The morbidity and mortality rates associated with *Streptococcus pneumoniae* remain very high worldwide. The virulence of this bacterium is largely dependent on its polysaccharide capsule, which is quite heterogeneous and represents a serious obstacle for designing effective vaccines. However, it has been demonstrated that numerous protein virulence factors are involved in the pathogenesis of pneumococcal disease. An important related finding from experimental animal models is that non-capsulated strains of pneumococci are protective against capsulated ones. Hence, new vaccine designs are focused on the surface proteins (e.g., PspA and PspC) and on the cytolysin, pneumolysin. Moreover, several virulence factors have potential value for pneumococcal diagnosis by urinalysis. In this paper, we review the virulence factors involved in bacteria-host interactions, and the new developments in vaccines and diagnostic methods.

**Key words: Streptococcus pneumoniae. Virulence factors. Vaccines. Diagnosis.**

In humans, *Streptococcus pneumoniae* typically colonizes the nasopharynx asymptomatically. The innate and adaptive immune system generally prevents colonization from progressing to disease. However, alterations of the host-pathogen homeostasis is associated with life-threatening, invasive diseases such as meningitis, septicemia, and pneumonia. Pneumococcus is also the leading cause of acute otitis media and sinusitis. Pneumococcal infections continue to be highly prevalent all over the world. Pneumococcal-related morbidity and mortality remains high, particularly in developing countries. In Spain, the incidence of invasive pneumococcal infections in children ≤2 years was 96 in 100,000. Illness rates increase in the elderly and in patients with predisposing factors, particularly AIDS. Although resistance to antibiotics is a problem worldwide, there is some evidence that it can be reduced by decreasing the use of these agents. The 23-valent polysaccharide vaccine is scanty immunogenic in high-risk groups and in children under the age of two. The 7-valent conjugate pneumococcal vaccine is more effective in this latter group. In developing countries, although the efficacy of conjugate vaccines is lower, some evidence indicates that they are effective in the prevention of invasive disease and in reducing the frequency of carriage of drug-resistant strains is of concern. Furthermore, the initially dominant vaccine serotypes can be replaced by serotypes not covered by the vaccine. Higher rates of *S. pneumoniae*-related acute otitis media have been reported in children following vaccination. For all these reasons, the development of new and improved diagnostic tools and therapies to combat pneumococcal disease are necessary.
Pathogenicity and new vaccine development

The polysaccharide capsule has been considered the primary virulence factor of \textit{S. pneumoniae} and is a major determinant in antibody accessibility to surface antigens. The pneumococcal capsule has a modular structure which facilitates the exchange of specific genes between serotypes. The quorum-sensing system, which is a chemically-mediated alert, exist in many bacteria and help them to monitor their population densities, genetic transformation, and regulate several cellular functions. Inhibiting this cell-to-cell communication may provide a means of treating pneumococcal infections\textsuperscript{11,13}. The phenomenon of capsular switching is seen in capsular types isolated from invasive disease, as well as in serogroups carried in the human nasopharynx\textsuperscript{11,16}. The potential replacement of most common serotypes is of great clinical importance (especially when it takes place between antibiotic-resistant strains) and has implications for long-term efficacy of conjugate pneumococcal vaccines. Each serotype typically includes a number of genetically divergent clones with a different invasive potential\textsuperscript{13,16}. Depending on the site of infection the combination of capsule type and genetic background is important in determining virulence\textsuperscript{15}. The pneumococcal intra-strain phenotypic variants (opaque and transparent) are evident in colonies growing in solid transparent media as TSA-, and are associated with both virulence and capsular polysaccharide, which exposes adhesive molecules; the transparent phenotype has less capsule expression. The opaque phenotype is more virulent and common in systemic infections. Both phenotypic variants have recently been detected in nasal mucosal tissues. The opaque pneumococci probably penetrate into the nasal tissues, creating a reservoir that is not affected by mucus flow or by competition from normal nasal flora and, over time, may repopulate the nasal surface\textsuperscript{17}. In addition to the capsule, interactions between bacteria and host involve extracellular and intracellular virulence factors that are expressed by the pneumococci\textsuperscript{15}. Current research is focused on developing vaccines based on protein antigens common to all pneumococcal types\textsuperscript{13,15,16} (table 1).

\textbf{Table 1. Virulence factors of \textit{S. pneumoniae} involved in vaccine development}

<table>
<thead>
<tr>
<th>Virulence factor</th>
<th>Bacterial function</th>
<th>Mechanism of virulence</th>
<th>Protection$^a$</th>
<th>Comments</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capsule</td>
<td>Isolation from external medium</td>
<td>Inhibition of phagocytosis</td>
<td>High\textsuperscript{b}</td>
<td>Switching serotype, Phenotypic change</td>
<td>22, 23</td>
</tr>
<tr>
<td>C-polysaccharide and lipoteichoic acids</td>
<td>Binding of surface proteins</td>
<td>Pneumotaxic (?)</td>
<td>Low</td>
<td>Number of acyl groups is associated with species-specific responses</td>
<td>24, 25</td>
</tr>
<tr>
<td>Peptidoglycan</td>
<td>Protection of osmotic pressure</td>
<td>Macrophage activation, Cytotoxic</td>
<td>ND</td>
<td>Nod L2 and nod 2 are sensors of unique muramidase</td>
<td>26, 27</td>
</tr>
<tr>
<td>Ppa</td>
<td>Stabilization of capsular charge</td>
<td>Inhibition of complement</td>
<td>Good</td>
<td>Clades and families</td>
<td>28, 29, 30, 31</td>
</tr>
<tr>
<td>PpaC</td>
<td>Adhesion, binding pIgR, secretion LytA, Cl, and factor H</td>
<td>Inhibition of complement</td>
<td>Good</td>
<td>Also known as SpdA, ChpA, and Hic</td>
<td>32</td>
</tr>
<tr>
<td>FBA and GAPDH</td>
<td>Glycolytic enzymes</td>
<td>Immunogenic in children</td>
<td>Good</td>
<td>Immunoproteomics</td>
<td>33</td>
</tr>
<tr>
<td>LytA</td>
<td>Cell wall lysis and growth</td>
<td>Pneumotaxic (?)</td>
<td>Low</td>
<td>Allosylation</td>
<td>31, 34</td>
</tr>
<tr>
<td>PsaA</td>
<td>Mn$^{2+}$ transporter</td>
<td>Inhibition of complement</td>
<td>Low</td>
<td>Good protection in otitis media</td>
<td>30, 35</td>
</tr>
<tr>
<td>PmaA and PiaA</td>
<td>Iron uptake ABC transporters</td>
<td>Mutants had reduced virulence</td>
<td>Good</td>
<td>Protection against intraperitoneal infection</td>
<td>36</td>
</tr>
<tr>
<td>PpyA</td>
<td>Peptidyl-predyl cis-trans isomerase</td>
<td>Mutants pydd-deficient reduced virulence</td>
<td>Low</td>
<td>Controversial accessibility of antibodies</td>
<td>30, 37</td>
</tr>
<tr>
<td>Hyl</td>
<td>Spreading</td>
<td>Mutants had no decrease in virulence</td>
<td>None</td>
<td>Inhibitors could be useful pharmacological tools</td>
<td>31</td>
</tr>
<tr>
<td>NanA</td>
<td>Adhesion, Spreading</td>
<td>Mutants had no decrease in virulence</td>
<td>Very low</td>
<td>Good protection in otitis media</td>
<td>31, 38</td>
</tr>
<tr>
<td>PLY</td>
<td>Cytolytic, Spreading</td>
<td>Cytotoxic, Proinflammatory</td>
<td>Good</td>
<td>Cytoplasmic</td>
<td>31, 32, 39</td>
</tr>
</tbody>
</table>

$^a$Protection in animal models.
$^b$Protection with conjugate-poly saccharides in humans.

\textsuperscript{11}Nell and Nod 2: nucleotide-binding oligomerization domain; PpaA: pneumococcal surface protein A; PpaC: pneumococcal surface protein C; pglR: polymorphic mannose-binding receptor; PBA: fructose-bisphosphate aldolase; GAPDH: glyceraldehyde-3-phosphate dehydrogenase; LytA: autolysin; PsaA: pneumococcal surface adhesin A; PiuA and PiaA: pneumococcal iron uptake ABC transporter; PpmA: Putative proteinase maturation protein A; Hyl: hyaluronidase; NanA: neuraminidase; PLY: pneumolysin; ND: not determined.

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mucoccal surface protein A (PspA) displays high-quality protection in animal models and is immunogenic in humans. This protein has a high polymorphism attributable to immunological selection because it is readily accessible to antibodies. In contrast, pneumolysin (PLY) is a highly conserved antigen capable of stimulating protective immunity and is an excellent vaccine candidate. It is likely that any future vaccine will turn out to be a combination of pneumococcal antigens generated by recombinant proteins that display the highest protective immunity and are common to all pneumococcal strains.

Carriage and immunity

The colonization of mucosal surfaces in the human respiratory tract is a dynamic process in which bacteria are acquired, eliminated, and reacquired many times over the course of a lifetime. In the nasopharynx, genetic exchange takes place by means of processes such as transformation with foreign DNA, bacterial intra- and interspecies conjugation, and phage transduction. In fact, the replacement of strains susceptible to antimicrobial agents by resistant ones is considered to occur during carriage and fostered by widespread and excessive use of antibiotics. Asymptomatic carriers comprise the reservoir of S. pneumoniae in humans; consequently, carriage rates must be lowered and by that, the incidence of pneumococcal infections should be decreased. Natural immunity to S. pneumoniae is thought to be induced by exposure to pneumococci or cross-reactive antigens and is initiated upon recognition of conserved pathogen-associated molecular patterns by various host cells expressing pattern recognition receptors. Recognition of bacterial components by the innate immune system, more specifically the interaction of bacterial components with Toll-like receptors (TLRs) has been recognized as an effective method by which to protect the host against several pathogens. TLRs are a family of 12 types of transmembrane proteins that recognize pathogens and are expressed on various immune cells including macrophages, dendritic cells, B cells, specific types of T cells, and even on nonimmune cells such as fibroblasts and epithelial cells. Phagocyte activation by inflammatory cytokines and apoptosis of infected phagocytes and other cells play an important role in clearing the pathogen (fig. 1). Distinct TLRs may differentially regulate innate versus adaptive immunity to intact S. pneumoniae. PLY is involved in the innate immune response to pneumococci, and triggers their proinflammatory and proapoptotic properties by interacting with TLR4.

The humoral response to some virulence factors such as PspA, PLY, and pneumococcal surface adhesin A (PsaA) has been studied extensively in asymptomatic carriers. Recent findings have demonstrated differential and specific mucosal, humoral, and T helper cell cytokine responses to PsaA, PspA, pneumococcal surface protein C (PspC), and PLY during pneumococcal carriage. In addition to systemic immunity, mucosal immunity may also play an important role in local protection against pneumococcal carriage and in preventing invasive infection. Mucosal immunization of mice with PsaA is known to be highly protective against pneumococcal carriage.
other hand, acquired immunity to pneumococcus has long been assumed to depend on the presence of anticapsular antibodies. However, the age-specific incidence of pneumococcal disease in humans declines simultaneously and parallel to a wide range of serotypes, long before natural acquisition of anticapsular antibodies, which suggests a common and probably capsular serotype-independent mechanism of protection. Additionally, intranasal administration of unencapsulated pneumococci whole-cell vaccine in mice prevents colonization by pneumococci of various capsular serotypes, supporting the possibility that other components of the immune response, independently of anticapsular antibodies, play an important role in this process. In fact, recent studies reveal that protection against pneumococcal colonization is CD4 T cell-dependent and is possibly acquired independently of antibodies.

### TABLE 2. Diagnostics, identification, and typing methods for *S. pneumoniae* that involve virulence factors

<table>
<thead>
<tr>
<th>Tools</th>
<th>Target</th>
<th>Performance</th>
<th>Comments</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binax NOW*</td>
<td>Capsular polysaccharide</td>
<td>86% sensitivity, 94% specificity in urine</td>
<td>False-positive with upper respiratory tract colonization Binax, Inc.</td>
<td></td>
</tr>
<tr>
<td>ELISA assay</td>
<td>PLY</td>
<td>100% sensitivity in urine</td>
<td>False-positive with S. <em>mitis</em></td>
<td>54</td>
</tr>
<tr>
<td>Capsular polysaccharide</td>
<td></td>
<td>90% sensitivity, 99% specificity in urine</td>
<td>Only detects 13 serotypes</td>
<td>55</td>
</tr>
<tr>
<td>Immunosensor</td>
<td>PLY</td>
<td>Simple, cheaper, and faster than ELISA</td>
<td>Doesn’t improve chemiluminescent ELISA</td>
<td>56</td>
</tr>
<tr>
<td>PCR</td>
<td>fap</td>
<td>78% sensitivity in pleural fluid</td>
<td>False-positive with upper respiratory tract colonization</td>
<td>57</td>
</tr>
<tr>
<td>Nested-PCR</td>
<td>pld</td>
<td>78% sensitivity, 93% specificity in pleural fluid</td>
<td>4% false-positive rate</td>
<td>58</td>
</tr>
<tr>
<td>Real-time PCR</td>
<td>pld</td>
<td>90% sensitivity, 80% specificity in sputum</td>
<td>13% false-negative rate</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td></td>
<td>96% sensitivity in nasopharyngeal samples</td>
<td>Potential false-positive with upper respiratory tract colonization</td>
<td>60</td>
</tr>
<tr>
<td><strong>Identification</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Binax NOW</td>
<td>Capsular polysaccharide</td>
<td>100% sensitivity, 81% specificity in BCB</td>
<td>False-positive due to the S. <em>mitis</em> group</td>
<td>53</td>
</tr>
<tr>
<td>Agglutination</td>
<td>PLY</td>
<td>95% sensitivity, 100% specificity</td>
<td>False-negatives correspond to low PLY-producing isolates</td>
<td>51</td>
</tr>
<tr>
<td>ELISA assay</td>
<td>PLY</td>
<td>Sensitivity 100%</td>
<td>No false-negative results.</td>
<td>61</td>
</tr>
<tr>
<td>LAMP</td>
<td>fapA</td>
<td>Simple equipment, visible results with the naked eye</td>
<td>Differentiates <em>S. pneumoniae</em> vs. <em>S. mitis</em> and <em>S. oralis</em></td>
<td>62</td>
</tr>
<tr>
<td><strong>Typing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCR-RFLP</td>
<td>Capsular polysaccharide focus</td>
<td>Serotype/serogroup identification. Fully portable, cost-effective</td>
<td>Laboratory with sufficient molecular experience</td>
<td>63</td>
</tr>
<tr>
<td>Multiplex PCR</td>
<td>Capsular polysaccharide focus</td>
<td>Fast and far more cost-effective</td>
<td>Only determines seven serotypes</td>
<td>64</td>
</tr>
<tr>
<td>MCT</td>
<td>Capsular polysaccharide focus</td>
<td>Serotype/serogroup identification. Specific, objective</td>
<td>Geneschip microarrays would make more practical for routine use</td>
<td>65</td>
</tr>
<tr>
<td>MLST + ply sequencing</td>
<td>arud, gabh, gbi, rec, spi, xpt, dld, pld</td>
<td>Serotypeable/nonserotypeable identification</td>
<td>ply alleles different. Useful to resolve difficult cases</td>
<td>66</td>
</tr>
</tbody>
</table>

---

4 Used in clinical samples in clinical microbiological laboratories.

PLY: pneumolysin; fapA: autolysin gene; pld: pneumolysin gene; BCB: blood culture bottles; LAMP: Loop-mediated isothermal amplification; RFLP: restriction fragment length polymorphism; MCT: molecular capsular typing; MLST: multilocus sequence typing; arud: shikimate dehydrogenase; gabh: glucose-6-phosphate dehydrogenase; gbi: glucose kinase; rec: D-fructose kinase; spi: signal peptidase I; xpt: xanthine phosphoribosyltransferase; dld: D-alanine-D-alanine ligase.

New perspectives on diagnostics, identification, and typing

*S. pneumoniae* is identified in clinical microbiology laboratories by colony morphology, bile solubility, and optochin sensitivity. However, a number of isolates shows resistance to one or both compounds, leading to misinterpretation in their characterization. On the other hand, the amount of...
nonsertypeable pneumococcal strains is low (7%) when recovering from respiratory tract, blood and usually sterile sites, but this percentage could reach 20% in conjunctival and nasopharyngeal exudates (15). In these conditions, DNA techniques are needed for accurate species identification. In 1989, a simple test based on PLY immunodetection for fast, reliable species identification with good sensitivity and specificity was developed (15). Pneumococcal serotyping by capillary swelling (Quellung reaction) is labour intensive and requires a certain degree of expertise; thus, its use has been restricted to specialized reference or research laboratories. A new rapid latex agglutination kit (Pneumotest-Latex, Statens Serum Institut, Copenhagen, Denmark) is available for more general use (15).

Low recovery rate of S. pneumoniae from clinical samples could be difficult if patient received previous antimicrobial therapy. Therefore, it is often hard to correlate pneumococcal in non-invasive clinical samples (especially from the upper respiratory tract) with clinical infection. Detection of C-poly saccharide in urine samples and cerebrospinal fluid with Binax NOW S. pneumoniae test (Binax, Inc., Portland, Maine) represents a major step forward in the diagnosis of pneumococcal infections (15), avoiding the need to obtain representative clinical samples by means invasive procedures. However, C-poly saccharide can be found in the urine of healthy children car riers as well as in patients recovering from pneumococcal infections. Several tools for microbial diagnostics, identification, and typing are now based on the detection of virulence factors (table 2). Recent observations have demonstrated the presence of PLY-derived peptides in the urine of patients with pneumococcal pneumonia confirmed by blood culture (20). This work was supported in part by the MCT-03-BIO-06008-C0302.

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References


