

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

ABSTRACT

Extended spectrum beta-lactamase producing *Enterobacteriaceae* have become widespread among hospitals and even in the community. Such phenomenon poses a therapeutic dilemma against certain antimicrobial drugs that limit therapeutic options. This study was conducted to evaluate the prevalence of ESBL producing *Enterobacteriaceae* in a tertiary hospital in Bacolod City and their antibiotic resistance profile for the year 2014. Out of 662 isolates, 125 (18.89%) were found to be ESBL producing and were frequently seen in *Escherichia coli* (4.96%), *Klebsiella pneumoniae* (4.08%) and *Enterobacter aerogenes* (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 difference 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 becomes 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 US alone, and hundreds of thousands more dying in other areas of the world. Furthermore, studies estimate that 300 million people worldwide are expected to die prematurely because of drug resistance over the next 35 years [2].

One of the major factors in drug resistance is the production of enzymes like the ESBL. According to Rawat et al. [3], ESBL are 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, but has been observed to spread in the community [4]. For the reason that local data is not available, this study was initiated to give baseline information and to 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. 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.

Detection of Extended Spectrum Beta-Lactamase

Screening and confirmatory tests for production of Extended Spectrum Beta-Lactamase (ESBL) were determined using the antibiotic discs Ceftazidime (30 µg), Aztreonam (30 µg), Cefotaxime (30 µg), Ceftriaxone (30 µg), Cefotaxime-clavulanic acid (30/10 µg), and Ceftazidime-clavulanic acid (30/10 µg) as mentioned in the M100-S23 [18]. Screening of ESBL was made by observing the zones of inhibition that are equal to or lower than any isolate with a zone of 22 mm for ceftazidime, 27 mm for aztreonam and cefotaxime, and 25 mm for ceftriaxone. Isolates that fell in the aforementioned screening criteria were then phenotypically confirmed using disc potentiation assay utilizing ceftazidime, cefotaxime, cefotaxime-clavulanate discs, and ceftazidime-clavulanate discs. A 5 mm increase in zone diameter of either antimicrobial agent tested in combination with clavulanate versus the zone diameter of the agent when tested alone confers ESBL production [5].

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* were 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. pneumonia</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 found in urine with 40.8% followed by wounds and abscesses 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
TOTAL	662	125	17

Table 3: Distribution of Bacteria as to Specimen Source

Organism	Urine	Blood	Sputum & ETA	Wound & Abscess	Total
<i>C. freundii</i>	3	3	2	3	11
<i>C. koseri</i>	4	2	1	9	16
<i>E. tarda</i>	4	2	1	4	11
<i>E. aerogenes</i>	15	3	19	20	57

<i>E. cloacae</i>	7	1	5	9	22
<i>E. gergoviae</i>	2	5	3	14	24
<i>E. coli</i>	151	45	10	50	256
<i>E. hermannii</i>	14	1	1	2	18
<i>H. alvei</i>	6	3	3	4	16
<i>K. oxytoca</i>	1	0	1	1	3
<i>K. ozaenae</i>	12	1	7	2	22
<i>K. pneumoniae</i>	35	9	36	27	107
<i>P. agglomerans</i>	15	0	2	11	28
<i>P. mirabilis</i>	8	0	4	21	33
<i>P. penneri</i>	0	0	0	1	1
<i>P. rettgeri</i>	1	0	0	0	1
<i>P. vulgaris</i>	3	0	0	17	20
<i>Salmonella sp.</i>	0	12	0	0	12
<i>S. marcescens</i>	1	1	0	2	4
TOTAL	282	88	95	197	662

122

123 As to the distribution of isolates with regard to specimen
124 source, *E. coli* was still the most common bacteria isolated from
125 urine, wounds and abscesses, and blood specimens while *K.*
126 *pneumoniae* was frequently found in sputum and ETA. Table 3 shows
127 the frequency of the isolated *Enterobacteriaceae* per specimen.

128

129 **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%.

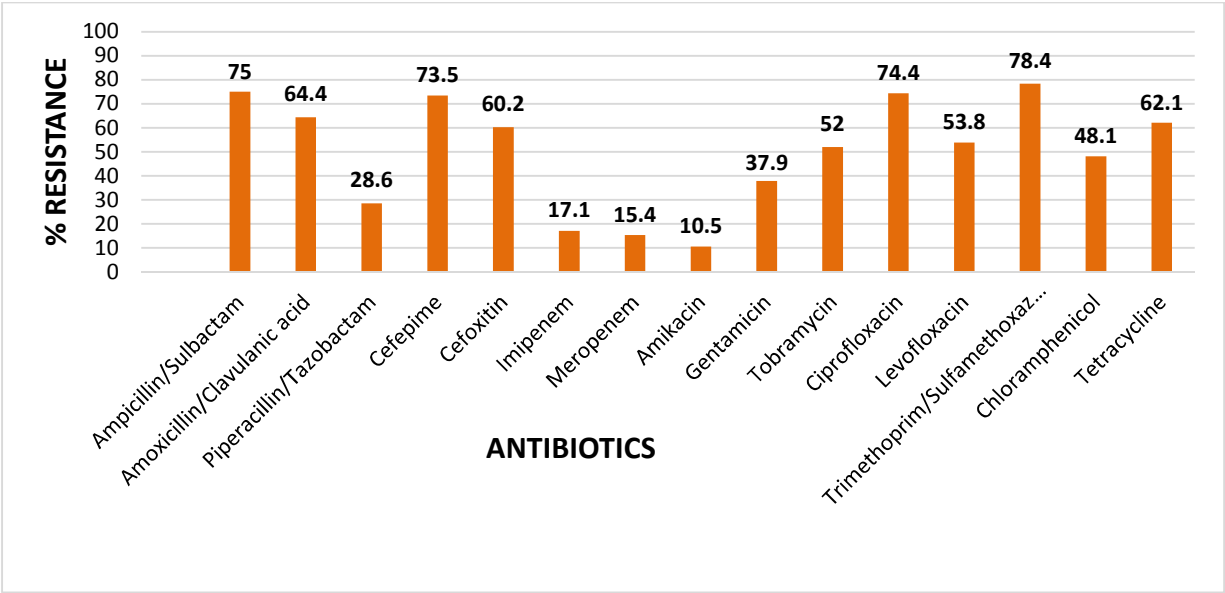


Figure 2: Antibiotic resistance rates (%) of ESBL-producers

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 [6]. This type of isolates that produce the said enzyme is clinically relevant and remains an important cause of cephalosporin therapy failure [7]. This finding, as supported by Ali et al.[8], 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 [9].

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 [10]. *E. coli* is known to invade urothelial cells and form quiescent intracellular bacterial reservoirs [11]. This is followed by *K. pneumoniae* that causes serious respiratory tract infections and is also one of the frequent pathogen causing urinary tract infections [12]. Both *K. pneumoniae* and *E. coli* remain as the major ESBL producing organism worldwide and are recommended to be tested routinely for ESBL production [13]. This data is also at par with the data of Lenhard-Vidal et al. [9] in Brazil, Jabeen et al.[14] in Pakistan and Ghafourian et al. [15] in Iran.

Urine was observed to be the most common specimen source that contains ESBL producing species in this study. This is because recurrence of urinary tract infection is common even for a healthy individual [11] and a common problem of women throughout their lifetimes [16]. Statistically, urinary tract infection is the most common bacterial infection that counts for more than 8 million clinic visits and 1 million emergency department visits each year [17]. Furthermore, urinary tract infection is twice as common among women of all ages compared with men. Females have the highest prevalence of ESBL compared to males because they are more prone to urinary infections, necessitating repeated use of antibiotics [16, 18]. Moreover, UTI is also very common both in the community and hospitalized patients that ranks high amongst the most common reasons that compel a patient to seek medical attention [6]. Urinary tract infection can range from asymptomatic bacteriuria, to symptomatic and recurrent, and finally, sepsis [17].

As to age group, the maximum number of ESBL producers was seen in the adult age group and that the prevalence was more among the females comprising 48% of the 125 ESBL producing strains. ESBLs-producing gram-negative rods were most frequent at latter part of life where they most commonly infect individuals due to exposure to antibiotics and other factors [19]. The least prevalence was seen in the last two groups; the pediatric males and pediatric females. Pediatric males comprise 6% of the total ESBL positive isolates. Out of 125 ESBL positive isolates, only 4% of the pediatric females are found to be ESBL producers. Hence, the pediatric females have the lowest prevalence of ESBL as to this study. According to Paterson and Bonomo [20], the age distribution of β -lactamase and ESBLs producers among the patients showed high prevalence among the adult age group. This

215 may be due to the fact that old people often become immune-
216 compromised and stand greater chances of coming down with
217 infections. Such infections are of many types but in patients
218 with low immunity they are more difficult to treat. This may
219 explain the relatively high presence of extended spectrum *beta*-
220 *lactamase* producers among the aged. [21]

221

222 The top 5 antibiotics where ESBL-producing *Enterobacteriaceae*
223 showed highest resistance against were
224 trimethoprim/sulfamethoxazole (78.4), ampicillin/sulbactam
225 (75%) and ciprofloxacin (74.4%). It is not surprising that
226 antibiotic choice for infections with such ESBL-producing
227 organisms is seriously reduced given the ability of such
228 organisms to hydrolyze many β -lactam antibiotics [20]. This
229 result may have been caused by frequent antibiotic use over long
230 periods of time which in turn, puts selective pressure on
231 bacteria, and causes resistance to spread. Since many
232 antibiotics are used too often or incorrectly, it is expected
233 that resistance would spread faster than it would naturally
234 [21]. Additionally, the three aforementioned antibiotics are
235 considered to be the least effective to use as medications in
236 ESBL-producing organisms because a high resistance rate is an
237 indication that the organism is no longer susceptible to the
238 said drug, making treatment ineffective and null.

239

240 Meanwhile, the ESBL-producing organisms were least resistant to
241 amikacin, meropenem, and imipenem. Amikacin had 10.5% resistance
242 rate followed by meropenem with 15.4% resistance rate and
243 imipenem which has 17.1% resistance rate. This is an implication
244 that the organisms in the study were most susceptible to the
245 three aforementioned antibiotics. This finding is also similar
246 to the study of Juayang et al. [5], Maina et al. [7] and

Muharrmi et al. [22]. Amikacin has good in vitro activity against ESBL-producing organisms such as *K. pneumoniae* strains [23]. 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 carbapenems [20]. With this, Pitout & Laupland[24] and Juayang et al. [5], 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, 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 [5]. These results are analogous to that of Jabeen et al. [14] 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 levels 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. pneumonia* 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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