

Original Research Article

EXTENDED SPECTRUM β -LACTAMASES AMONG ENTEROBACTERIACEAE ISOLATED FROM CLINICAL SPECIMENS OF A TERTIARY HOSPITAL IN 2014

ABSTRACT

Extended spectrum beta-lactamase producing *Enterobacteriaceae* has become widespread among hospitals even in the community that poses therapeutic dilemma against certain antimicrobial drugs that limits therapeutic options. This study was conducted to evaluate the prevalence of ESBL producing *Enterobacteriaceae* in a tertiary hospital in Bacolod City and its antibiotic resistance profile for the year 2014. Out of 662 isolates, 125 (18.89%) were found to be ESBL producing and was frequently seen in *Escherichia coli* (4.96%), *Klebsiellapneumoniae* (4.08%) and *Enterobacteraerogenes* (3.36%). Urine was found to be the most common specimen to contain this type of bacteria (7.70%), followed by wounds and abscess (5.14%), and sputum (3.63%). These isolates were also found to be least resistant to amikacin with 10.5% followed by imipenem and meropenem with 17.1% and 15.4% respectively. Furthermore, there was no significant difference with regard to sex ($p=0.051664$) and with significant different in terms of age ($p=0.11415$).

Keywords: Extended Spectrum β -Lactamases; *Enterobacteriaceae*; tertiary hospital, Bacolod City

INTRODUCTION

Resistance of pathogenic organisms to countenance antibiotics, has become a worldwide problem with serious consequences on the treatment of infectious diseases [1]. The heightened use or misuse of antibiotics in human medicine is primarily contributing to the phenomenon. Because of this, there is an

alarming increase of antibiotic resistance in bacteria that cause either community infections or hospital acquired infections. Antimicrobial-resistant infections currently claim approximately 700,000 lives each year with at least 50,000 of it across Europe and the US alone, and many hundreds of thousands more dying in other areas of the world [2]. Furthermore, studies estimate that 300 million people are expected to die prematurely because of drug resistance over the next 35 years.

One of the major factors in drug resistance is the production of ESBL. According to Rawat et al. [3], extended-spectrum β -lactamases are a group of plasmid-mediated, diverse, complex and rapidly evolving enzymes that are posing a major therapeutic challenge today in the treatment of hospitalized and community-based patients. ESBLs are a rapidly evolving group of β -lactamases which share the ability to hydrolyze third-generation cephalosporins and aztreonam but are inhibited by clavulanic acid. Most infections caused by these organisms are described as nosocomial or healthcare related [4], but has started to spread in the community. For the reason of unavailability of local data pertaining to ESBL producing isolates, thus, this study was initiated to give a baseline information describe the presence of ESBL producing *Enterobacteriaceae* in the area.

MATERIALS AND METHODS

Inclusion / Exclusion Criteria

Data on culture and antibiotic susceptibility tests were collected from the tertiary hospital from January 2014 to December 2014, after the grant of permission from the laboratory supervisor. The hospital where the data was gathered however opted not to point out their identity. Data such as age, sex, specimen source, ID of the isolated *Enterobacteriaceae* and

susceptibility testing were included. No personal data was retrieved from patients in order to preserve confidentiality.

Statistical Analysis

The gathered data were analyzed statistically to determine the frequency, resistance profile and distribution of ESBL producing *Enterobacteriaceae* among patients in terms of age and sex using WHONET version 5.6 software downloaded from World Health Organization website. Age was divided into two categories, adult (19 years old and above) and pediatric (0 - 18 years old) automatically by the WHONET software.

RESULTS

From January 2014 to December 2014, a total of 662 *Enterobacteriaceae* was isolated and identified to genus and species level from different clinical specimens. *E. coli* was the most frequent isolate having a total of 256 (38.67%), followed by *K. pneumoniae* with 107 (16.16%) and *E. aerogenes* with 57 (8.61%). From these 662 isolates, 125 (18.89%) were observed to produce the enzyme ESBL and noted to be the most numbered producer is *E. coli* (24.8%), followed by *K. pneumoniae* (20.72%) and *E. aerogenes* (3.17%) as shown in Table 1.

Table 1. Frequency of Identified *Enterobacteriaceae* and ESBLs among the Recovered Isolates

Organisms	Number of Isolates	%	ESBL producers	% of ESBL producers
<i>E. coli</i>	256	39	31	12
<i>K. pneumoniae</i>	107	16	27	25
<i>E. aerogenes</i>	57	9	21	37
<i>P. mirabilis</i>	33	5	3	9
<i>P. agglomerans</i>	28	4	7	25

<i>E. gergoviae</i>	24	4	4	17
<i>E. cloacae</i>	22	3	7	32
<i>K. ozaenae</i>	22	3	6	27
<i>P. vulgaris</i>	20	3	1	5
<i>E. hermannii</i>	18	3	4	22
<i>C. koseri</i>	16	2	3	19
<i>H. alvei</i>	16	2	4	25
<i>Salmonella sp.</i>	12	2	0	0
<i>C. freundii</i>	11	2	4	36
<i>E. tarda</i>	11	2	2	18
<i>S. marcescens</i>	4	1	0	0
<i>K. oxytoca</i>	3	0	0	0
<i>P. penneri</i>	1	0	0	0
<i>P. rettgeri</i>	1	0	1	100
TOTAL	662	100	125	19

For the distribution of bacterial isolates and ESBL producers as to the sample source, urine was found to be the major source with 42.60% of the total specimen, followed by wounds and abscess with 29.76%. Out of 125 ESBL producing isolates, it was observed that it was frequently observed in urine with 40.8% followed by wounds and abscess with 27.2%. Table 2 summarizes the specimen wise distribution of ESBL producers.

Table 2: Specimen Wise Distribution of ESBL Producers.

Type of Specimen	Number of Isolates	ESBL producers	(%)
Urine	282	51	18
Wound & Abscess	197	34	18

Blood	88	13	15
Sputum& ETA	95	24	25
Cerebro Spinal Fluid	0	0	0
TOTAL	662	125	17

101

102 **Table 3:** Distribution of Bacteria as to Specimen Source

Organism	Urine	Blood	Sputum & ETA	CSF	Wound & Abscess	Total
<i>C. freundii</i>	3	3	2	0	3	11
<i>C. koseri</i>	4	2	1	0	9	16
<i>E. tarda</i>	4	2	1	0	4	11
<i>E. aerogenes</i>	15	3	19	0	20	57
<i>E. cloacae</i>	7	1	5	0	9	22
<i>E. gergoviae</i>	2	5	3	0	14	24
<i>E. coli</i>	151	45	10	0	50	256
<i>E. hermannii</i>	14	1	1	0	2	18
<i>H. alvei</i>	6	3	3	0	4	16
<i>K. oxytoca</i>	1	0	1	0	1	3
<i>K. ozaenae</i>	12	1	7	0	2	22
<i>K. pneumoniae</i>	35	9	36	0	27	107
<i>P. agglomerans</i>	15	0	2	0	11	28
<i>P. mirabilis</i>	8	0	4	0	21	33
<i>P. penneri</i>	0	0	0	0	1	1
<i>P. rettgeri</i>	1	0	0	0	0	1
<i>P. vulgaris</i>	3	0	0	0	17	20
<i>Salmonella sp.</i>	0	12	0	0	0	12
<i>S. marcescens</i>	1	1	0	0	2	4
TOTAL	282	88	95	0	197	662

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104 As to the distribution of isolates with regard to specimen

105 source, *E. coli* was still the most common bacteria isolated from

urine, wounds and abscesses, and blood specimens while *K. pneumoniae* was frequently found in sputum and ETA. Table 3 shows the frequency of the isolated *Enterobacteriaceae* per specimen.

Table 4: Age and Sex Wise Distribution of the ESBL Producers

Organism	Pediatric		Adult	
	Male	Female	Male	Female
<i>C.freundii</i>	1	0	1	2
<i>C. koseri</i>	1	0	0	2
<i>E.tarda</i>	0	0	0	2
<i>E.aerogenes</i>	1	1	8	11
<i>E. cloacae</i>	1	0	3	3
<i>E.gergoviae</i>	0	0	4	0
<i>E. coli</i>	1	2	9	19
<i>E.hermannii</i>	0	0	0	4
<i>H.alvei</i>	0	0	2	2
<i>K.oxytoca</i>	0	0	0	0
<i>K.ozaenae</i>	0	0	3	3
<i>K.pneumoniae</i>	1	1	17	8
<i>P.agglomerans</i>	1	1	4	1
<i>P. mirabilis</i>	0	0	0	3
<i>P.rettgeri</i>	0	0	1	0
<i>P. vulgaris</i>	0	0	1	0
<i>S.marcescens</i>	0	0	0	0
TOTAL	7	5	53	60

The age and sex wise distribution of the ESBL producers which is shown in Table 4, revealed that the maximum number of ESBL producers were seen in the adult age group and that the prevalence was more among the females (the highest) comprising 48% of the 125 ESBL producing strains than among the males

covering 42% of the total ESBL producing strains. The least prevalence was seen in the last two groups; the pediatric males and pediatric females.

Table 5: Significant Difference of ESBL-positive organisms as to selected variables

Variable	Category	p-value	Interpretation
Age	Pediatric (0-18 yrs old)	0.011415	Significant
	Adult (19 and above)		
Sex	Male	0.051664	Not Significant
	Female		

Based on the gathered data, Trimethoprim/Sulfamethoxazole had the highest resistance with 78.4%, followed by ampicillin/sulbactam and ciprofloxacin with 75% and 74.4% respectively. Amikacin was most effective with 10.5% resistance rate followed by meropenem and imipenem with 15.4% and 17.1%.

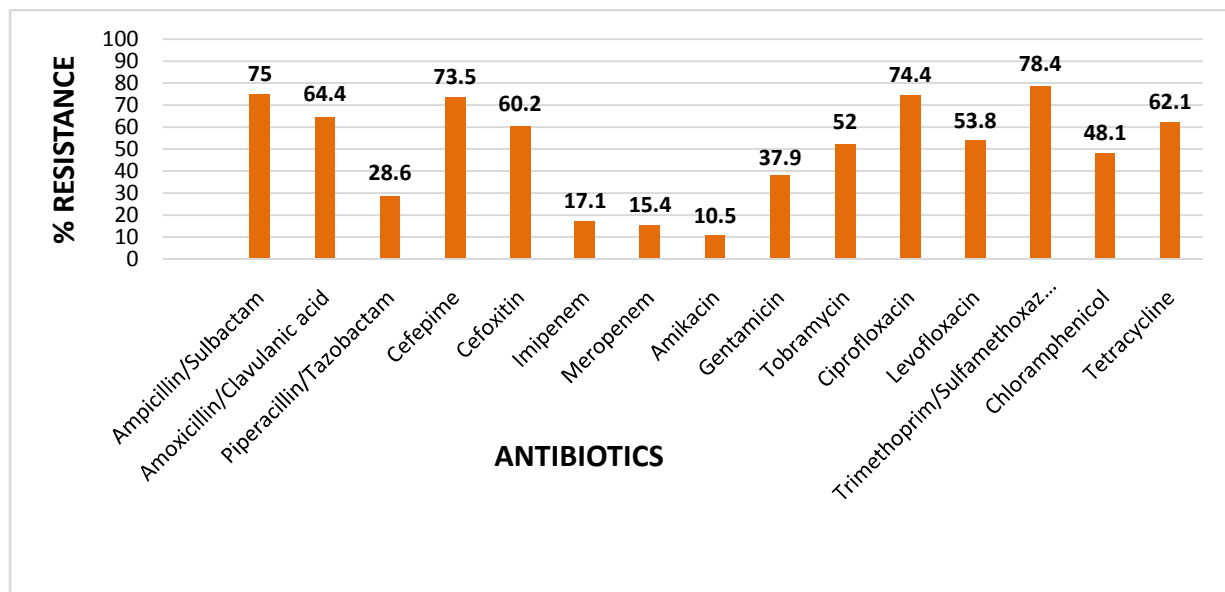


Figure 2: Antibiotic resistance rates (%) of ESBL-producers

Out of the total 662 isolates, *E. coli* was noted to be the most common of the said bacteria that produces the enzyme ESBL, followed by *K. pneumoniae* and *Enterobacter species* with frequencies of 24.8%, 21.6% and 16.8% respectively. This is because *Enterobacteriaceae* can harbor plasmid-mediated ESBL genes and both *E. coli* and *K. pneumoniae* are the most common ESBL positive species [5]. This type of isolates that produces the said enzyme is clinically relevant and remains an important cause of cephalosporin therapy failure [6]. This finding, as supported by Ali et al.[7], is accounted to the said organisms' emerging resistance to agents such as extended-spectrum cephalosporins, monobactams, carbapenems and β -lactam- β -lactamase inhibitor combinations through the production of a variety of β -lactamases, alterations in the penicillin-binding proteins, outer membrane permeability and combinations of multiple mechanisms of resistance [8].

In the current study, *E. coli* is noted to be the most prevalent pathogen isolated in wound and abscess, urine and blood taking into consideration that *E. coli* is a member of the human microbiota that can cause several kinds of nosocomial and community acquired infections [9]. *E. coli* is known to invade urothelial cells and form quiescent intracellular bacterial reservoirs [10]. This is followed by *K. pneumoniae* that causes serious respiratory tract infections and is also one of the frequent pathogen causing urinary tract infections [11]. Both *K. pneumoniae* and *E. coli* remain as the major ESBL producing organism worldwide and are recommended to be tested routinely for ESBL production [12]. This data is also at par with the data of Lenhard-Vidal et al. [9] in Brazil, Jabeen et al.[13] in Pakistan and Ghafourian et al. [14] in Iran.

164 Urine was observed to be the most common specimen source that
 165 contains ESBL producing species in this study. This is because
 166 recurrence of urinary tract infection is common even for a
 167 healthy individual [10] and a common problem of women throughout
 168 their lifetimes [15]. Statistically, urinary tract infection is
 169 the most common bacterial infection that counts for more than 8
 170 million clinic visits and 1 million emergency department visits
 171 each year [16]. Furthermore, urinary tract infection is twice as
 172 common among women of all ages compared with men. Females have
 173 the highest prevalence of ESBL compared to males because of
 174 their short urethra, certain behavioral factors like micturition
 175 and sexual activities [15,17]. Moreover, UTI is also very common
 176 both in the community and hospitalized patients that ranks high
 177 amongst the most common reasons that compel a patient to seek
 178 medical attention [5]. Urinary tract infection can range from
 179 asymptomatic bacteriuria, to symptomatic and recurrent to sepsis
 180 [16].

181
 182 As to age group, the maximum number of ESBL producers were seen
 183 in the adult age group and that the prevalence was more among
 184 the females (the highest) comprising 48% of the 125 ESBL
 185 producing strains. ESBLs-producing gram-negative rods were most
 186 frequent at latter part of life where they were most commonly
 187 infects individual due to exposure to antibiotics and other
 188 factors [18]. The least prevalence was seen in the last two
 189 groups; the pediatric males and pediatric females. Pediatric
 190 males comprise 6% of the total ESBL positive isolates. Out of
 191 125 ESBL positive isolates, only 4% of the pediatric females are
 192 found to be ESBL producers. Hence, the pediatric females have
 193 the lowest prevalence of ESBL as to this study. According to
 194 Paterson and Bonomo [19], the age distribution of β -lactamase
 195 and ESBLs producers among the patients showed high prevalence

among the adult age group. This may be that in the old people often become immune-compromised and stand greater chances of coming down with infections. Such infections are of many types but in patients with low immunity they are more difficult to treat. This may explain the relatively high presence of extended spectrum *beta-lactamase* producers among the aged.

The top 5 antibiotics where ESBL-producing Enterobacteriaceae, showed highest resistance to trimethoprim/sulfamethoxazole (78.4), ampicillin/sulbactam (75%) and ciprofloxacin (74.4%). It is not surprising that antibiotic choice for infections with such ESBL-producing organisms is seriously reduced given the ability of such organisms to hydrolyze many β -lactam antibiotics [19]. This result may have been caused by the frequent antibiotic use over long periods of time which in turn, puts selective pressure on bacteria, and causes resistance to spread. Since many antibiotics are used too often or incorrectly, it is expected that resistance spread faster than it would naturally [20]. Additionally, the three aforementioned antibiotics are considered to be the least effective to use as medications in ESBL-producing organisms because a high resistance rate is an indication that the organism is no longer susceptible to the said drug, making treatment ineffective and null.

Meanwhile, the ESBL-producing organisms were least resistant to amikacin, meropenem, and imipenem. Amikacin had 10.5% resistance rate followed by meropenem with 15.4% resistance rate and imipenem which has 17.1% resistance rate. This is an implication that the organisms in the study were most susceptible to the three aforementioned antibiotics. This finding is also similar to the study of Juayang et al. [8], Maina et al. [6] and Al Muharrmi et al. [21]. Amikacin has good in vitro activity

against ESBL-producing organisms such as *K. pneumoniae* strains [22]. In vitro, the carbapenems have the most consistent activity against ESBL-producing organisms, given their stability to hydrolysis by ESBLs. This implies that ESBLs are generally inactive against the carbapenem antibiotics [19]. With this, Pitout & Laupland[23] and Juayang et al. [8], indicated that carbapenems or amikacin are widely regarded as the drugs of choice for the treatment of severe infections caused by ESBL-producing *Enterobacteriaceae*. Unfortunately however, even though amikacin was noted to be the most effective, it has toxic side effects such as nephrotoxicity and neurotoxicity, making carbapenems and piperacillin/tazobactam as the treatment of choice as of this time [8]. These results are analogous to that of Jabeen et al. [13] which showed results of higher resistance to classes of antibiotics such as aminoglycosides and quinolones and no resistance to carbapenems.

CONCLUSION:

ESBL producing *Enterobacteriaceae* displays high level of antimicrobial resistance that hinders efficacy of cephalosporins and other related drugs, thus, making carbapenem as the drug of choice for treatment. *E. coli* was observed to be the most frequent ESBL producer followed by *K. pneumoniae* that are commonly isolated in urine, wound and abscess, and even respiratory specimens that presents mostly in adults. It is therefore imperative that monitoring of ESBL producing organisms among hospitals to evaluate local status, stricter antimicrobial stewardship and for formulation of policies for empiric therapy.

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