# Developing an Antimicrobial Strategy for Sepsis in Malawi

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blah blah

Regression difficulties and solutions

colinearity/variable selection -> FAMD nonidentifiability (zero cells) -> bayesian regression with weakly informative priors

## 4.3 Results

### 4.3.1 Study population

Figure 4.1 shows flow through the study. 225 participants were recruited in 20 months between 19th February 2017 and 2nd October 2018. Participants were recuited, in general, soon after arrival in hospital, a median (IQR) of 1.5 (0.8-2.6) hours after fist attendance. In total, 4 participants (2%) were lost to follow up over the 180-day study period; 5 participants (2%) withdrew; and 7 participants (3%) transferred out of the study area before 180 days. Four of the five participants who withdrew gave a reason for their wish to withdraw, all that they no longer wished the inconvenience of being involved in the study. 15/225 (7%) participants had their final study visit before 180 days, and so were not included in the 180-day outcome analysis.

### 4.3.2 Symptoms and health-seeking behaviour

Table 4.1 shows the baseline characteristics of the recruited participants. They were young (median [IQR] age 36 [28-44]) and predominantly HIV-infected. Of those who were HIV-infected, the majority (117/143 [82%]) were on ART, almost exclusively the Malawian first-line regimen of efavirenz, lamivudine and tenofovir, and 88/117 (75%) had been taking ART for more than three months. Figure 4.2 shows the presenting symptoms of the participants. Almost all (221/225 [98%] of participants) experienced subjective fever. Participants had been unwell for some time, a median (IQR) of 7 (3-14) days; 32/225 (14%) of participants had been unwell for more than 4 weeks. 18/225 (8%) of participants had been admitted to hospital within the last 4 weeks. Over half (123/225 [55%]) of participants had sought care for their current ilness (Table 4.2), most commonly (101/123 [82%] of participants) at a government health centre, a median (IQR) of 2 (1-6) days previously. 60/225 (27%) of all participants had recieved an antimicrobial for their current illness: 7/60 (12%) of all prehospital antimicrobials were antimalarials, the remainder anitbacterial, most commonly co-trimoxazole or ciprofloxacin. Prehopsital intravenous or intramuscular antimirobials were administered in 16/60 (27%) participants recieving antimicrobials: ceftriaxone (n=6), benzylpenicillin (n=4), gentamicin (n=3) and artesunate (n=3).

Table 4.1: Participant Characteristics

| Variable | Value |
|---|---|
| **Demographics** | |
| Age (years) | 36 (28-44) |
| Male sex | 114/225 (51%) |
| **HIV/TB status** | |
| HIV Reactive | 143/225 (64%) |
| HIV Non Reactive | 70/225 (31%) |
| HIV Unknown | 12/225 (5%) |
| Ever treated for TB | 37/225 (16%) |
| Of those, current TB treatment | 10/37 (27%) |
| **ART status*** | |
| Current ART | 117/143 (82%) |
| Months on ART | 29 (4-73) |
| ART regimen: EFV/3TC/TDF | 110/117 (94%) |
| ART regimen: other | 7/117 (6%) |
| Current CPT$^{\dagger}$ | 98/141 (70%) |
| **Tobacco/alcohol use** | |
| Never tobacco | 196/225 (87%) |
| Ex tobacco | 17/225 (8%) |
| Current tobacco | 12/225 (5%) |

Table 4.1: Participant Characteristics *(continued)*

| Variable | Value |
|---|---|
| Current alcohol | 51/225 (23%) |
| **Education** | |
| Primary incomplete or complete | 97/225 (43%) |
| Secondary school complete | 48/225 (21%) |
| Some secondary education | 47/225 (21%) |
| College or higher | 17/225 (8%) |
| No formal schooling | 16/225 (7%) |
| **Employment** | |
| Unemployed | 82/225 (36%) |
| Currently employed | 65/225 (29%) |
| Self-employed | 56/225 (25%) |
| Student | 21/225 (9%) |
| Retired | 1/225 (0%) |
| **Toilet facilities** | |
| Pit latrine with slab +/- foot rest | 104/225 (46%) |
| Hanging toilet/latrine | 59/225 (26%) |
| Pit latrine with slab and cover +/- foot rest | 45/225 (20%) |
| Flush Toliet (any type) | 14/225 (6%) |
| No toilet | 2/225 (1%) |
| Composting toilet | 1/225 (0%) |
| **Main water source** | |
| Piped outside dwelling | 69/225 (31%) |
| Tube well/borehole | 64/225 (28%) |
| Public tap/standpipe | 51/225 (23%) |
| Piped into dwelling | 30/225 (13%) |
| Unprotected well/spring | 5/225 (2%) |
| Surface water (including rainwater collection) | 4/225 (2%) |
| Tube well with powered pump | 2/225 (1%) |
| **Electricty** | |
| Electricity available in house | 119/225 (53%) |
| **Main cooking fuel** | |
| Charcoal | 161/225 (72%) |
| Wood | 61/225 (27%) |
| Electricity | 3/225 (1%) |
| **Animals at home?** | |
| Any animal | 71/225 (32%) |
| Poultry | 46/71 (65%) |
| Dogs | 18/71 (25%) |
| Goats | 12/71 (17%) |
| Dogs | 18/71 (25%) |
| Other | 11/71 (15%) |

Table 4.1: Participant Characteristics *(continued)*

| Variable | Value |
|---|---|

*Note:*
ART = Antiretroviral therapy, CPT = Co-trimoxazole preventative therapy, EFV: Efavirenz, 3TC: Lamivudine, TDF: Tenofovir. Numeric values are median (IQR)) unless otherwise stated.

* ART status includes HIV reactive only as denominator

† Missing CPT data for two participants.

Table 4.2: Prehospital heathcare seeking and antimicrobial exposure

| Variable | Value |
|---|---|
| **Pre-hospital healthcare seeking** | |
| Sought care prior to attendance at hospital | 123/225 (55%) |
| At health centre | 101/123 (82%) |
| At hospital | 16/123 (13%) |
| At private doctor | 8/123 (7%) |
| Somewhere else | 1/123 (1%) |
| Days prior to today that participant sought care | 2 (1-6) |
| **Prehospital antimicrobial exposure** | |
| Recieved any antimicrobial prior to attendance at hospital | 60/225 (27%) |
| Co-trimoxazole | 12/60 (20%) |
| Ciprofloxacin | 10/60 (17%) |
| Amoxicillin | 9/60 (15%) |
| Ceftriaxone | 6/60 (10%) |
| Metronidazole | 5/60 (8%) |
| Benzylpenicillin | 4/60 (7%) |
| Artesunate | 3/60 (5%) |
| Gentamicin | 3/60 (5%) |
| Erythromycin | 2/60 (3%) |
| LA | 2/60 (3%) |
| SP | 2/60 (3%) |
| Azithromycin | 1/60 (2%) |
| Flucloxacillin | 1/60 (2%) |
| Days prior to today that antimicrobials started | 2 (1-5) |
| **Method of transport to hospital** | |
| Minibus | 78/225 (35%) |
| Taxi | 65/225 (29%) |
| Private car/truck | 42/225 (19%) |
| Ambulance | 37/225 (16%) |
| Other | 2/225 (1%) |
| Walk | 1/225 (0%) |
| Cost (MWK) of transport to hospital | 1000 (275-3000) |

*Note:*
LA = Lumefantrine-artemether, SP = Sulfamethoxazole-pyrimethamine, MWK = Malawian Kwacha. Numeric values are median (IQR)) unless otherwise stated.

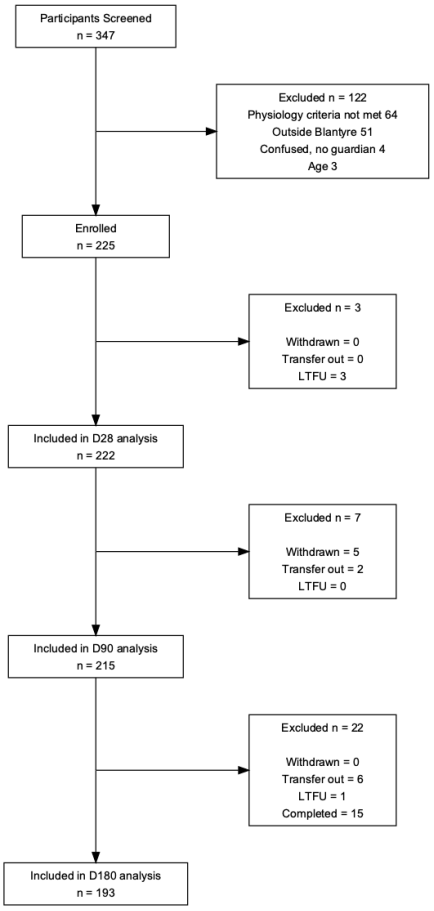


Figure 4.1: Study recruitment and follow up.

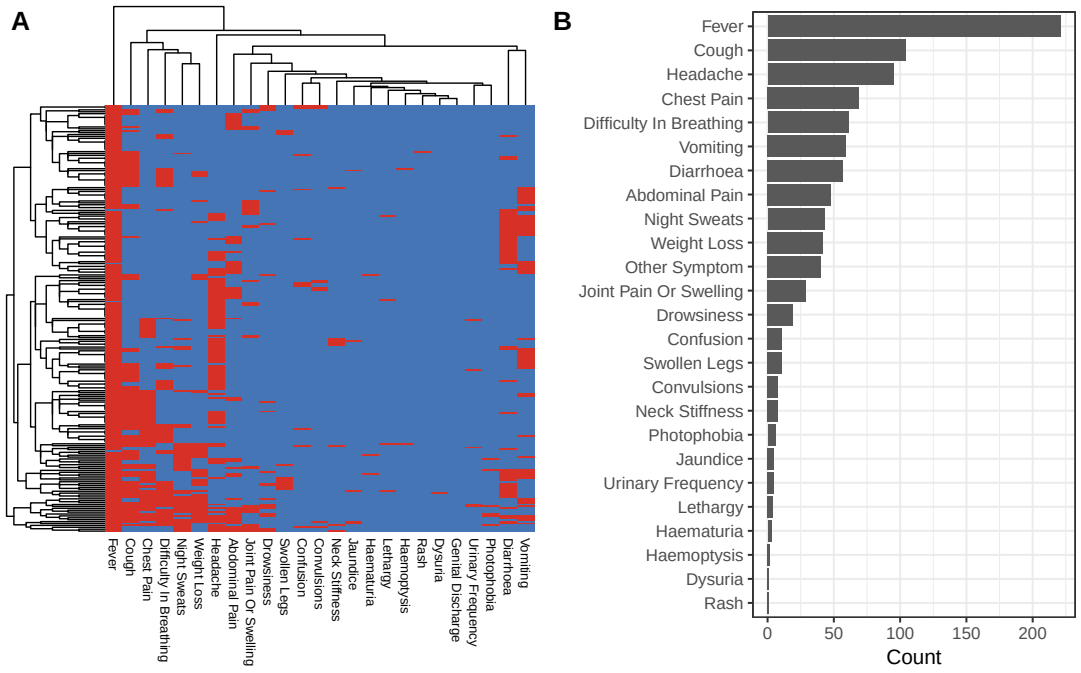


Figure 4.2: Symptoms of recruited participants. A: Row and column clustered heatmap of participant symptoms. Each row represents a patient. Red = presence, blue = absence. B: Frequency of occurence of symptoms

### 4.3.3 Admission physiology and laboratory investigations

Admission vital signs and laboratory investigations are shown in Table 4.3. Despite high ART coverage (117/143 [82%]) amongst HIV-infected participantsfor a median of 29 months, the median (IQR) CD4 count was low at 98 (31-236) cells $\mu L^{-1}$. 108/141 (70%) of participants had a CD4 count below 200 cells $\mu L^{-1}$. CD4 count was similar in participants who had started ART more than 6 months ago as compared to less than three months ago (median [IQR] 99 [27-260] vs 93 [39-137] cells $\mu L^{-1}$ respectively) and 42/83 (51%) of participants who had been taking ART for more than 6 months had a CD4 count of less than 100 cells $\mu L^{-1}$, and would fulfil a WHO definition of immunological failure.

Table 4.3: Admission physiology, haematology and biochemistry

| Variable | Value |
|---|---|
| **Admission physiology** | |
| Temperature (°C) | 38.5 (37.9-39.0) |
| Heart rate ($min^{-1}$)) | 121 (102-132) |
| Systolic BP (mmHg) | 99 (85-119) |
| Diatsolic BP (mmHg) | 66 (56-76) |
| MAP (mmHg) | 76 (65-89) |
| Respiratory rate ($min^{-1}$) | 34 (32-38) |
| Oxygen saturation (%) | 96 (94-98) |
| 15 | 204/225 (91%) |
| 11-14 | 16/225 (7%) |
| < 11 | 5/225 (2%) |
| Unable to stand | 63/225 (28%) |
| **Admission CD4 count** | |
| CD4 count* ($\mu L^{-1}$) | 98 (31-236) |
| **Admission haematology** | |
| Haemoglobin ($x10^9$ g $dL^{-1}$) | 10.8 (8.2-13.2) |
| White cell count ($x10^9$ $L^{-1}$) | 6.5 (4.4-11.4) |
| Neutrophil count ($x10^9$ $L^{-1}$) | 4.0 (2.1-7.5) |
| Platelet count count ($x10^9$ $L^{-1}$) | 218 (146-297) |
| **Admission biochemistry** | |
| Sodium (mmol $L^{-1}$) | 134 (130-137) |
| Potassium (mmol $L^{-1}$) | 4.0 (3.6-4.4) |
| Bicarbonate (mmol $L^{-1}$) | 19 (17-22) |
| Chloride (mmol $L^{-1}$) | 101 (97-104) |
| Urea (mmol $L^{-1}$) | 4.8 (3.5-8.0) |
| Creatinine (mmol $L^{-1}$) | 76 (59-103) |
| Lactate (mmol $L^{-1}$) | 3.4 (2.3-5.2) |

*Note:*
GCS = Glasgow coma scale, BP = Blood pressure, MAP = Mean arterial blood pressure. Numeric values are median (IQR)) unless otherwise stated.

* CD4 count includes only HIV-infected participants; 2 values were missing.

### 4.3.4 Aetiology

In total, 51% (114/225) of the 225 participants had at least one infectious agent identified (Table 4.4), most commonly tuberculosis (76/225 [34%]) followed by bloodstream infection (24/225 [11%]) and malaria (21/225 [9%]). Table 4.5 shows the availability of test and proportion of positive tests across the cohort, stratified by HIV status. 2/225 patients (1%) had a missing aerobic blood culture; the remaining 223 patients had a total of 259 blood cultures performed. 15/259 (6%) blood cultures grew at least one contaminant, but 26 blood cultures from 24 patients were positive for a total of 28 pathogenic bacteria (Figure 4.3): *Salmonella* Typhi was the most commonly isolated pathogenic bacterium, and seemed to show an association with HIV-negative participants: all (8/8) of the participants from whom *S.* Typhi was isolated and whose HIV status was known were HIV noninfected. Of the 18 Gram negative bacteria isolated, 3/18 (17%) were cefpodoxime resistant on AST via disc diffusion testing, and likely ESBL producers: one *K. pneumoniae* and one *E. coli* (both from the same blood culture and same patient) and one *Acinetobacter baumannii*. Both *Staphyloccus aureus* isolates were oxacillin sensitive. The one *Streptococcus pneumoniae* cultured was penicillin intermediate on AST.

Lumbar puncture and CSF culture was carried out in 44 participants: 5/44 (11%) of samples grew a contaminent and no pathogenic bacteria were recovered from any sample. 4/44 (9%) had a detectable cryptococcal antigen (CRAG) in CSF. Malaria testing was missing for 6/225 (3%) of participants, but of the remainder, a positive malaria test was more likely in the HIV-uninfected (12/69 [17%] vs 6/138 [4%], p = 0.01 on pairwise Fisher's exact test). Positive aerobic blood culture showed no statistically significant association with HIV, nor did positive CSF testing, though in the latter case numbers were small and all positive tests (all positive CRAG) were in fact in the HIV-infected (Table 4.5).

Testing for TB, with the exception of sputum Xpert testing, was restricted to HIV-infected participants. Sputum Xpert was carried out in 44/225 (20%) of participants, and was more commonly carried out in the HIV-infected: 35/143 [24%] of HIV-infected participants had sputum testing performed vs 8/70 (11%) of HIV uninifected (p = 0.07 by Fisher's exact test). 53 sputum samples were sent in total from the 44 patients, and 8/44 (18%) diagnoses of TB made, all except one in HIV-infected participants. One sample identified a rifampicin resistance gene; the remainder of infections were rifampcin-sensitive.

155 participants were eligible for urinary lipoarabinomannan (uLAM) and mycobacterial blood culture testing, being either HIV-infected (n=143) or of unknown HIV status (n=12). Urine was available for 145/155 (94%) of those eligible, and 74/145 (51%) of samples were positive for uLAM. 150/155 (97%) of eligible participants had blood samples collected and cultured

Table 4.4: Final diagnosis of all participants

| Diagnosis | Proportion of participants |
|---|---|
| Tuberculosis | 76/225 (34%) |
| Bloodstream infection | 24/225 (11%) |
| Malaria | 21/225 ( 9%) |
| Meningitis | 4/225 ( 2%) |
| No diagnosis | 111/225 (49%) |

Table 4.5: Positive diagnostic tests for all participants, stratified by HIV status.

| | HIV status | | | | |
|---|---|---|---|---|---|
| Test | Positive | Negative | Unknown | **All** | p |
| Number of participants | 143 | 70 | 12 | **225** | - |
| **TB diagnostics** | | | | | |
| Urinary LAM | 70/136 (51%) | - | 4/9 (44%) | **74/145 (51%)** | - |
| Sputum Xpert | 7/35 (20%) | 1/8 (12%) | 0/1 (0%) | **8/44 (18%)** | 0.835 |
| TB blood culture | 7/128 (5%) | - | 1/10 (10%) | **8/138 (6%)** | - |
| **Other diagnostics** | | | | | |
| Aerobic blood culture | 13/141 (9%) | 9/70 (13%) | 2/12 (17%) | **24/223 (11%)** | 0.647 |
| CSF culture or CRAG | 4/31 (13%) | 0/12 (0%) | 0/1 (0%) | **4/44 (9%)** | 0.445 |
| Malaria RDT | 6/138 (4%) | 12/69 (17%) | 3/12 (25%) | **21/219 (10%)** | 0.007 |

*Note:*
LAM = Lipoarabinomannan, CSF = Cerebrospinal fluid, CRAG = Cryptococcal antigen, RDT = Rapid diagnostic test. p-values are chi-squared test across the three HIV status strata, and hence may be different from the pairwise exact Fisher's tests presented in the text. Urinary LAM and TB blood culture were not carried out in HIV negative participants.

for mycobacteria. 12/150 (8%) grew contaminents and are excluded from the denominators in Table 4.5; of the remainder 8/138 (6%) grew mycobacteria, all *M. tuberculosis*.

Figures 4.5 and 4.4 show the overlap of positive tests form the different diagnostic modalities. Of the 114 patients with at least one positive diagnosic test, 90/114 (79%) had only one positive diagnostic test. The exceptions to this were mycobacterial blood culture and sputum Xpert: patients who had TB diagnosed by these tests tended to also have a positive uLAM. 2/4 (50%) of patients with positive CSF testing (all of whom had detectible CRAG) had also grew *Cryptococcus neoformans* in aerobic blood culture. 111/225 (49%) of patients remained with no diagnosis.

### 4.3.5 Treatment

At least one antimicrobial drug was recieved by 95% (214/225) of the cohort during their admission (Table @ref:(time-to-ab-table)), most commonly an antibacterial (207/225 [92%]), but also a significant minority recieved antitubercular therapy (63/225 [28%]). Of those

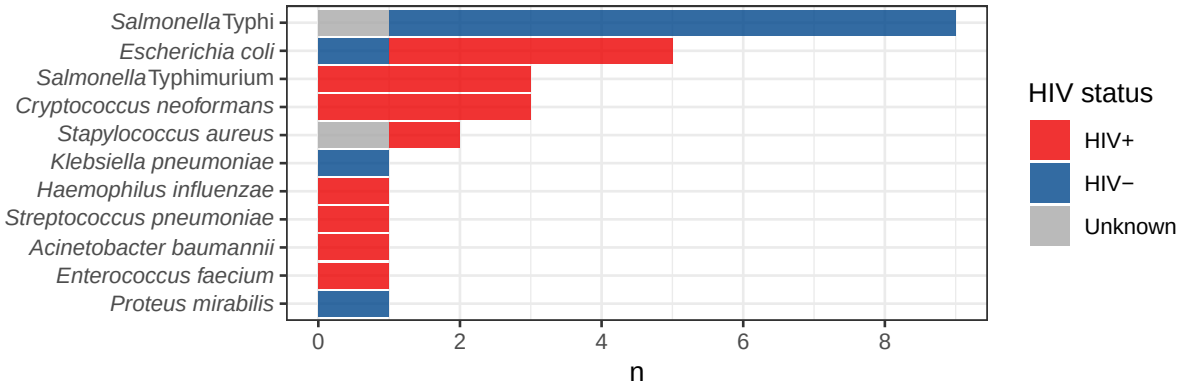


Figure 4.3: Pathogenic isolates recovered from aerobic blood culture. 26 blood cultures in 24 participants were positive for 28 pathogens in total

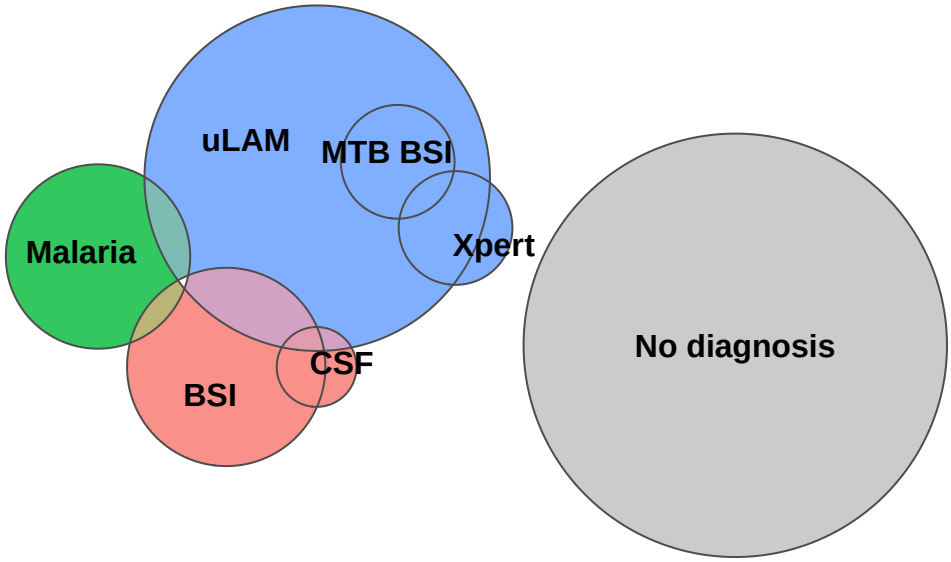


Figure 4.4: Venn diagram showing overlap of positive diagnostic tests; culture of blood and CSF shown in red, malaria in green and TB diagnostics in blue. The CSF variable in includes either a positive culture for a pathogenic bacteria or positive cryptococcal antigen, BSI a positive aerobic culture of pathogenic bacteria from blood and MTB BSI a positive mycobacterial culture of tuberculosis from blood. BSI: Bloodstream infection, CSF: Cerebrospinal fluid, CRAG: Cryptococcal antigen, mRDT: Malaria rapid diagnostic test, MTB BSI: Mycobacterium tuberculosis bloodstream infection, uLAM: urinary lipoarabinomannan.

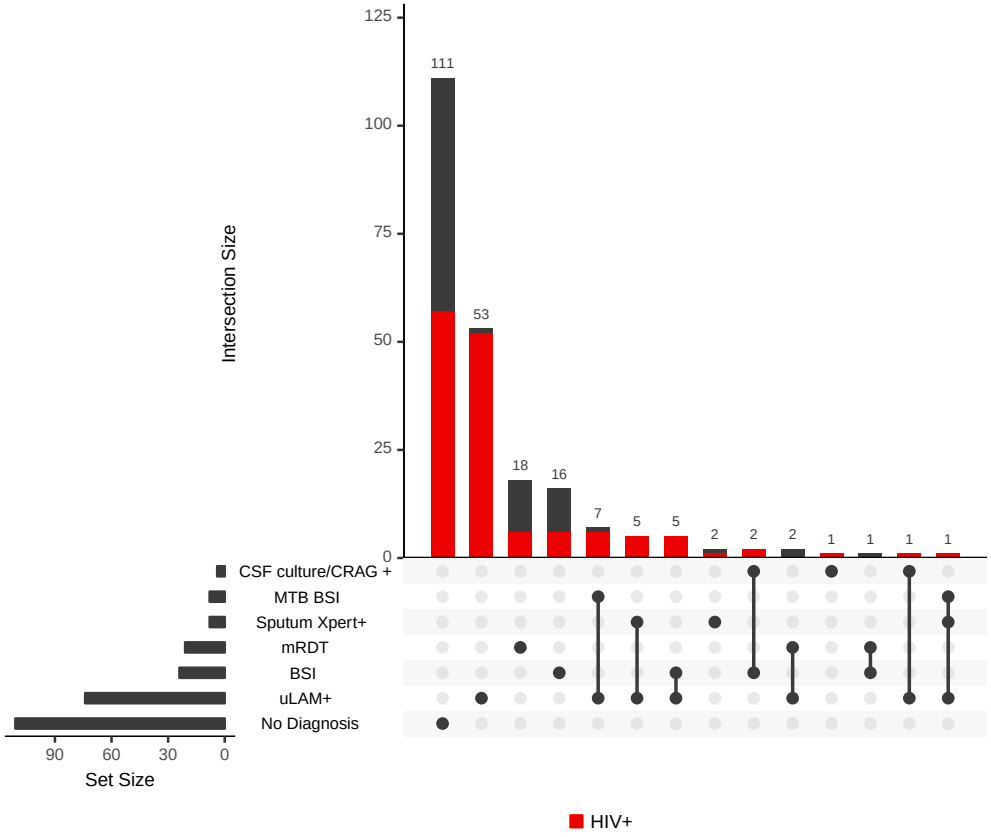


Figure 4.5: UpSet plot of overlap of positive diagnostic tests, showing that for the majority of participants, one test alone is positive. Red colour indicates HIV-infected; black is a composite of HIV-negative and unknown. The CSF variable in includes either a positive culture for a pathogenic bacteria or positive cryptococcal antigen, BSI a positive aerobic culture of pathogenic bacteria from blood and MTB BSI a positive mycobacterial culture of tuberculosis from blood. BSI: Bloodstream infection, CSF: Cerebrospinal fluid, CRAG: Cryptococcal antigen, mRDT: Malaria rapid diagnostic test, MTB BSI: Mycobacterium tuberculosis bloodstream infection, uLAM: urinary lipoarabinomannan.

Table 4.6: Door-to-antimicrobial times.

| Antimicrobial class | No. participants | Median [IQR] time (hours) |
|---|---|---|
| Antibacterial | 207/225 (92%) | 5.3 (3.7-10.8) |
| Antitubercular | 63/225 (28%)* | 120.9 (63.7-171.0) |
| Antifungal | 26/225 (12%) | 47.7 (27.9-73.9) |
| Antimalarial | 12/225 (5%) | 4.5 (3.1-21.7) |

* 10/63 participants who received antitubercular agents during admission were taking them prior to admission; they are excluded from the calculation of median door-to-antimicrobial time for this class.

receiving antitubercular therapy, 16% (10/63) were taking the medication prior to admission, and the remainder were initiated on therapy during admission. The first antibacterial agent administered was most often ceftriaxone, in 87% (181/207) of cases but ciprofloxacin (18/207 [9%] of participants), amoxicillin (6/207 [3%]) and metronidazole (2/207 [1%]) were also used. Median door to antimicrobial time was 5.3 (IQR 3.7-10.8) hours for antibacterials and 4.5 (IQR 3.1-21.7) hours for antimalarials but longer for antifungals at 47.7 (IQR 27.9-73.9) hours and longer still for antitubercular therapy at 120.9 (IQR 63.7-171.0). Cumulative incidence curves for administration of the different antimicrobial classess are shown in Figure 4.6A-D.

Of all participants, 85% (192/225) received any intravenous fluid in the first 6 hours of enrollment to the study; of these, most received 0.9% saline (160/192 [83%] of those recieving fluid) but 5% dextrose (91/192 [57%]) were also used; Ringer's lactate (6/192 [6%]) and blood (2/192 [1%]) were rarely administered. Of the 192 patients who were administered any fluid, a median of 1.5L (IQR 1-2L) was administered over the 6hr study period; fluid administration as a function of time is shown in Figure 4.6E.

### 4.3.6 Outcome

Median hospital stay was 4 (IQR 1-9) days. Mortality of the cohort was 18% (95% CI 13-23%) at 28 days, 24% (95% CI 18-30%) at 90 days and 31% (95% CI 25-38) at 180 days, and higher in HIV-infected participants at each time point (Table 4.7), though not statistically significant on pairwise Fisher's exact test (HIV-infected vs noninfected 19% vs 13%, [p = 0.14] at 28 days, 27% vs 17%, [p = 0.44] at 90 days and 36% vs 21% [p = 0.29] at 180 days). Kaplan-meier estimation of the survival function (Figure 4.7) showed a precipitous decline in survivorship to around day 30 but also continuous mortality therafter, to the end of the study period. Stratifying the analysis by HIV status revealed that early deaths (within the first 1-2 weeks) occur at similar rates in the two groups before the curves diverge; log-rank test suggested a significant difference in survival function between the two groups (p = 0.03).

Health related quality of life measures, as assessed by EQ-5D-3L, are shown in Figure 4.8 for

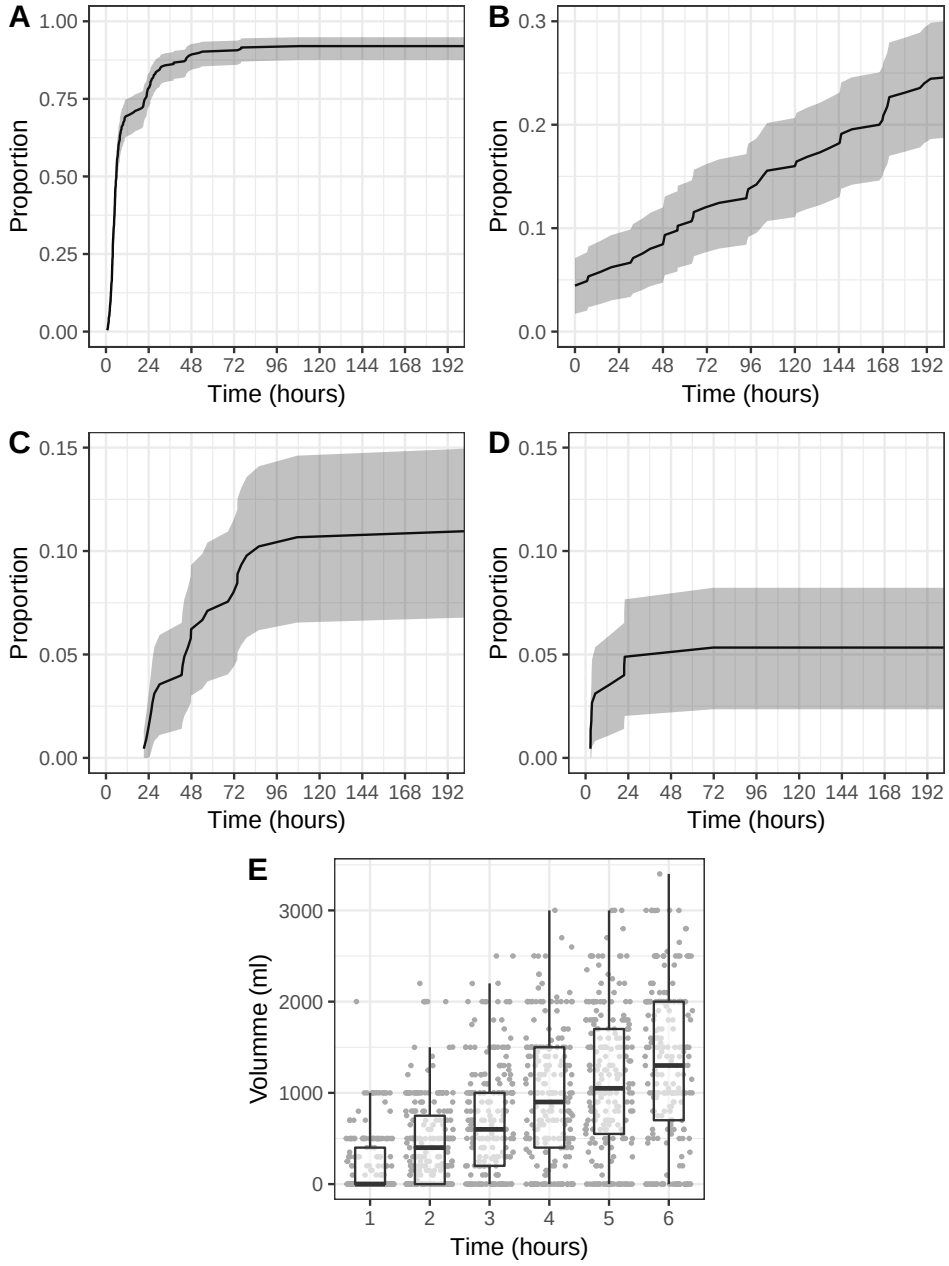


Figure 4.6: Timing of antimicrobial and fluid administration. A-D: Cumulative incidence of administration of antibacterial (A), antitubercular (B), antifungal (C) and antimalarial (D) agents as a function of time since arrival at hospital in hours. E: Total volumne of administered intavenous fluid as a function of time since enrollment to study in hours. Boxplots show median, quartiles box and 1.5 times interquartile range as whiskers. Points are jittered around the hour at which they were measured to show distribution.

Table 4.7: Day 28, 90 and 180 mortality stratified by HIV status

| | HIV+ | | HIV- | | HIV Unknown | | Total | |
|---|---|---|---|---|---|---|---|---|
| | n | Mortality | n | Mortality | n | Mortality | **n** | **Mortality** |
| Day 28 | 143 | 19% (13-26) | 67 | 13% (6-24) | 12 | 25% (5-57) | **222** | **18% (13-23)** |
| Day 90 | 139 | 27% (19-35) | 64 | 17% (9-29) | 12 | 25% (5-57) | **215** | **24% (18-30)** |
| Day 180 | 125 | 36% (28-45) | 58 | 21% (11-33) | 11 | 27% (6-61) | **194** | **31% (25-38)** |

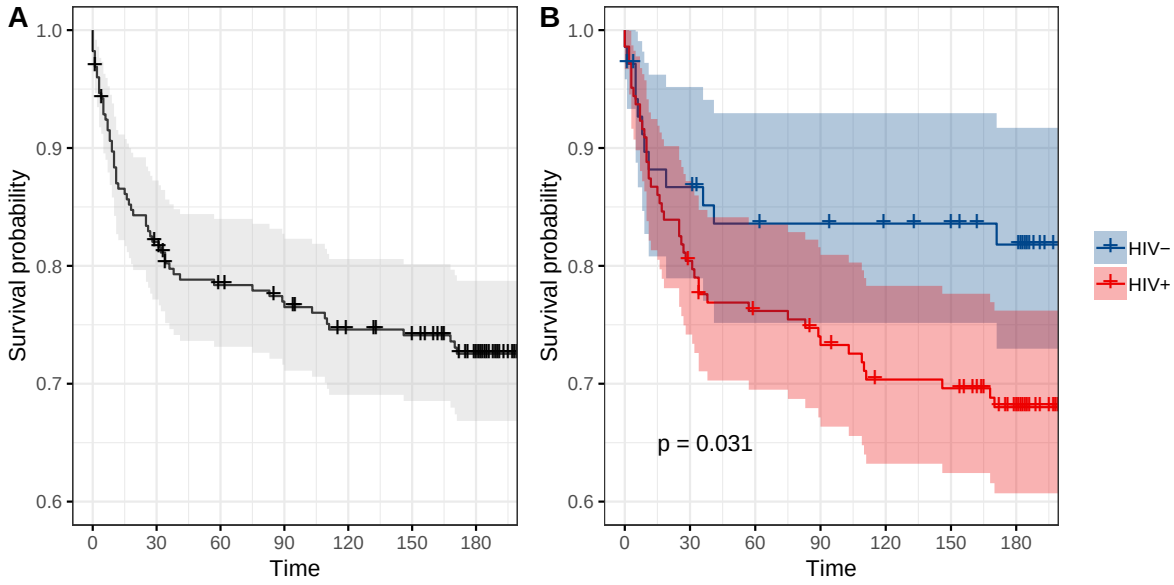


Figure 4.7: Kaplan-Meier survival curves of all included participants (A) and stratified by HIV status (B). Crosses indicate censoring. p value from log-rank test comparing survival of HIV-infected to HIV-noninfected participants shown (p = 0.03).

participants with sepsis and the community cohort as a comparator. Acutely, participants with sepsis reported were significantly disabled, reporting at least moderate impairment across all domains in the majority of cases, and over 90% of participants reporting at least moderate impairment in activities of daily living and experienceing at least moderate pain or discomfort. However, recovery following treatment in survivors was rapid. The mean EQ-5Q utility score (a measure of the weight compared to a health state compared to 1, perfect health) of healthy community controls was 0.910 (SD 0.102) at enrollment, significantly higher than participants with sepsis at enrollment (utility score 0.496 (SD 0.251), p = $<$ 0.0001 versus community scores by t-test), but comparable to participants with sepsis at their 12 week assessment (0.913 (SD 0.147), p = 0.903 versus community enrollment scores).

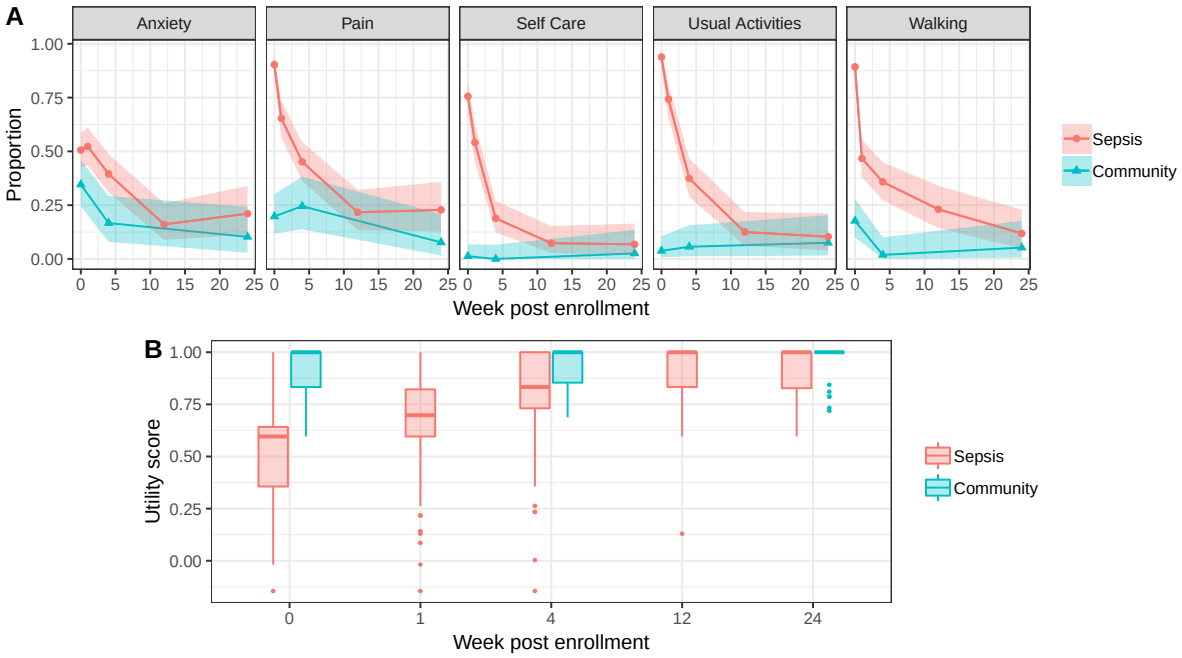


Figure 4.8: Health-related quality of life following sepsis admission, compared to community controls, showing a return to usual quality of life by 12 weeks following admission. A: proportion of participants across each of the five domains of the EQ-5D questionnaire who report at least moderate impariment. B: EQ-5D utility score derived using the Zimbabwean tariff set. The utility score is interpreted as the weight attached to a health state compared to perfect health, which is assigned a value of 1. By 12 weeks there is no statistically significant difference between sepsis and baseline community participant utility scores (p = 0.90 by t-test).

#### 4.3.6.1 Determinents of mortality

Bivariate associations of mortality with host, disease severity and treatment variables are shown in **??**

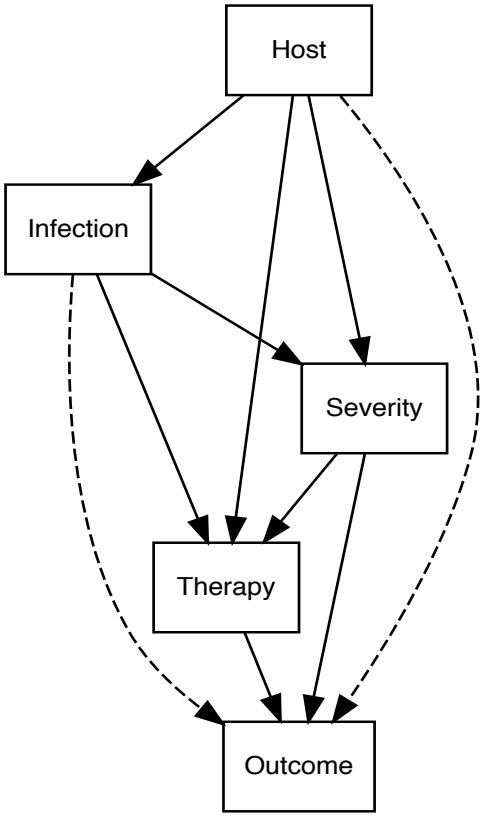


Figure 4.9: Hypothesised causal structre of death in sepsis. Host factors (e.g. age, sex, immune status) influence the type of infection; disseminated TB is more common in HIV, for example. Severity (variables quantifying e.g. shock or respiratory failure) is influenced by infection type and host factors. Therapy encodes which antimicrobials were administered and rapidity of administration of antimicrobials, and is influenced by disease severity (sicker patients may be given different therapies), host factors (HIV status may influence treatment) and the infection type (for example, malaria rapid diagnostic tests influenceing rapidity of malaria treatment). Dotted edges from host and infection to outcome are because it is not clear extita priori whether the effect of infection and host factors are entirely mediated by disease severity: in fact, even if this were the case in a theoretical sense, the available severity variables are unlikley to completely account for the causative effect of infection type on mortality and so conditioning on all available severity variables is likely to leave some residual causative effect of infection type. See text for further discussion

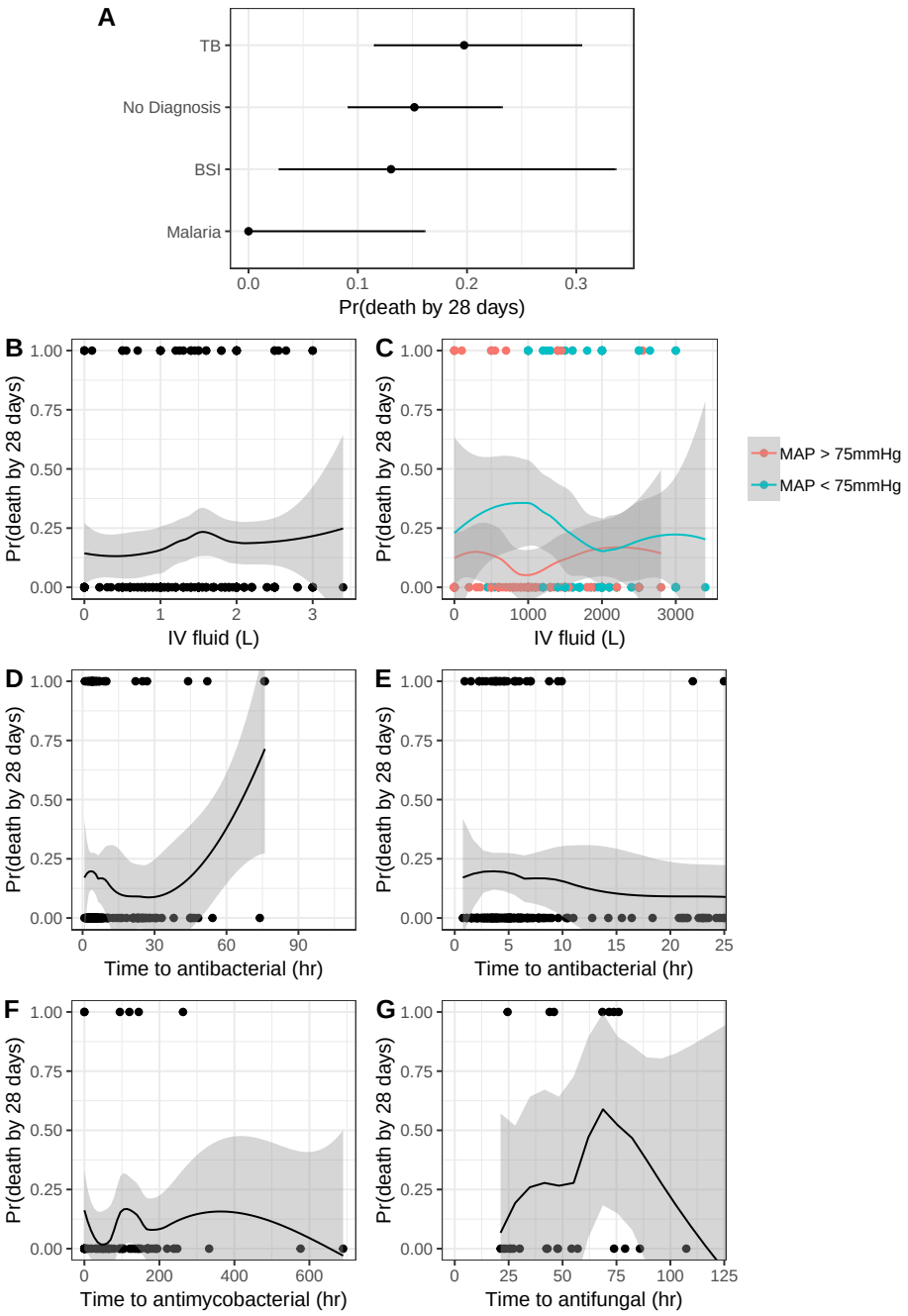


Figure 4.10: Bivariate associations of death by 28 days. A: 28-day mortality stratified by diagnosis. B-G show nonparametric regression (LOESS 2nd order polynomial) of outcome (with death coded as 1 for died and 0 for survived) against various covariates; the regression line can be interpreted as the probability of death by 28 days and can be used to assess for a bivariate relationship and also the nature of any relationship (i.e. linear versus nonlinear. B: IV fluid (L), C: IV fluid stratified by presence or absence of shock (defined as MAP $<$ 75mmHg), D: Time to antibacterials, E: Time to antibacterials with axes restricted to 24hrs to show lack of apparent relationship during first day of admission, F: Time to antimycobacterials, G: Time to antifungals. No plot is shown for antimalarials as no participant receiveing antimalarials died. Only D seems to show a relationship, which may be nonlinear.

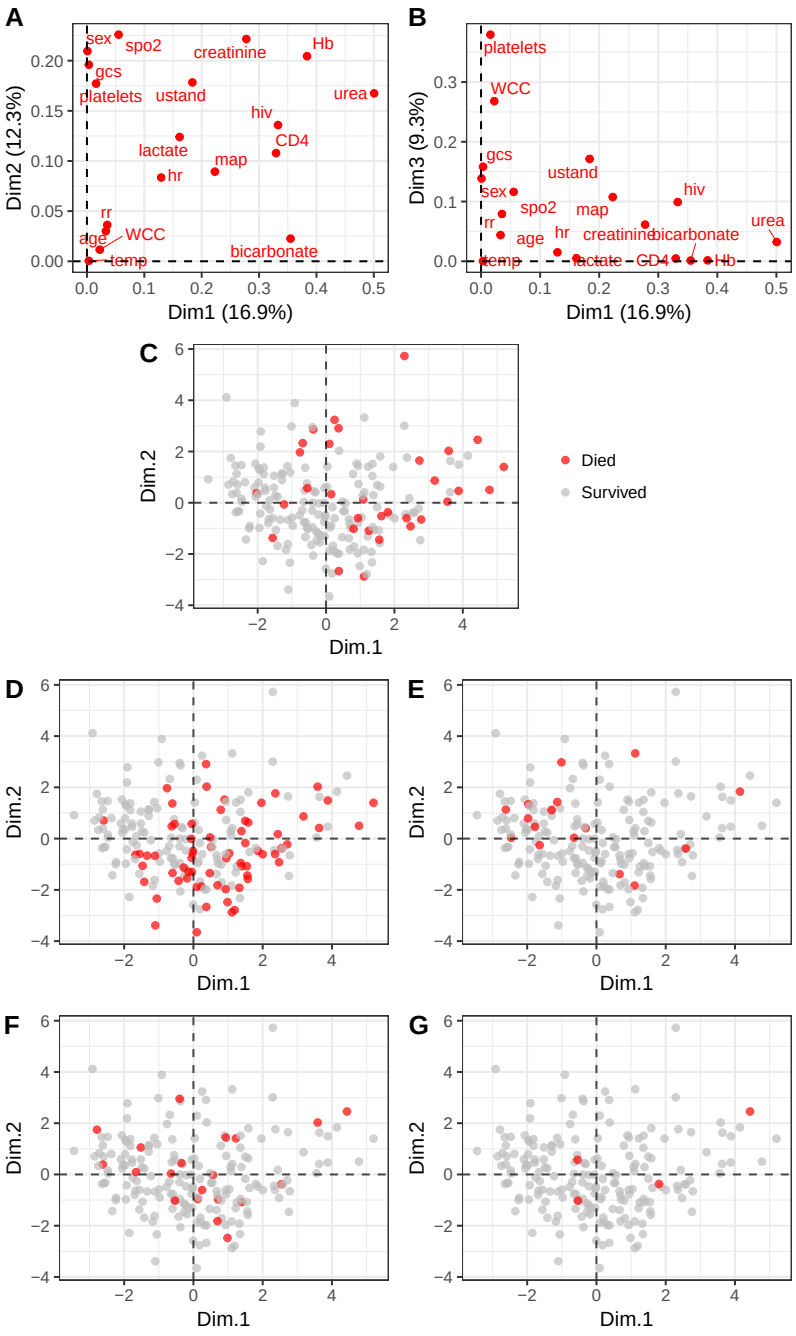


Figure 4.11: Dimensionality reduction of dataset using factor analysis of mixed data (FAMD); this is a combination of principal components analysis (PCA) for continuous variables and multiple correspondence analysis (MCA) for categorical variables, resulting in a new orthogonal coordinate system which maximises explained variance in each FAMD axis. A and B show the squared correlation ratio (for categoriacal variables) and the squared correlation coefficient (for continuous variables) with dimensions 1 and 2 (A) or 1 and 3 (B), along wih the proportion of variabce explained by each axis. C shows the location of all individuals in the FAMD space, with patients who died by 28 days coloured red to show that Dim.1 is associated with mortality. E-H show idividuals colored by diagnosis: TB (E), malaria (F), BSI (G) and meningtis (H) to show that malaria and tb seperate somewhat in Dim.1 and 2 with malaria patients clustering in top left and TB patients in bottom right

Table 4.8: Bivariate associations with death by 28 days

| Variable | Died | Survived | p |
|---|---|---|---|
| Host Variables | | | |
| Age (years) | 36.4 (31.5-46.0) | 35.9 (27.4-42.9) | 0.252 |
| Male sex | 19/39 (49%) | 93/183 (51%) | 0.861 |
| HIV Infected* | 27/36 (75%) | 116/174 (67%) | 0.433 |
| Taking ART† | 21/27 (78%) | 96/116 (83%) | 0.582 |
| **CD4 count† ($\mu$L$^{-1}$)** | **28.5 (9.5-124.5)** | **103.0 (43.5-251.0)** | **0.007** |
| **Haemoglobin (x10$^9$ g dL$^{-1}$)** | **9.1 (6.0-10.4)** | **11.0 (8.6-13.4)** | **<0.001** |
| Severity Variables | | | |
| **Temperature (°C)** | **38.1 (37.7-38.8)** | **38.5 (38.0-39.0)** | **0.024** |
| Heart rate (min$^{-1}$)) | 123.0 (104.5-138.5) | 120.0 (102.0-131.0) | 0.510 |
| **Systolic BP (mmHg)** | **89.0 (76.0-106.0)** | **99.0 (86.5-118.5)** | **0.047** |
| **Diastolic BP (mmHg)** | **59.0 (51.0-72.0)** | **67.0 (57.0-75.5)** | **0.040** |
| **Mean arterial BP (mmHg)** | **69.7 (60.0-81.3)** | **78.7 (67.0-89.2)** | **0.035** |
| Respiratory rate (min$^{-1}$)) | 34.0 (32.0-36.5) | 34.0 (32.0-38.0) | 0.720 |
| **Oxygen saturation (%)** | **95.0 (89.5-97.0)** | **97.0 (95.0-98.0)** | **0.019** |
| **GCS** | **15.0 (15.0-15.0)** | **15.0 (15.0-15.0)** | **0.044** |
| **Unable to stand** | **27/39 (69%)** | **36/183 (20%)** | **<0.001** |
| **Lactate (mmol L$^{-1}$)** | **4.6 (3.0-10.6)** | **3.2 (2.1-4.5)** | **0.001** |
| White cell count (x10$^9$ L$^{-1}$) | 5.9 (3.5-11.0) | 6.9 (4.5-11.5) | 0.165 |
| Platelet count (x10$^9$ L$^{-1}$) | 181.5 (86.8-300.8) | 223.0 (148.0-296.5) | 0.291 |
| **Bicarbonate (mmol L$^{-1}$)** | **17.0 (14.0-21.0)** | **20.0 (17.0-22.0)** | **0.007** |
| **Urea (mmol L$^{-1}$)** | **7.8 (4.5-14.3)** | **4.5 (3.2-7.0)** | **<0.001** |
| Creatinine (mmol L$^{-1}$) | 90.0 (60.0-185.0) | 73.0 (59.0-96.0) | 0.100 |
| Diagnosis | | | |
| BSI | 3/39 (8%) | 20/183 (11%) | 0.773 |
| TB | 15/39 (38%) | 61/183 (33%) | 0.579 |
| **Malaria** | **0/39 (0%)** | **21/183 (11%)** | **0.030** |
| **Meningitis** | **3/39 (8%)** | **1/183 (1%)** | **0.018** |
| No diagnosis | 21/39 (54%) | 88/183 (48%) | 0.598 |
| Treatment Recieved | | | |
| Antibacterials | 37/39 (95%) | 167/183 (91%) | 0.746 |
| Time to Antibacterials (hr) | 4.7 (3.8-8.8) | 5.3 (3.6-10.8) | 0.648 |
| Antifungals | 7/39 (18%) | 19/183 (10%) | 0.180 |
| Time to Antifungals (hr) | 68.5 (45.0-72.7) | 47.6 (26.6-76.4) | 0.665 |
| Antimalarials | 0/39 (0%) | 12/183 (7%) | 0.132 |
| Time to Antimalarials (hr) | NA (NA-NA) | 4.5 (3.1-21.7) | NA |
| **Antimycobacterials** | **4/39 (10%)** | **49/183 (27%)** | **0.037** |
| Time to Antimycobacterials (hr) | 107.3 (23.6-138.7) | 99.0 (37.0-169.4) | 0.778 |
| IV fluid (ml) | 1450.0 (1000.0-2000.0) | 1300.0 (625.0-2000.0) | 0.368 |

*Note:*
BP = Blood pressure, GCS = Glasgow coma scale. Numeric variables are presented as median (IQR) and categoric variables as proportions. P-values are from Kruskal-Wallace test for continuous variables and Fisher's exact test for categorical variables.

* Participants with HIV status unknown not included in this row

† Includes only HIV-infected participants

Table 4.9: Adjusted odds ratios (aOR) for death by 28 days for complete case analysis (CCA) and multiply imputed data

| | Adjusted Odds Ratio | |
|---|---|---|
| Variable | CCA | Imputed |
| FAMD composite variables | | |
| FAMD Dimension 1 | 2.39 (1.70-3.55) | 2.58 (1.85-3.81) |
| FAMD Dimension 2 | 1.36 (1.00-1.86) | 1.28 (0.95-1.72) |
| FAMD Dimension 3 | 1.18 (0.84-1.66) | 1.10 (0.79-1.52) |
| Diagnosis | | |
| TB | 0.74 (0.27-1.94) | 0.70 (0.26-1.76) |
| Malaria | 0.06 (0.00-1.55) | 0.04 (0.00-0.76) |
| BSI | 0.17 (0.01-0.93) | 0.24 (0.04-1.09) |
| Meningitis | 17.46 (1.22-679.98) | 16.10 (1.08-595.67) |
| Therapies recieved | | |
| TB Therapy | 0.18 (0.04-0.62) | 0.14 (0.03-0.48) |
| Antifungals | 1.11 (0.28-4.11) | 1.05 (0.29-3.48) |
| Antimalarials | 0.24 (0.00-12.08) | 0.31 (0.00-17.08) |
| IV Fluid Recieved (per L) | 0.62 (0.32-1.14) | 0.65 (0.35-1.16) |

*Note:*
FAMD = Factor Analysis of Mixed Data, BSI = Bloodstream infection, TB = Tuberculosis, CCA = Complete case analysis

# Chapter 5

# Early response to resusitation in sepsis

# Chapter 6

# Gut mucosal carriage of ESBL-E in Blantyre, Malawi

# Chapter 7

# Whole genome sequencing of ESBL *E. coli* carriage isolates

Placeholder

## 7.1 Chapter overview

## 7.2 Methods

### 7.2.1 Bioinformatic pipeline

### 7.2.2 Global *E. coli* collection

### 7.2.3 Statistical analysis

## 7.3 Results

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### 7.3.2 Phylogroup, MLST and core genome phylogeny of study isolates

### 7.3.3 Study isolates in a global context

### 7.3.4 Antimicrobial resistance determinants

#### 7.3.4.1 $\beta$-lactam resistance

#### 7.3.4.2 Quinolone resistance

#### 7.3.4.3 Aminoglycoside resistance

#### 7.3.4.4 Chloramphenicol, co-trimoxazole, tetracycline and other resistance determinants

#### 7.3.4.5 Clustering and lineage association of AMR determinants

### 7.3.5 Plasmid replicons

### 7.3.6 Testing metadata associations: SNP distance, hierBAPS sequence clusters and ESBL-clusters

#### 7.3.6.1 Hierarchical BAPS clustering of core gene pseudosequences

#### 7.3.6.2 ESBL-clusters

#### 7.3.6.3 Assessing for healthcare-associated lineages

#### 7.3.6.4 Assessing for within-patient conservation of lineage or MGE

## 7.4 Discussion

# References