Legionnaires’ disease:
Seek and ye shall find

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■ ABSTRACT
Legionella pneumophila is among the top three or four microbial causes of community-acquired pneumonia, yet is often misdiagnosed and inadequately treated. New laboratory tests should simplify the diagnosis. Also, contrary to common perception, the disease is usually spread via aspiration of water from contaminated hot water distribution systems, not from air conditioning systems. The treatment of choice has shifted from erythromycin to the newer macrolides and quinolones. Routine culturing of the hospital water supply is a requisite first step in preventing hospital-acquired Legionnaires’ disease.

This will change. With new, convenient diagnostic tests and improved understanding, physicians will recognize many more cases of Legionnaires’ disease that have been under our noses the whole time. The key, however, is to suspect it in the first place.

■ PATIENTS AT RISK

Particularly at risk of infection are patients weakened by underlying disease: those with chronic obstructive pulmonary disease, transplant recipients, patients receiving corticosteroids, patients with chronic lung abscesses, neonatal intensive care patients, and immunosuppressed children.

■ NEW UNDERSTANDING OF HOW THE DISEASE IS TRANSMITTED

Although air conditioners were implicated in the first outbreak of Legionnaires’ disease (in Philadelphia in 1976), more recent data show that the Legionella bacterium is actually found in water distribution systems in large buildings, such as hospitals, workplaces, and nursing homes. Other habitats include private residences, whirlpool spas, hot springs, and mist machines. Optimal growth conditions for the bacterium are in water temperatures of 100° to 120°F. Aspiration of contaminated water is now considered the major mode of transmission. Inhaling aerosols containing the bacterium is another, less frequent mode. Patients with compromised lung conditions, such as smokers and ill patients, are particularly at risk of acquiring the disease through aspiration because of impaired action of the cilia, which allows bacteria to more easily get into the respiratory tract. A study of patients who un-
Hyponatremia and nonresponse to treatment are diagnostic clues

TABLE 1

Specialized laboratory tests for Legionnaires’ disease

<table>
<thead>
<tr>
<th>Test Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sputum culture</td>
<td>Uses multiple selective media that contain dyes and are pretreated with acid or heat to minimize overgrowth of competing microorganisms. Sputum of patients with suspected Legionnaires’ disease should have culture studies regardless of quality.</td>
</tr>
<tr>
<td>Direct fluorescent-antibody stain of sputum</td>
<td>Rapid test that requires the presence of a large number of organisms to be readily visualized.</td>
</tr>
<tr>
<td>Urinary antigen assay</td>
<td>Inexpensive and rapid. Detects antigens of <em>L. pneumophila</em> in urine. Unlike cultures, the test results remain positive for weeks even after antibiotic therapy. Only detects <em>L. pneumophila</em> serogroup 1; however, serogroup 1 accounts for most cases of Legionnaires’ disease.</td>
</tr>
<tr>
<td>Serologic tests for antibody</td>
<td>Requires IgG and IgM testing of serum samples obtained during both the acute phase and convalescence. Evidence of infection is considered suspicious in a patient with pneumonia who has a single titer of ≥ 1:128. Evidence of infection is considered presumptive in a patient with a single titer of &gt; 1:256 or definitive with a fourfold increase in antibody titer. Test is more useful for epidemiological studies than it is for individual persons because of the measurement required during convalescence.</td>
</tr>
</tbody>
</table>

ADAPTED FROM INFORMATION IN STOUT JE, YU VL. LEGIONELLOSIS. N ENGL J MED 1997; 337:682-687.

CLINICAL SIGNS

Pneumonia is the main clinical presentation, with symptoms that can include fever (often higher than 103°F), cough, chest pain, diarrhea (watery stool), stupor, respiratory failure, and multiorgan failure. Low-grade fever, malaise, anorexia, headaches, and myalgias are common symptoms in the early stages.

Legionnaires’ disease is easily mistaken for other types of pneumonia, such as pneumonia due to Streptococcus pneumoniae or Mycoplasma pneumoniae. Although the diagnosis cannot be made by a physical examination alone, clinical clues include:

- Hyponatremia (serum sodium concentration ≤ 130 mmol/L), which is found significantly more often in patients with Legionnaires’ disease than in patients with other types of pneumonia.
- Presence of gastrointestinal symptoms, especially diarrhea.
- Nonresponse to the typical antibiotics, particularly the beta lactam agents and aminoglycosides, used for severe pneumonia or sepsis.

TEST ALL PATIENTS HOSPITALIZED WITH COMMUNITY-ACQUIRED PNEUMONIA

I recommend that all patients hospitalized for community-acquired pneumonia be tested for Legionnaires’ disease. The diagnosis depends on testing the microbiology of the disease. An immediate diagnosis may be suggested by a Gram stain that shows leukocytes with few microorganisms, as seen in “atypical” pneumonia.
Several specialized laboratory tests are available (TABLE 1), although, unfortunately, they are not routinely performed for patients presenting with pneumonia. Ideally, one rapid test should be available in every clinical microbiology laboratory. I recommend the new urinary antigen assay because of its high specificity (100%) and fairly high sensitivity (70%), along with its rapid detection and low cost.12

Culture of respiratory secretions is the ideal method and should be available in every tertiary care hospital.

**ANTIBIOTIC THERAPY: EARLY TREATMENT IS IMPERATIVE**

Early appropriate treatment is imperative to prevent death. Erythromycin was once the drug of choice, but newer antibiotics are now proving to be more effective with fewer side effects.12 Newer macrolides (particularly azithromycin) and quinolones (particularly levofloxacin and ciprofloxacin) are the best classes of antibiotics to treat Legionnaires’ disease.5,12 Specific drugs are recommended on the basis of particular risk factors:

- Ciprofloxacin or levofloxacin for transplant patients
- A macrolide or quinolone combined with rifampin for severely ill patients.12

Other antibiotic agents reported to be effective include tetracycline, minocycline, doxycycline, imipenem, trimethoprim-sulfamethoxazole, ofloxacin, and clindamycin.12,14

A patient who presents with an undiagnosed pneumonia severe enough to require hospitalization should be empirically treated for *Legionella*. The treatment of choice for such a patient may be a new macrolide because it covers typical pathogens (Hemophilus influenzae, *Moraxella catarrhalis*, *Streptococcus pneumoniae*, and *Staphylococcus*).

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**TABLE 1**

<table>
<thead>
<tr>
<th>AGENT</th>
<th>DOSE</th>
<th>ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Macrolides</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Azithromycin</td>
<td>500 mg*</td>
<td>Orally or intravenously every 24 hours</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td>500 mg</td>
<td>Orally or intravenously every 12 hours</td>
</tr>
<tr>
<td>Roxithromycin</td>
<td>300 mg</td>
<td>Orally every 12 hours</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>1 g</td>
<td>Intravenously every 6 hours</td>
</tr>
<tr>
<td></td>
<td>500 mg</td>
<td>Orally every 6 hours</td>
</tr>
<tr>
<td><strong>Quinolones</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>400 mg</td>
<td>Intravenously every 8 hours</td>
</tr>
<tr>
<td></td>
<td>750 mg</td>
<td>Orally every 12 hours</td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>500 mg*</td>
<td>Orally or intravenously every 24 hours</td>
</tr>
<tr>
<td>Ofloxacin</td>
<td>400 mg</td>
<td>Orally or intravenously every 12 hours</td>
</tr>
<tr>
<td><strong>Other antimicrobial agents</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doxycycline</td>
<td>100 mg*</td>
<td>Orally or intravenously every 12 hours</td>
</tr>
<tr>
<td>Minocycline</td>
<td>100 mg*</td>
<td>Orally or intravenously every 12 hours</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>500 mg</td>
<td>Orally or intravenously every 6 hours</td>
</tr>
<tr>
<td>Trimethoprim-sulfamethoxazole</td>
<td>160 and 800 mg</td>
<td>Intravenously every 8 hours</td>
</tr>
<tr>
<td></td>
<td>160 and 800 mg</td>
<td>Orally every 12 hours</td>
</tr>
<tr>
<td>Rifampin</td>
<td>300 to 600 mg</td>
<td>Orally or intravenously every 12 hours</td>
</tr>
</tbody>
</table>

*Doubling the first dose is recommended

1 Intravenous administration is investigational in the United States

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Legionnaires’ disease

Eradiation of the Legionella organism by identifying the environmental source is one way to prevent Legionnaires’ disease. Guidelines for this approach, provided by the Allegheny County Health Department and the State of Maryland, recommend routine evaluation for Legionella in all hospital water distribution systems.18–20

If Legionella is found, disinfection of the water supply may be required based on the frequency of the bacterium found. Several methods of disinfection have been tried, with two methods now commonly in use:

- Heating the water to 70° to 80°C and flushing the distal sites
- Installing copper-silver ionization units.12

The first method is good for immediately halting an outbreak, but its effectiveness is problematic over time. Currently, more than 75 hospitals in the United States have copper-silver ionization systems.19 This method is cost-effective for many hospitals.12

Give antibiotics intravenously for the first 3 days

Antibiotics are usually started intravenously until a clinical response is noted, often about 3 days. Oral therapy can then be substituted for about 10 to 14 days.15–17 For patients with suppressed immune systems or evidence of extensive disease on chest x-rays, 21 days of therapy is recommended.12 Typical dosage schedules are shown in Table 2.

Ways to Prevent Outbreaks

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REFERENCES


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