis [19–21], meconium aspiration syndrome [22, 23], stillbirth [24, 25], and neurodevelopmental disorders including cerebral palsy [26–37].

The microbiology of clinical chorioamnionitis was originally described in 1982 using cultivation techniques of amniotic fluid (AF) obtained with transcervical catheters placed in the amniotic cavity [5]. However, retrieval of AF with a transcervical catheter is frequently associated with contamination of the AF with microorganisms that are part of the vaginal ecosystem. Therefore, characterization of the microorganisms associated with clinical chorioamnionitis based on samples obtained by transabdominal amniocentesis is necessary to have an accurate description of the microbiology of this condition. Moreover, the use of molecular techniques to identify microorganisms, which may escape detection with cultivation techniques [38–56], allows adequate classification based upon the sequence of the amplicons and can provide additional information about microbial diversity [57–60].

The objectives of this study were: 1) to determine the AF microbiology of patients with the diagnosis of clinical chorioamnionitis at term using both cultivation and molecular techniques; 2) to assess the frequencies of intraamniotic inflammation that were and were not accompanied by detectable microorganisms in these patients; and 3) to examine the relationship between intra-amniotic inflammation with and without microorganisms and placental lesions consistent with acute AF infection.

Materials and methods

Study population

This retrospective cohort study includes patients with clinical chorioamnionitis at term. Patients were identified by searching the clinical database and Bank of Biological Samples of the Perinatology Research Branch of the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development (NICHD). The inclusion criteria were: 1) singleton gestations; 2) gestational age > 37 weeks; and 3) sufficient AF obtained by transabdominal amniocenteses for molecular microbiologic studies. Patients with multiple gestations or fetal malformations were excluded from the study.

Maternal and neonatal data were obtained from clinical chart review, including information about the use of epidural analgesia, intrapartum antibiotic administration, number of vaginal examinations during labor, status of the membranes at the time of amniocentesis (intact or ruptured), and mode of delivery. Patients with the diagnosis of clinical chorioamnionitis were counseled by their treating physicians about the potential value of knowing the precise microorganism involved in the suspected infection. Women who agreed to undergo an amniocentesis were asked to donate additional AF other than that required for clinical

studies and allow collection of clinical information for research purposes. Further management of these patients was at the discretion of the attending physician. All patients provided written informed consent and the use of biologic specimens as well as clinical and ultrasound data for research purposes were approved by the Institutional Review Boards of NICHD, Wayne State University and the Sótero del Río Hospital, Santiago, Chile. All patients were enrolled in this protocol at the Sótero del Río Hospital in Santiago, Chile.

Clinical definitions

Gestational age was determined by the last menstrual period and was confirmed by ultrasound examination; the date derived from ultrasound was used if inconsistent with menstrual dating. Clinical chorioamnionitis was diagnosed by the presence of maternal fever (temperature > 37.8°C) accompanied by two or more of the following criteria: 1) uterine tenderness; 2) malodorous vaginal discharge; 3) fetal tachycardia (heart rate > 160 beats/min); 4) maternal tachycardia (heart rate > 100 beats/min); and 5) maternal leukocytosis (leukocyte count > 15,000 cells/mm³) [6, 16]. Spontaneous term labor was defined as the presence of regular uterine contractions with a frequency of at least 1 every 10 min and cervical changes after 37 weeks of gestation.

Microbial invasion of the amniotic cavity was defined according to the results of AF culture and polymerase chain reaction with electrospray ionization mass spectrometry (PCR/ESI-MS) (Ibis® Technology – Athogen, Carlsbad, CA) [51, 55, 61, 62]. Intra-amniotic inflammation was diagnosed when AF interleukin (IL)-6 concentration was ≥ 2.6 ng/mL [63, 64]. Based on the results of AF cultures, PCR/ESI-MS and AF concentration of IL-6, patients were classified as having: 1) no intra-amniotic inflammation/infection (either using AF culture or PCR/ESI-MS); 2) MIAC (identification of microorganisms by either AF cultures or PCR/ESI-MS without intra-amniotic inflammation); 3) microbial-associated intra-amniotic inflammation (combination of MIAC and intra-amniotic inflammation); or 4) intra-amniotic inflammation without detectable microorganisms (an elevated AF IL-6 concentration without evidence of microorganisms using cultivation or molecular methods). Acute histologic chorioamnionitis was diagnosed based on the presence of inflammatory cells in the chorionic plate and/or chorioamniotic membranes [65], and acute funisitis was diagnosed by the presence of neutrophils in the wall of the umbilical vessels and/or Wharton's jelly, using criteria previously described [65, 66].

Sample collection

Amniotic fluid was transported to the clinical laboratory in a capped sterile syringe and was cultured for aerobic and anaerobic bacteria, including genital mycoplasmas. Evaluation of white blood cell (WBC) count, AF glucose concentration, and Gram stain of AF were also performed shortly after collection. AF not required for clinical assessment was centrifuged for 10 min at 4°C shortly after amniocentesis, and the supernatant was aliquoted and stored at -70°C until analysis. Following delivery, the placenta, umbilical cord, and chorioamniotic membranes were collected and the presence or absence of acute histologic chorioamnionitis and/or funisitis was determined.

Detection of microorganisms with cultivation and molecular methods

Amniotic fluid was analyzed using cultivation techniques (for aerobic and anaerobic bacteria as well as genital mycoplasmas) and with PCR/ESI-MS (Ibis® Technology). Briefly, DNA was extracted from 300 µL of AF using a method that combined bead-beating cell lysis with a magnetic-bead based extraction method [67, 68]. The extracted DNA was amplified on the bacterial artificial chromosome (BAC) spectrum assay according to the manufacturer's instructions. PCR/ESI-MS can identify 3400 bacteria and 40 *Candida* spp., which are represented in the platform's signature database [69–71]. A total of 200 µL of extract was used per sample.

After PCR amplification, 30-µL aliquots of each PCR product were desalted and analyzed by ESI-MS as previously described [70, 72]. The presence of microorganisms was determined by signal processing and triangulation analysis of all base composition signatures obtained from each sample and compared to a database. Along with organism identification, the ESI-MS analysis includes a *Q*-score and level of detection (LOD). The *Q*-score, a rating between 0 (low) and 1 (high), represents a relative measure of the strength of the data supporting identification; only *Q*-scores > 0.90 were reported for the BAC spectrum assay [73]. The LOD describes the amount of amplified DNA present in the sample: this is calculated with reference to an internal calibrant, as previously described [74], and is reported herein as genome equivalents per PCR reaction well (GE/well). The sensitivity (LOD) of PCR/ESI-MS for the detection of bacteria in blood is, on average, 100 CFU/mL (95% CI, 6–600 CFU/mL) [71]. A comparison of detection limits between blood and AF showed that the assays have comparable detection limits (100 CFU/mL) [75].

Determination of IL-6 in amniotic fluid

Amniotic fluid concentrations of IL-6 were determined to assess the magnitude of the intra-amniotic inflammatory response. We used a sensitive and specific enzyme immunoassay obtained from R&D Systems (Minneapolis, MN, USA). The quantitative sandwich enzyme immunoassay technique and the concentrations were determined by interpolation from the standard curves. The inter- and intra-assay coefficients of variation for IL-6 were 8.7% and 4.6%, respectively. The detection limit of the IL-6 assay was 0.09 pg/mL. The AF IL-6 concentrations were determined for research purposes, and such results were not used in patient management. We have previously reported the use of IL-6 for the assessment of intra-amniotic inflammation [44, 51, 61, 63, 75–91].

Maternal and umbilical blood samples

Maternal and umbilical venous blood samples were collected in tubes that contained EDTA. Samples were collected at the time of diagnosis of clinical chorioamnionitis and at delivery from the mother and the neonate, respectively. Blood samples were centrifuged, and supernatants were stored in polypropylene tubes at –70°C. Plasma concentrations of IL-6 were measured with a high sensitivity IL-6 immunoassay (R&D, Minneapolis, MN, USA). The sensitivity of the assay was 0.10 pg/mL. Inter- and intra-assay coefficients of variation were 4.6% and 6.6%, respectively.

Statistical analysis

The Kolmogorov-Smirnov test and visual plot inspection were used to assess the normality of continuous data distributions. Patients were stratified by the status of the membranes (intact or ruptured) at the time of amniocentesis and according to the presence of intraamniotic inflammation or MIAC. Between-group comparisons were performed using the Kruskal-Wallis and the Mann-Whitney *U* tests to examine the differences in arithmetic variable distributions. The χ^2 or Fischer's exact test was used to test for differences in proportions, as appropriate. A two-tailed P-value of < 0.05 was considered statistically significant. The statistical package used was SPSS v.15.0 (SPSS, Chicago, IL, USA).

Results

Characteristics of the study population

A total of 46 patients with clinical chorioamnionitis diagnosed between 37 and 43 weeks of gestation were included in this study. Demographic and clinical characteristics of the study population are displayed in Table 1. The median [interquartile range (IQR)] gestational age of the study population was 39.8 (IQR: 38.9–40.5) weeks. Upon admission, 83% (38/46) of patients presented with spontaneous labor at term, and 98% (45/46) had intact membranes. Some 65% (30/46) of patients had rupture of membranes during labor. Only 19% (9/46) of the women were admitted with fever; the remainder (81%, 37/46) developed fever after hospital admission. In addition to maternal fever, the most frequent criteria that configured the diagnosis of clinical chorioamnionitis were maternal and fetal tachycardia [91% (42/46) and 76% (35/46), respectively], followed by maternal leukocytosis [72% (33/46)]. Most patients had a vaginal delivery [74% (34/46)], and 26% (12/46) were delivered by cesarean (Table 1).

All patients received epidural analgesia during labor. Amniocenteses were performed before the administration of epidural analgesia in 24% (11/46) of patients. Among patients who received antibiotics (n = 43), 88% (38/43) were administered after amniocentesis. Five patients received antibiotics before undergoing amniocentesis (in three cases the amniocentesis was performed 5 minutes after administration of antibiotics and in 2 cases 45 minutes after administration of antibiotics). Ampicillin [83% (38/46)] and gentamicin [85% (39/43)] were the most common antibiotics administered. Three patients did not receive antibiotics.

Prevalence of microbial invasion of the amniotic cavity and microbial diversity

Culture identified bacteria in AF from 46% (21/46) of patients with the diagnosis of clinical chorioamnionitis at term, whereas PCR/ESI-MS was positive for microorganisms in 59% (27/46). When considering positive tests either by culture or PCR/ESI-MS, microorganisms were identified in 61% (28/46) of the study participants. Table 2 shows the microorganisms identified by PCR/ESI-MS for each patient with a positive AF culture and/or PCR/ESI-MS. Eight patients had discordant test results. *Veillonella* spp. and *Lactobacillus* spp. were identified in the single patient with a positive AF culture and negative PCR/ESI-MS result, whereas the remaining seven patients had positive PCR/ESI-MS results and negative AF cultures (denoted by "a" in Table 2).

Among patients with a positive AF culture for bacteria, the most frequent microorganism identified was *Ureaplasma urealyticum* [38% (8/21)], followed by *Mycoplasma hominis* [19% (4/21)], and *Streptococcus agalactiae* [19% (4/21)]. Interestingly, more than half of these patients [57% (12/21)] had an AF culture positive for two or more bacteria.

Among patients with a positive AF PCR/ESI-MS, the most frequent microorganism identified was *Gardnerella vaginalis* [37% (10/27)], followed by *U. urealyticum* [26% (7/27)] and *Lactobacillus* spp. [19% (5/27)] (Table 2). Two or more bacteria were identified in 41% (11/27) of these patients.

Among the 28 patients whose AF tested positive by culture or PCR/ESI-MS, 16 bacterial species and 1 fungal species were identified. Of the sixteen bacterial taxa identified, five were detected by both culture and PCR/ESI-MS (*Ureaplasma* spp., *S. agalactiae*, *Lactobacillus* spp., *G. vaginalis*, and *Fusobacterium* spp.); four were detected only by AF culture (*M. hominis*, *Porphyromonas* sp., *Streptococcus viridans*, and *Veillonella* spp.); and seven were detected by only PCR/ESI-MS (*Peptostreptococcus anaerobius*, *Abiotrophia defectiva*, *Sneathia*, *Propionibacterium acnes*, *Acinetobacter* species, *Pseudomonas aeruginosa*, and *Escherichia coli*). *Candida* spp. was identified in two cases (Table 2).

Intra-amniotic inflammatory response in patients with clinical chorioamnionitis

Intra-amniotic inflammation (AF IL-6 ≥ 2.6 ng/mL) was identified in 78% (36/46) of the study participants. When combining the results of AF culture, PCR/ESI-MS and AF IL-6 concentrations – 15% (7/46) of the patients did not have intra-amniotic inflammation or infection; 6.5% (3/46) had MIAC; 54% (25/46) had microbial-associated intraamniotic inflammation; and 24% (11/46) had intra-amniotic inflammation without detectable microorganisms.

The prevalence of microbial-associated intra-amniotic inflammation and intra-amniotic inflammation without detectable microorganisms differed according to whether the chorioamnionic membranes were intact or ruptured at the time of amniocentesis (Figure 1). Microbial-associated intra-amniotic inflammation was diagnosed in 70% (21/30) of the women with ruptured membranes, and in only 25% (4/16) of those with intact membranes. Likewise, 31% (5/16) of patients who had intact membranes at the time of amniocentesis did not have evidence of intraamniotic inflammation, whereas only 7% of those whose membranes were ruptured did not have evidence of intraamniotic inflammation.

Table 3 describes differences in distributions of markers of inflammation in AF and maternal blood among the study groups. The median (IQR) AF WBC counts, AF IL-6, and maternal WBC concentrations were each significantly higher in patients with microbial-associated intraamniotic inflammation/infection than in those without intra-amniotic inflammation [AF WBC count: 300 cells/mm³ (39–900) vs. 5 cells/mm³ (0–42); $P = 0.003$; AF IL-6: 14.1 ng/mL (5.7–36.8) vs. 0.9 ng/mL (0.4–1); $P < 0.001$; maternal WBC count: 16.7 cells/mm³ (13.1–21) vs. 15 cell/mm³ (10.6–16.8); $P = 0.04$]. However, there was no significant differences in maternal and umbilical cord blood IL-6 among these groups ($P = 0.3$ and $P = 0.1$, respectively; Table 3). Among patients with intra-amniotic inflammation, those with detectable microorganisms had significantly higher median AF WBC count than women

without detectable microorganisms ($P = 0.03$). Moreover, the median AF IL-6 concentrations were marginally higher in microbial-associated intra-amniotic inflammation than in intra-amniotic inflammation without detectable organisms ($P = 0.06$).

Among patients with a positive PCR/ESI-MS, the median (IQR) AF IL-6 concentration was significantly higher in cases with polymicrobial infection ($n = 12$) than in those in whom a single microorganism was identified ($n = 15$) [18.8 ng/mL (9.4–72.6) vs. 6.4 ng/mL (4.0–14.1); $P = 0.04$]. In addition, the microbial inoculum size, expressed as GE/well, was significantly correlated with AF concentration of IL-6 (Spearman's $\rho = 0.63$; $P < 0.001$) (Figure 2). There was no correlation between microbial burden and AF WBC concentration (Spearman's $\rho = 0.23$; $P > 0.05$).

Relationship between detectable microorganisms in the amniotic fluid and placental lesions consistent with amniotic fluid infection

The extraplacental membranes and umbilical cord were examined in 97.8% (45/46) of the study participants; 51% (23/45) had placental lesions consistent with AF infection (acute histologic chorioamnionitis and/or funisitis); 48.8% (22/45) had acute histologic chorioamnionitis; and 28.9% (13/45) had funisitis. Figure 3 shows the frequency of placental lesions consistent with AF infection among the study groups. The prevalence of such placental lesions was significantly higher in patients with microbial-associated intra-amniotic inflammation than in patients with no intra-amniotic inflammation/infection [70.8% (17/24) vs. 28.6% (2/7); $P = 0.04$], while there was no statistical difference in the frequency of these placental lesions between patients with intra-amniotic inflammation without detectable microorganisms and those without intra-amniotic infection/inflammation [36.4% (4/11) vs. 28.6% (2/7); $P = 0.7$] (Figure 3). The rate of placental lesions consistent with AF infection was nearly two-fold greater in patients with microbial-associated intra-amniotic inflammation than in those with intra-amniotic inflammation without detectable microorganisms, yet this difference was only marginally significant in light of the sample size in each group [70.8% (17/24) vs. 36.4% (4/11); $P = 0.053$] (Figure 3).

Discussion

Principal findings of this study

1) Microorganisms were identified in the AF in 61% (28/46) of women with clinical chorioamnionitis at term; 2) the most common microorganisms identified were *G. vaginalis* and *U. urealyticum*; 3) PCR/ESI-MS identified more microorganisms than cultivation of AF, yet some bacterial taxa were preferentially identified by each test, meaning both might be required to determine whether clinical chorioamnionitis at term is microbial-associated; and 4) when combining the results of AF culture, PCR/ESI-MS and AF IL-6 concentrations, 54% of the study participants had microbial-associated intra-amniotic inflammation, whereas 24% had intra-amniotic inflammation without detectable microorganisms.

Microbiology of clinical chorioamnionitis at term

Despite its clinical importance, the microbiology of AF from patients with clinical chorioamnionitis at term has not been adequately characterized. The study of Gibbs et al.

used transcervical catheters in 52 patients with clinical signs of chorioamnionitis and 52 patients matched for gestational age [5]. However, AF retrieved by a transcervical catheter is prone to contamination. Approximately, 75% of all samples from patients without clinical chorioamnionitis had $>10^2$ colony-forming units/mL in AF cultures [5]. In contrast, when transabdominal amniocentesis was used to assess the amniotic cavity of patients in labor at term without evidence of clinical chorioamnionitis, only 19% (17/90) had positive AF cultures for microorganisms [92]. Transcervical collection of AF for microbiologic studies is associated with a high rate of contamination, making interpretation of microbiologic studies difficult; therefore, this approach has been abandoned in modern studies of the microbiology of the amniotic cavity [93–96]. A study of the microbiology of clinical chorioamnionitis at term using AF retrieved by transabdominal amniocentesis is needed.

The key sign used to diagnose clinical chorioamnionitis is fever, a nonspecific host response to infection or tissue injury. It is now well established that 11%–19% of patients with epidural anesthesia/analgesia develop hyperthermia [23, 97–104]. The mechanism responsible for fever in these cases is unknown, but accumulating evidence suggests it is of an inflammatory nature [103–108]. It is possible that in some cases in which the diagnosis of clinical chorioamnionitis was made after the placement of an epidural, fever is the consequence of the epidural, rather than intra-amniotic inflammation or infection. This differential diagnosis has become a major clinical challenge in labor and delivery rooms worldwide. In our study, 76% (35/46) of patients had clinical signs of chorioamnionitis after the use of epidural analgesia, and of those, 63% ($n = 22/35$) had microbial-associated intra-amniotic inflammation and 20% ($n = 7/35$) had intra-amniotic inflammation without demonstrable microorganisms. We propose that analysis of AF can help with a precise diagnosis, and this has implications for both mothers and neonates.

Microorganisms in the AF are present in 61% of patients with clinical chorioamnionitis at term

Clinical chorioamnionitis is diagnosed by the combination of fever and other clinical signs, such as uterine tenderness, foul-smelling odor, fetal and maternal tachycardia, and maternal leukocytosis [109, 110]. The clinical diagnosis at term is rarely confirmed by microbiologic studies [110, 111], yet it is an indication for antibiotic treatment to improve maternal and neonatal outcome [112]. A major finding of our study is that about four out of 10 patients (40%) with the diagnosis of clinical chorioamnionitis did not have any evidence of bacteria in the amniotic cavity identified by culture or molecular methods, and 49% of patients with clinical chorioamnionitis at term did not have any evidence of acute inflammatory placental lesions. Therefore, we conclude that a large fraction of patients with the diagnosis of clinical chorioamnionitis at term do not have bacterial infection. This has clinical implications, as all of these patients and their neonates receive antibiotics [113–120] which can change the neonatal microbiota [121–129] and may have long-term effects in their immune response [130, 131]. It is important to determine which patients require medical intervention, and this can be accomplished through characterization of the AF microbiology for a rational choice of antimicrobial therapy.

Microorganisms in the amniotic cavity in clinical chorioamnionitis at term

Ureaplasma urealyticum was the most common microorganism retrieved from the AF using cultivation techniques, followed by *M. hominis*, *S. agalactiae*, and *Fusobacterium* spp. In contrast, the most common microorganisms detected by PCR/ESI-MS were *G. vaginalis*, followed by *U. urealyticum* and *Lactobacillus* spp. Of three cases in which PCR/ESI-MS identified *Acinetobacter* spp., AF cultures were negative. In 44% (12/27) of cases with positive AF results by PCR/ESI-MS, multiple organisms were isolated from the same fluid (polymicrobial infection), and in such cases, the magnitude of the intra-amniotic inflammatory response (IL-6) was higher than in cases having only one microorganism.

Gardnerella vaginalis was identified in the AF of 10 patients (Table 2). Cultivation methods identified this microorganism in only three cases; the remainder was identified using only molecular techniques. The number of microbial genomes was similar in both patients with negative culture and those with positive culture. Thus, factors other than the inoculum size may determine microorganism identification by culture. Six patients had *Lactobacillus* spp., three had *Sneathia*, and other patients had *Veillonella* spp. All of these microorganisms have been previously identified in AF [51, 92, 132–135].

For one patient, the PCR/ESI-MS result might have been false negative, as the AF culture was positive for *Veillonella* spp. and *Lactobacillus* spp., and this patient also had intra-amniotic inflammation. It is unclear whether results for the seven patients with positive PCR/ESI-MS results and negative AF cultures were affected by contamination (i.e., false-positive PCR/ESI-MS) as three of these patients were positive for *Acinetobacter* spp., which has occasionally been found in nosocomial infections [136]. However, three of the remaining four patients had intra-amniotic inflammation and/or placental lesions consistent with acute AF infection, suggesting that the discordant results of PCR/ESI-MS were likely to represent true positives. Further studies are warranted to examine the importance and significance of discordant AF culture and PCR/ESI-MS test results in patients with clinical chorioamnionitis at term.

We have previously used PCR/ESI-MS to characterize the microorganisms in the AF in patients with preterm labor and intact membranes [75]. It is noteworthy that the most common organism in preterm labor with intact membranes was *Ureaplasma parvum*, while in clinical chorioamnionitis, it was *Gardnerella*, suggesting that the microbiology of the two conditions is somewhat different. Knowledge of the microbiology of the amniotic cavity is important for rational antimicrobial therapy. The observation that genital *Mycoplasmas* are frequently involved is relevant because these microorganisms are not successfully treated with the antibiotics generally used for the treatment of clinical chorioamnionitis [137], puerperal endometritis [138–145], or neonatal sepsis [146–152]. *Ureaplasma* has been treated with erythromycin [153], while *Mycoplasma* requires treatment with other antimicrobial agents [154–156]. Although some may argue that infections with *Mycoplasmas* can resolve without treatment, an important question is whether this is optimal and always the case. It is not known if infections with genital *Mycoplasmas* which were not adequately treated may cause endometritis [157], impaired wound healing of the hysterotomy or skin incision, or even secondary infertility [158–161]. Indeed, *Ureaplasma* spp. is the most common microorganism from incisional wounds after a cesarean delivery

[162]. It is unclear if appropriate antimicrobial treatment could reduce the rate of wound complications in patients with clinical chorioamnionitis and intra-amniotic infection due to these microorganisms. The consequences of genital *Mycoplasma* infection of newborns have also been a subject of study and it remains to be determined whether neonates may benefit from adequate coverage with antimicrobial agents against this microorganism [147, 150].

Intra-amniotic inflammation in clinical chorioamnionitis at term

The AF IL-6 concentrations were used to assess the presence and magnitude of an inflammatory response based upon previous studies conducted by us and others [78–81,85, 90, 96, 163–172], which indicate that AF IL-6 concentrations correlate with the outcome of preterm labor [11,63, 79, 88, 173–179], preterm PROM [173, 180, 181], cervical insufficiency [182], placenta previa [89], and a short cervix [183–186]. The median AF IL-6 concentration in patients with clinical chorioamnionitis and microbial-associated intra-amniotic inflammation was 14 ng/mL, which was higher than that of patients with intra-amniotic inflammation without detectable microorganisms (4.7 ng/mL). However, it is interesting that the median AF concentration of IL-6 in patients with clinical chorioamnionitis and microbial-associated inflammation was substantially lower than that of patients with preterm labor with intact membranes and microbial-associated inflammation, even when most of the latter patients did not have clinical chorioamnionitis (e.g., fever and other signs) (PTL, 96 ng/mL vs. chorioamnionitis at term with microbial-associated intra-amniotic inflammation, 14 ng/mL) [187]. The intensity of the inflammatory response was greater with a larger microbial burden, an observation that is in keeping with our previous findings [51, 55, 75]. We report for the first time that polymicrobial infections are associated with a more intense intra-amniotic inflammatory response. Whether this observation represents engagement of multiple pattern recognition receptors with a more robust inflammatory response remains to be determined [188–191].

Clinical chorioamnionitis without demonstrable bacteria in the amniotic cavity

Intra-amniotic inflammation in the absence of bacteria was identified by cultivation and/or molecular methods in 24% of women with clinical chorioamnionitis at term. What is the cause of intra-amniotic inflammation in these cases? Viruses may play a role; however, our previous studies in preterm labor and other complications of pregnancy indicate that the prevalence of viral invasion of the amniotic cavity is extremely low [75, 192]. Therefore, although possible, we do not believe that this is the most likely cause of nonbacterial intra-amniotic inflammation [187]. Another possibility is that “danger signals” induce an inflammatory response [174–179,193–198]. It is now recognized that cellular damage and stress could lead to release of alarmins [199, 200], which are normal cell constituents released during necrosis or cellular stress capable of inducing an inflammatory response [201–204]. We have previously reported that clinical chorioamnionitis at term is associated with a significant increase in the AF concentrations of high mobility group protein-B1 [179], the prototypic alarmin. One question is whether patients with intra-amniotic inflammation and elevated AF HMGB-1 concentrations correspond to those with intra-amniotic inflammation without detectable microorganisms [187].

Are there consequences of intra-amniotic inflammation without demonstrable microorganisms? The recognition of intra-amniotic inflammation without detectable microorganisms had to await the availability of molecular methods, which excluded the presence of bacteria and a large number of viruses. The current study used molecular microbiologic methods for the detection of bacteria, but not viruses. Therefore, we have not employed the term “sterile inflammation” in this report. The observation that intra-amniotic inflammation without demonstrable microorganisms is accompanied by evidence of a maternal systemic inflammatory response (i.e., acute histologic chorioamnionitis) in 36% (4/11) suggests that the inflammatory process is not confined to the amniotic cavity.

Clinical chorioamnionitis and histologic evidence of placental lesions consistent with amniotic fluid infection

Histologic chorioamnionitis is a maternal host response to the presence of microorganisms in the amniotic cavity or other inducers of inflammation [13, 205]. In this study, 51% (23/45) of patients with clinical chorioamnionitis had placental lesions consistent with AF infection. Our observations are consistent with those of Smulian et al. who reported that 62% (86/139) of patients with clinical chorioamnionitis had histologic confirmation of inflammation in the chorioamniotic membranes [206]. Therefore, a subset of patients with clinical chorioamnionitis does not have acute inflammatory lesions of the placenta. The stimuli for fever and other clinical signs of systemic maternal inflammation in these cases remain to be determined, particularly in those who did not have an epidural.

The frequency of acute histologic chorioamnionitis without evidence of placental or intra-amniotic infection ranged from 30% to more than 50% in prior studies [207–209]. Roberts et al. recently reported the histologic and microbiologic evaluation of 195 placentas from low-risk pregnancies who delivered at term. The authors found that grade 1 or 2 histologic chorioamnionitis was present in 34% (67/195), but microorganisms in the chorioamniotic space were present in only 4% (8/195) [210]. However, Hillier et al. demonstrated that 33% (3/9) of patients with acute histologic chorioamnionitis at term had negative chorioamniotic cultures [208]. Similarly, Zhang et al. reported that microorganisms were cultured in 44% (49/111) of the placentas with histologic evidence of acute chorioamnionitis. They noted that in many instances, “pathogens are not recovered by conventional aerobic and anaerobic bacteriologic studies.” Thus, taken together, it is clear that a sizable proportion of patients with acute histologic chorioamnionitis do not have bacteria either in the AF, chorioamniotic membranes, or in the subchorionic fibrin [207].

Strengths and limitations

Strengths of this study include the use of both molecular and cultivation techniques for the identification of microorganisms, blinding of pathologists to obstetrical diagnoses and outcomes, and use of standardized protocols for placental examination. Limitations include those related to sample size, and like all observational studies, causation cannot be inferred from the reported associations.

Conclusions

Microorganisms were identified in the AF in 61% of patients with clinical chorioamnionitis at term; 54% had microbial-associated intra-amniotic inflammation, whereas 24% had intra-amniotic inflammation without detectable bacteria. Despite its frequency and importance, there are major gaps in knowledge about the diagnosis, pathogenesis, microbiology, maternal and fetal immune response, and short-and-long term consequences of clinical chorioamnionitis, as well as optimal treatment. Systems biology can help us make major gains in the understanding of this important condition [211–228].

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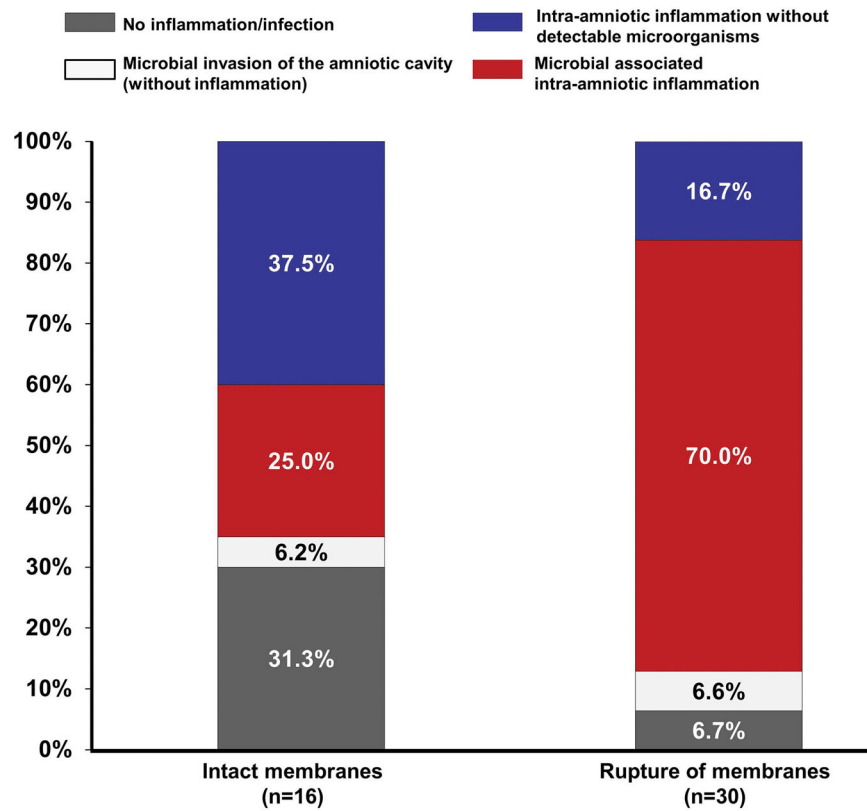


Figure 1. Prevalence of microbial-associated intra-amniotic inflammation and intra-amniotic inflammation without detectable microorganisms in patients with clinical chorioamnionitis at term according to the status of the membranes at the time of amniocentesis (intact vs. ruptured). Microbial-associated intra-amniotic inflammation was diagnosed in 70% (21/30) of the cases with rupture of the membranes, and in 25% (4/16) of patients with intact membranes.

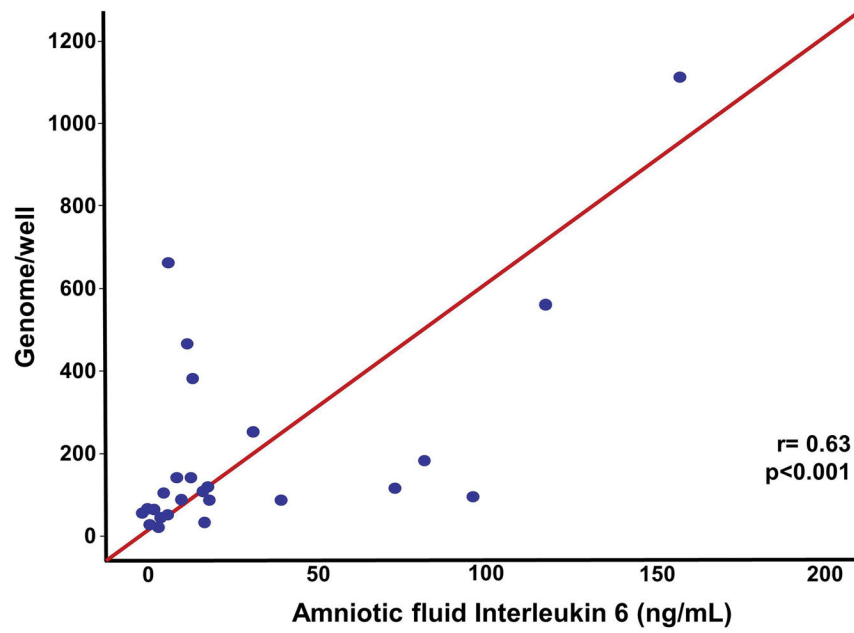


Figure 2. Correlation between amniotic fluid interleukin-6 concentration and the microbial burden (GE/well) in patients with a positive PCR/ESI-MS. The microbial inoculum size was significantly correlated with an AF concentration of IL-6 (Spearman's $\rho = 0.63$; $P < 0.001$).

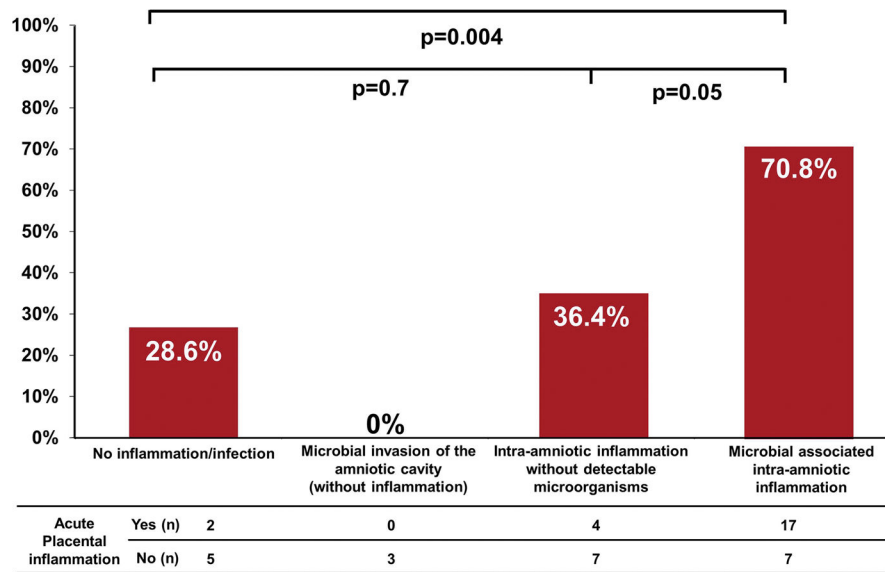


Figure 3. Prevalence of placental acute inflammation (acute histologic chorioamnionitis and/or funisitis) according to the presence or absence of microbial-associated intra-amniotic inflammation, intra-amniotic inflammation without detectable microorganisms, or microbial invasion of the amniotic cavity in patients with clinical signs of chorioamnionitis at term.

Table 1

Clinical characteristics of the study population

	Median (IQR) or % (n/N)
Age (years)	21 (18 – 25)
Body mass index (kg/m ²)	23.7 (21.6 – 24.8)
Nulliparity	65.2% (30/46)
Smoking	10.9 (5/46)
Rupture of the membranes at the time of amniocentesis	65.2 (30/46)
GA at amniocentesis (weeks)	39.8 (38.9 – 40.5)
Maternal tachycardia (>100 beats/min)	91.3 (42/46)
Fetal tachycardia (>160 beats/min)	76.1 (35/46)
Uterine tenderness	8.7 (4/46)
Foul-smelling amniotic fluid	6.5 (3/46)
Maternal leukocytosis	71.7 (33/46)
Labor	
Spontaneous	82.6 (38/46)
Induced	15.2 (7/46)
C-section	26.1 (12/46)
Epidural analgesia before amniocentesis	76.1 (35)
AF white blood cells (cells/mm ³)	66.5 (5 – 692.5)
AF glucose (mg/dL)	9 (9 – 9)
AF Gram stain positive	13 (6/46)
AF interleukin-6 (ng/mL)	6.6 (3.0 – 18.0)

Data presented as median (IQR) or % (n).

IQR: interquartile range; AF: amniotic fluid; GA: gestational age; PCR: polymerase chain reaction; ESI-MS: electrospray ionization mass spectrometry; C-section: cesarean section.

Table 2

Microorganisms detected in the amniotic fluid of patients with clinical chorioamnionitis at term using cultivation techniques vs. PCR/ESI-MS.

Case	Microorganisms determined by cultivation				Microorganisms determined by PCR/ESI-MS				PCR germ 4
	MIAC by culture	AF germ 1	AF germ 2	AF germ 3	MIAC by PCR/ESI-MS	PCR germ 1	PCR germ 2	PCR germ 3	
1	Yes	<i>Ureaplasma urealyticum</i>	<i>Bacteroides</i> spp	<i>Gardnerella vaginalis</i>	Yes	<i>U. urealyticum</i>	<i>G. vaginalis</i>	<i>Sneathia</i>	
2	Yes	<i>Ureaplasma urealyticum</i>	<i>Enterococcus</i> spp	<i>G. vaginalis</i>	Yes	<i>U. urealyticum</i>	<i>G. vaginalis</i>	<i>Peptostreptococcus anaerobius</i>	
3	Yes	<i>U. urealyticum</i>	<i>Mycoplasma hominis</i>	<i>Streptococcus viridans</i>	Yes	<i>Ureaplasma parvum</i>			
4	Yes	<i>U. urealyticum</i>	<i>Streptococcus agalactiae</i>		Yes	<i>U. urealyticum</i>	<i>G. vaginalis</i>		
5	Yes	<i>U. urealyticum</i>	<i>Streptococcus viridans</i>		Yes	<i>G. vaginalis</i>	<i>Sneathia</i>		
6	Yes	<i>U. urealyticum</i>	<i>Peptostreptococcus</i> spp		Yes	<i>Ureaplasma parvum</i>	<i>Lactobacillus</i> species		
7	Yes	<i>U. urealyticum</i>			Yes	<i>Ureaplasma parvum</i>	<i>Lactobacillus</i> species		
8	Yes	<i>U. urealyticum</i>			Yes	<i>Firmicute</i>			
9	Yes	<i>M. hominis</i>	<i>Veillonella</i> spp	<i>Bacteroides</i> spp	Yes	<i>Ureaplasma parvum</i>			
10	Yes	<i>M. hominis</i>	<i>G. vaginalis</i>		Yes	<i>G. vaginalis</i>			
11	Yes	<i>M. hominis</i>			Yes	<i>Propionibacterium acnes</i>			
12	Yes	<i>S. agalactiae</i>	<i>Staphylococcus aureus</i>		Yes	<i>S. agalactiae</i>			
13	Yes	<i>S. agalactiae</i>			Yes	<i>S. agalactiae</i>			
14	Yes	<i>S. agalactiae</i>			Yes	<i>G. vaginalis</i>			
15	Yes	<i>Porphyromonas</i> spp			Yes	<i>Lactobacillus</i> species			
16	Yes	<i>Porphyromonas</i> spp			Yes	<i>G. vaginalis</i>	<i>Lactobacillus</i> species		
17	Yes	<i>Bacteroides</i> spp	<i>Eubacterium</i> sp		Yes	<i>Sneathia</i>			
18	Yes	<i>Candida albicans</i>	<i>Gram (-) bacilli</i>		Yes	<i>G. vaginalis</i>			
19 ^b	Yes	<i>Veillonella</i> spp	<i>Lactobacillus</i> spp		No	Negative			
20	Yes	<i>Peptostreptococcus</i> spp			Yes	<i>G. vaginalis</i>	<i>Abiotrophia defectiva</i>		
21	Yes	<i>Fusobacterium</i> spp			Yes	<i>Fusobacterium nucleatum/periodonticum</i>			
22 ^a	No				Yes	<i>Escherichia coli</i>			
23 ^a	No				Yes	<i>G. vaginalis</i>			
24 ^a	No				Yes	<i>Staphylococcus epidermidis</i>	<i>Lactobacillus</i> species	<i>Micrococcus luteus</i>	<i>Candida lamata</i>

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Case	Microorganisms determined by cultivation			Microorganisms determined by PCR/ESI-MS					
	MIAC by culture	AF germ 1	AF germ 2	AF germ 3	MIAC by PCR/ESI-MS	PCR germ 1	PCR germ 2	PCR germ 3	PCR germ 4
25 ^a	No				Yes	<i>Acinetobacter</i> species	<i>Pseudomonas aeruginosa</i>		
26 ^a	No				Yes	<i>Acinetobacter</i> species	<i>P. aeruginosa</i>		
27 ^a	No				Yes	<i>Acinetobacter</i> species			
28 ^a	No				Yes	<i>Escherichia coli</i>			

AF: amniotic fluid; PCR: polymerase chain reaction; ESI-MS: electrospray ionization mass spectrometry; MIAC: microbial invasion of the amniotic cavity.

^aPositive PCR/ESI-MS and negative AF culture for bacteria

^bPositive AF culture with negative PCR/ESI-MS

Table 3

Inflammatory markers in maternal blood, amniotic fluid, and umbilical cord in patients with clinical chorioamnionitis at term according to the results of amniotic fluid cultures and PCR/ESI-MS

	No inflammation/infection (n=7)	p-value ^d	Intra-amniotic inflammation without detectable microorganisms (n=11)	p-value ^b	Microbial-associated intra-amniotic inflammation (n=25)	p-value ^c
Maternal white blood cell count (10 ³ /mm ³)	15 (10.6 – 16.8)	0.3	15.3 (13.7 – 17.8)	0.2	16.7 (13.1 – 21)	0.04
Maternal blood IL-6 (pg/mL)	18.8 (11.7 – 37.7)	0.1	4.6 (0.9 – 29)	0.1	9.4 (5.4 – 45.5)	0.3
AF white blood cell count (cells/mm ³)	5 (0 – 42)	0.6	25 (0 – 85)	0.03	300 (39 – 900)	0.003
AF glucose (mg/dL)	9 (9 – 12)	1	9 (9 – 10)	0.04	9 (7 – 9)	0.3
AF IL-6 (ng/mL)	0.9 (0.4 – 1)	<0.001	4.7 (3.2 – 15)	0.06	14.1 (5.7 – 36.8)	<0.001
Cord blood IL-6 (pg/mL)	2.6 (1.9 – 5.8)	0.4	4.3 (2.3 – 6.2)	0.1	6.5 (2.5 – 23.2)	0.1

Data presented as median (interquartile) and percentage and (n); AF: amniotic fluid; IL: interleukin

^aComparison between no inflammation/infection and intra-amniotic inflammation without detectable microorganisms.

^bComparison between patients with intra-amniotic inflammation without detectable microorganisms and microbial-associated intra-amniotic inflammation.

^cComparison between patients with no inflammation and microbial-associated intra-amniotic inflammation.