

Original Research Article

Extended Spectrum Beta-Lactamases in Clinical Isolates of *Escherichia coli* and *Klebsiella pneumoniae* from University of Uyo Teaching Hospital, Uyo

ABSTRACT

Aims: This study was aimed at investigating the prevalence of ESBL-producing *Escherichia coli* and *Klebsiella pneumoniae* in clinical samples from University of Uyo Teaching Hospital (UUTH), Uyo-Nigeria, and determine the antibiogram of the isolates.

Study Design: This study involved sample collection and laboratory analysis of samples.

Place and Duration of Study: The study was conducted at the University of Uyo Teaching Hospital, Uyo between January and June 2013.

Methodology: Faecal, wound and urine samples were obtained from 280 in- and out-patients attending UUTH, Uyo. *Escherichia coli* and *Klebsiella* isolates obtained were subjected to routine antimicrobial susceptibility testing and tests for ESBL production using the Double Disk Synergy Test (DDST).

Results: ESBL was detected in 40 (47.1%) of the 85 isolates and *E. coli* was the major ESBL producer, 21 (52.5%) followed by *K. pneumoniae*, 19 (47.5%). The detection rates of ESBL producing organisms was higher in female patients (57.5%) than their male counterparts (42.5%), and infants under 1 year of age were among the age brackets with high prevalence of ESBL producing organisms (20%). The ESBL-producers were most frequently detected in paediatric ward, 11 (27.5%); surgical ward, 10 (25.0%) and GOPD, 7 (17.5%). Majority of the isolates encountered were multidrug resistant strains. Tetracycline and Trimethoprim/Sulfamethoxazole were the least effective antimicrobials to *E. coli* and *K. pneumoniae* with susceptibility rates ranging from 14.6% - 24.3%, while less than 50% were Ciprofloxacin sensitive. Carbapenems were the most effective antimicrobials. All isolates were susceptible to Imipenem, while >90% of the isolates were susceptible to Ertapenem.

Conclusion: This study reveals that there is a high prevalence of ESBL-producing organisms in clinical samples, especially isolates from infants, in UUTH, Uyo with attendant high multi-drug resistance to commonly used antimicrobials. There is need for increased ESBL surveillance as it poses serious threat to successful treatment of infections and exacerbates the problem of antimicrobial resistance especially with commonly used drugs in resource poor settings.

Keywords: ESBL, *E. coli*, *K. pneumoniae*, Antimicrobial resistance

INTRODUCTION

The progressive emergence and rapid dissemination of antimicrobial resistance is one of the biggest challenges facing global public health [1]. The accelerated bacterial resistance to antimicrobials has emerged as perhaps the greatest threat worldwide to the favourable outcome of infections both in the hospital settings and in the community. Beta-lactamase production by several gram negative and gram positive organisms is the most important single mechanism of resistance to Penicillins, Cephalosporins, Monobactams and Carbapenems [2], which are the most commonly used antimicrobials in treatment of bacterial infections in hospitals [3]. Extended-Spectrum Beta-lactamases (ESBLs) are a group of diverse, complex and plasmid-mediated rapidly evolving enzymes that pose a major therapeutic challenge in the treatment of patients. The ESBLs are able to hydrolyse a broader spectrum of beta-lactam antibiotics than the simple parent beta-lactamases from which they were derived, hence, the term extended spectrum. They are able to inactivate beta-lactam antibiotics containing an oxyimino-group such as oxyimino-cephalosporins (e.g. Ceftriaxone, Cefotaxime, Ceftazidime), oxyimino-monobactam (e.g. Aztreonam) [4], as well as the Penicillins [5].

ESBLs are most commonly produced by *E. coli* and *Klebsiella* species, with *Klebsiella pneumoniae* seemingly the major ESBL producer [6]. Other members of the Enterobacteriaceae family producing ESBLs include *Salmonella* species, with a growing incidence [7], *Citrobacter freundii*, *Enterobacter aerogenes* and *Proteus mirabilis* [8]. Non-Enterobacteriaceae ESBL producers are relatively rare with *Pseudomonas aeruginosa* being the most important organism [9]. Others reported include *Acinetobacter* species, *Burkholderia cepacia* and *Alcaligenes faecalis* [4].

Organisms producing ESBL have been increasingly detected worldwide with prevalence rates varying from country to country and from institution to institution [6]. A survey carried out from 1997 to 2002 in some countries put the prevalence rate of ESBL producing *Klebsiella* species at 42.7% in

Latin America, 21.7% in Europe and 5.8% in North America [7]. The Pan European Antimicrobial Resistance using Local Surveillance (PEARLS) study (2001-2002) showed that Egypt had the highest prevalence of 38.5%; Greece, 27.4%; while the lowest, 2% and 2.6% were reported in Netherlands and Germany respectively [10]. In the USA, the prevalence ESBL producing *Klebsiella* species ranged from 0 – 25% with the national average being around 3% [11]. In Japan, the prevalence of ESBL producing *E. coli* and *Klebsiella pneumoniae* organisms remains low at 0.1% and 0.3% respectively [12]. Some studies have been carried out in Nigeria especially in the South East with reports of ESBL-producing bacteria ranging from as low as 2.5% to as high as 76.9% prevalence [13,14]. Nevertheless, the prevalence of ESBL-producing organisms in many hospitals in Nigeria as well as ESBL types remains unknown [15,16]. Therefore, the objective of this study was to investigate the prevalence of ESBL-producing *Escherichia coli* and *Klebsiella pneumonia* from clinical samples in University of Uyo Teaching Hospital (UUTH), Uyo.

MATERIALS AND METHODS

Study population

This study was carried out at the University of Uyo Teaching Hospital (UUTH), being a referral and tertiary health facility located in Uyo, the capital of Akwa Ibom State, Niger Delta region of Nigeria. Patients attending the out-patient clinics and in-patients at UUTH, Uyo were recruited into the study following informed consent. They included patients from Surgical, Paediatric, General Outpatient Department (GOPD), Medical and Antenatal clinic attendees. Others were from Accident and Emergency, Gynaecology, Orthopaedic and Staff clinics of the Hospital. The age group of patients recruited ranged from <1 to 82 yr.. Ethical Approval was sought and obtained from the institutional ethical review board of UUTH, Uyo.

Sample collection, culture and identification of isolates

A total of 280 samples were collected comprising stool, urine and superficial wound swabs. Samples were cultured on Blood and MacConkey agars (Biomark, India) overnight at 37°C. *Escherichia coli* and *Klebsiella pneumoniae* isolates were identified on the basis of conventional microbiological procedures [17].

90 **Antimicrobial susceptibility testing**

91 Antimicrobial susceptibility assay was performed according to Clinical Laboratory Standards
92 Institute (CLSI) guidelines (20) using the Kirby-Bauer disc diffusion method to evaluate the sensitivity
93 of the test organisms. Antimicrobial agents used include Ciprofloxacin (5µg), Tazobactam-Piperacillin
94 (10/100µg), Cefotaxime (30µg), Gentamicin (10µg), Aztreonam (30µg), Cefpodoxime (10µg),
95 Ceftazidime (30µg), Tetracycline (10µg), Ertapenem (10µg), Imipenem (10µg), and Trimethoprim-
96 Sulfamethoxazole (1.25/23.75µg) (Oxoid, UK). The results were interpreted according to the CLSI
97 guidelines [18]. *Escherichia coli* American Type Culture Collection (ATCC) 25922 reference strain was
98 used as control to test the performance of the method.

99

100 **Double Disk Synergy Test for ESBL**

101 Isolates with zone diameters suspicious of ESBL production as pre-determined by the
102 susceptibility test results (Cefpodoxime: ≤17mm; Ceftazidime: ≤22mm; Aztreonam: ≤27mm;
103 Cefotaxime: ≤27mm) were subjected to the Double Disk Synergy Test [19] to test for the presence of
104 ESBL producing enzymes.

105 Briefly, test organisms (suspected of ESBL production) were cultured overnight on nutrient
106 agar, and a suspension prepared to match a 0.5 McFarland turbidity standard was inoculated on the
107 surface of each of the molten Mueller Hinton agar plates using a sterile swab. Amoxicillin (20µg)/
108 Clavulanic acid (10µg) combination disc was placed at the center of each inoculated Mueller–Hinton
109 agar plate. Cefotaxime (30ug), Ceftazidime (30ug), Aztreonam (30µg) and Cefpodoxime (10µg) single
110 discs were then placed 20mm (center to center) from the Amoxycillin/Clavulanic acid disc and
111 incubated at 37°C overnight (18-24hr).

112 Enhancement of the zones of inhibition of any of the cephalosporin beta-lactam antibiotic
113 discs (i.e. Cefotaxime, Aztreonam, Cefpodoxime or Ceftazidime) towards the Amoxycillin/Clavulanic
114 acid disc caused by the synergy with clavulanate was taken as an evidence of ESBL production.
115 *Escherichia coli* ATCC 25922 (β-lactamase negative), *Klebsiella pneumoniae* ATCC 700603 (ESBL-
116 producer) were used as reference strains for quality control.

117

RESULTS

The Antimicrobial susceptibility pattern of *E. coli* and *K. pneumoniae* isolates from clinical samples in UUTH, Uyo are shown in table 1. Imipenem was the most effective antimicrobial agent with 100% activity against all the isolates. Ertapenem was sensitive to 93.7% of *E. coli* and 91.9% of *K. pneumoniae* isolates. Tetracycline and Trimethoprim/Sulfamethoxazole were the least effective antimicrobials to *E. coli* with susceptibility rates of 16.7% and 14.6% respectively and 24.3% each for *K. pneumoniae*.

Table 2 shows the prevalence of extended-spectrum Beta-lactamase organisms isolated from clinical samples in UUTH, Uyo. Of the 85 bacterial isolates obtained, 40 were ESBL-producing organisms giving a prevalence rate of 47.1%. Out of a total of 40 ESBL producing organisms, *E. coli* was the major ESBL producer 21 (52.5%) followed by *K. pneumoniae*, 19 (47.5%).

The age and gender distribution of ESBL-producing organisms in UUTH, Uyo are shown in table 3. Generally, infants under 1 year had relatively high prevalence (20%) of ESBL-producing organisms than older children, while females were detected with the highest rate, 23 (57.5%) of ESBL-producing bacteria compared with their male counterparts, 17 (42.5%). The gender difference in the isolation rates was not statistically significant ($P>.05$). Specifically, ESBL-producing *K. pneumoniae* were more frequently isolated in females than in males, so also were ESBL-producing *E. coli* isolates.

The distribution of ESBL producers according to ward/clinic in UUTH, Uyo is shown in table 4. ESBL-producing organisms were most frequently encountered in the Paediatric ward, 11 (27.5%) closely followed by the Surgical ward, 10 (25.0%), then GOPD, 7 (17.5%). No ESBL producer was encountered among isolates from the Orthopaedic and Surgical wards.

DISCUSSION

The prevalence of ESBL-producing organisms has been increasing rapidly worldwide. This situation is alarming because ESBL producers have been reported to exhibit co-resistance to many other classes of antibiotics resulting in limited therapeutic options [5]. In addition, the prevalence of ESBL, type of enzyme, gender and age group of persons affected varies in different geographical areas.

In this study, the overall prevalence of ESBL producing isolates from clinical samples was 47.1%. This is comparable to 39.8% reported in Enugu [13] and 33.6% in Abuja [20]. Higher prevalence rates of 58.6% (Enugu) and 76.9% (Ibadan) have been reported in other Nigerian studies [15,16]. Global reports show that Pakistan [21], Sudan [22] and India [23] recorded 29.45%, 59.6% and 57.5% prevalence respectively. The variation in ESBLs prevalence rates reported between geographical areas, institutions and countries may be attributed to the complex epidemiology of ESBLs, specific type of bacteria involved and methods used for ESBL detection among other factors [6,24].

In this study, *E. coli* was identified as the major ESBL producing microorganism (52.5%) followed by *K. pneumoniae* (47.5%). *E. coli* has recently been reported as the major ESBL producer in similar studies conducted in Enugu [16], Osun [25] and Ogun States [14] as well as in Bangladesh [26] and Pakistan [21]. However, other Nigerian reports, Ogun [27], Benin [28] and Abuja [20] as well as Ghana [29] and Sudan [22] indicated *K. pneumoniae* as the major ESBL producer. Even though both organisms have been identified in various studies within and outside Nigeria as the major ESBL producing microorganisms, there has been no consensus on which has a greater capacity to produce ESBL.

Regarding gender classification, the fact that more ESBL producing organisms were recovered from females than their male counterparts, the difference was however not statistically significant and similar results have been documented elsewhere, Abuja, Nigeria [20] and Pakistan [21]. Children under one year of age were among the age brackets with high prevalence of ESBL producing organisms in this study (20%). Similar high prevalence have been reported elsewhere [14,30]. This observation has serious therapeutic implications that may impact on clinical outcomes in infants. More so, ESBL producing organisms have been associated with increased mortality and morbidity [31].

In this study, it was observed that ESBL producers were most frequently encountered in the Paediatric ward (27.5%) closely followed by surgical wards (25.0%) and General Outpatient Department (GOPD) (17.5%). A study by Alipourfard and Nili [26] reported most of the ESBL-producing isolates (29.6%) were from the medical wards, followed by outpatient's clinic (24.3%).

Majority of the isolates encountered in this study were multidrug resistant strains showing resistance to 4 to 5 antimicrobials or more. The gross misuse or over-use of antimicrobials in the

hospital, non-compliance or adherence of antimicrobial use by patients, could lead to development of multidrug resistant bacteria [2,4]. The existence of ESBL-producers in an individual could lead to increased antibiotic resistance because the plasmid which carries the ESBL enzymes also harbour resistance genes to other classes of antimicrobials [33].

Findings from this study shows that Imipenem is the drug of choice against ESBL-producers followed by Ertapenem as equally reported in other studies [34]. Commonly used antimicrobials in our locality such as Trimethoprim/Sulfamethoxazole, Tetracycline and Ciprofloxacin were among the least effective against the ESBLs as observed in this study. The reason could be attributed to the gross misuse and abuse of these inexpensive antimicrobials which are readily available as over-the-counter (OTC) drugs and can even be purchased without doctor's prescription. Consequently, this poses problems for treatment of infections caused by ESBL producers because these commonly used antimicrobials are usually ruled out in therapeutic options. However, Imipenem and which is the most effective drug against ESBL-producing organism is very expensive and is a broad spectrum antimicrobial. Also, its indiscriminate use could result in the development of Imipenem-resistant strains leaving no therapeutic alternative in the future.

There is an increased need to detect ESBL-producing gram negative bacteria in routine microbiological work. Rapid detection of ESBL is important, not only for treatment guidelines but also to facilitate improved prevention of nosocomial infections [34]. Failure to detect ESBL-mediated resistance has led to therapeutic failure and facilitated the spread of ESBL-producing organism. For cost-effective isolation and effective medical treatments, there is a need to screen patients for ESBL production [35].

CONCLUSIONS

The findings from this study showed that there is a high prevalence of ESBL-producing organisms in clinical samples, especially isolates from infants in University of Uyo Teaching Hospital, Uyo-Nigeria. Majority of the ESBL enzymes producers in this study were *E. coli* strains. Most of the organisms isolated were multidrug resistant strains while the ESBL producers further compounded the problem by exhibiting co-resistance to other classes of antimicrobials including the Fluoroquinolones and Aminoglycosides. However, the Carbapenems remain the most effective therapeutic option for both ESBL and non-ESBL producing organisms, Imipenem being the most effective followed by Ertapenem. There is need for increased surveillance of ESBL producing

organisms as they pose serious threat to successful treatment of infections and exacerbates the problem of antimicrobial resistance in the hospitals, especially in resource poor settings.

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332 **Table 1: Antimicrobial Sensitivity Pattern of *E. coli* and *K. pneumoniae* Isolates from Clinical**
 333 **Samples**

Antimicrobial (µg)	<i>E. coli</i> (n=48)			<i>K. pneumoniae</i> n=37)		
	S %	I %	R %	S %	I %	R %
ATM(30)	58.3	0	41.7	32.4	0	25
CTX (30)	58.3	0	41.7	32.4	0	67.6
CPD (10)	58.3	2.1	39.6	45.9	2.7	51.4
CAZ (30)	54.2	4.2	41.7	40.5	2.7	56.8
CIP (5)	45.8	4.2	50.0	48.6	13.6	37.8
ETP(10)	93.7	6.3	0	91.9	0	8.1
CN (10)	66.8	8.3	22.9	51.4	10.8	37.8
IPM(10)	100.0	0	0	100.0	0	0
TZP (10/100)	62.5	29.2	8.3	67.6	21.6	10.8
TE (30)	16.7	0	83.3	24.3	2.7	73.0
SXT (1.25/23.75)	14.6	0	85.4	24.3	0	75.7

334 Key: S=Susceptible, I=Intermediate, R=Resistant, ATM=Aztreonam, CTX=Cefotaxime, CPD=Cefpodoxime,
 335 CAZ=Ceftazidime, CIP=Ciprofloxacin, ETP=Ertapenem, CN=Gentamicin, IPM=Imipenem,
 336 TZP=Tazobactam/Piperacillin, TE=Tetracycline, SXT=Sulfamethoxazole/Trimethoprim
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339 **Table 2: Distribution of ESBL producing bacteria among clinical samples in UUTH,**
 340 **Uyo**
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Sample	No. of Isolates (ESBL producers)			
	No. Tested	<i>E. coli</i>	<i>K. pneumoniae</i>	Total
Stool	47	21 (5)	15 (6)	36 (11)
Urine	173	21 (10)	11 (5)	32 (15)
Wounds	60	6 (6)	11 (8)	17 (14)
Total	280	48 (21)	37 (19)	85 (40)
Percentage ESBL producer	-	43.8	52.5	47.1

Table 3: Age and Gender Distribution of ESBL-producing bacteria from clinical samples in UUTH, Uyo

Patient Group	No. Isolates Tested	ESBL- <i>Escherichia coli</i>	ESBL- <i>Klebsiella pneumoniae</i>	Total (%)
Age group(yr)				
<1	23	3	5	8 (20.0)
1-10	15	2	1	3 (7.5)
11-20	2	0	1	1 (2.5)
21-30	5	1	1	2(5.0)
31-40	18	3	5	8 (20.0)
41-50	9	7	4	11 (27.5)
51-60	8	4	1	5 (12.5)
61-70	3	0	0	0
71-80	2	1	1	2 (5.0)
Total	85	21	19	40 (100.0)
Gender				
Male	41	9	8	17 (42.5)
Female	44	12	11	23 (57.5)
Total	85	21	19	40 (100.0)

351 **Table 4: Distribution of ESBL producing Organisms According to Ward/Clinic in**
 352 **UUTH, Uyo**

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Location	No. of isolates	No. ESBL organisms		
		<i>E. coli</i>	<i>K. pneumoniae</i>	Total No. (%)
GOPD (General Outpatient Department)	24	5	2	7 (17.5)
Staff Clinic	2	1	0	1 (2.5)
A&E (Accident and Emergency)	6	1	1	2 (5.0)
Medical Wards	7	2	0	2 (5.0)
GYNAE (Gynaecology Ward)	2	0	1	1 (2.5)
ANW (Antenatal Clinic)	4	1	1	2 (5.0)
Paediatric Ward	22	5	6	11 (27.5)
Orthopaedic Ward	12	2	2	4 (10.0)
Surgical Ward	6	4	6	10 (25.0)
Total (%)	85	21	19	40(100.0)

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