Prevalence of Environmental Gram-negative Bacilli in the Intensive Care Units of Hospitals from the City of Qom

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1. Background
Nosocomial infections are defined as the infections that appear after 48-72 hours in patients admitted to hospital. These infections are usually transferred through contaminated instruments and equipment, aerosols contaminated with infectious agents, or hospital staff (1-3). Several studies have identified major pathogens of nosocomial infections that can circulate between the patients and the environment and might persist in the environment for a long time and can easily be transferred to the hospital staff hands (2). More than 1.4 million people worldwide suffer from complications of nosocomial infections (4). The report of the World Health Organization (WHO) from 14 countries including 4 WHO regions showed that the average prevalence of nosocomial infections was 8.7% in the hospitalized patients. In this report, the highest frequency of nosocomial infections was recorded from hospitals in the Eastern Mediterranean and South-East Asia regions (11.8 and 10.0% respectively) (5). In addition, in studies that were performed in the hospitals around the world, the rate of nosocomial infection was ranged from 12% to 68% with the average of 32% (6-9). Long duration of hospitalization, use of a variety of maintenance and monitoring devices and use of vascular catheters cause the emergence of nosocomial infections in ICUs. These infections usually interfere with the functions of body organs (10). According to the reports of WHO in high-income countries, nearly 30% of patients in ICU are involved by at least one nosocomial infection. Also, in low- and middle-income countries the prevalence of intensive-care unit acquired (ICU-acquired) infection is 2-3 times more than high-income countries (11). The risk of nosocomial infection in the ICU was 5-10 times greater than those acquired in general medical and surgical wards in the European region (12).

2. Objectives
This study was performed to evaluate the most prevalent Gram-negative bacilli in the environmental surfaces of ICUs and NICUs in the hospitals of the city of Qom.

3. Materials and Methods
3.1. Sampling and data collection
During a 6 month period from November 2012 to April 2013, samples were collected from environmental surfaces of ICUs of four hospitals and NICU of one hospital located in the city of Qom. Sampling was done from equipment, fluids, and surfaces and identification was carried out based on culture and biochemical tests for Gram-negative bacilli.

Results: A total of 230 swab samples was collected and 50 colonies of Gram-negative bacilli were isolated from environmental surfaces. Overall, 64% of the isolates belonged to non-fermentative bacteria and 36% of the isolates belonged to Enterobacteriaceae family. Strains of Pseudomonas aeruginosa and Acinetobacter baumannii complex accounted for the highest rates of environmental isolates. In addition, Klebsiella pneumoniae was isolated from NICU.

Conclusion: The high frequency of genus Acinetobacter among Gram negative bacteria isolated from environmental surfaces has a public health impact and Acinetobacter spp. should be considered in the infection control programs in hospitals. Isolation of K. pneumoniae should be regarded as a risk factor for fatal neonatal infections.

Keywords: Nosocomial infections, Environmental surfaces, Gram-negative bacteria

The role of the hospital environment as a source of dissemination of pathogens is critical. Environmental surfaces in the Intensive Care Units (ICUs) are suitable for the growth of Gram-negative bacteria that normally circulate between the environment and patients and can cause outbreaks of nosocomial infections. In this study, the prevalence of Gram-negative bacilli in the environment of the ICUs and neonatal ICU (NICU) of hospitals in the city of Qom was evaluated.
labor, ventilator, electrocardiogram, and medical imaging devices, fluids and surfaces using a moistened sterile swab from a 10 cm² surface area or 1mL of liquids. Detailed information about each sample, including the name of the hospital, date of sampling, type of surface or equipment/devices was collected in the special data forms.

3.2. Identification of bacterial isolates
Swabs were cultured on Blood agar medium. After incubation at 35°C for 48 hours, colonies were sub-cultured on MacConkey agar for the selection of Gram negative bacteria. Gram-staining of the colonies grown on the MacConkey agar was performed and well-isolated single colonies recovered from agar plate were inoculated into the Triple sugar iron (TSI) agar and the media were incubated at 35°C for 18-24 hours. The TSI test results were used for screening the Gram-negative bacilli; if the organism could not ferment glucose, then an alkaline-salt/alkaline-deep reaction would be observed that indicated nonfermenters; an acid-salt/alkaline-deep or acid-salt/acid-deep reaction was considered as a characteristic of Enterobacteriaceae family. Preliminary identification of the bacteria was done based on colony characteristics of isolation media. Further, to differentiate species of Enterobacteriaceae family, phenotypic characteristics were determined using biochemical reactions, including methyl red (MR), Voges-Proskauer (VP) tests for sulfur reduction, Indole production and motility (SIM), Simmons Citrate Agar (Sc), and presence of lysine decarboxylase, urease, and oxidase. For identification of nonfermenting bacteria other characteristics, including growth at 44°C, oxidase test, urease, lysine decarboxylase, Oxidative-fermentative test (OF) with maltose, mannitol and dextrose, and DNase were measured.

4. Results
A total of 230 swab samples was collected and 50 colonies of Gram-negative bacilli were isolated from environmental surfaces. No colonies of Gram-negative bacilli were isolated from the hands of nurses and from the fluids. Overall, 86% of the isolated Gram-negative bacilli were recovered from environmental surfaces and 14% were recovered from medical equipment. In addition, 64% of the isolates belonged to nonfermenting bacteria and 36% of the isolates belonged to Enterobacteriaceae family. Frequency of species in accordance with ICU and NICU wards is summarized in Table 1.

<table>
<thead>
<tr>
<th>Microorganisms</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acinetobacter baumannii complex</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Acinetobacter spp.</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Klebsiella pneumoniae</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Enterobacter cloacae</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Citrobacter freundii</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Stenotrophomonas maltophilia</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Acinetobacter calcoaceticus</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Enterobacter spp.</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Pantoea agglomerans</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Enterobacter aerogenes</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>NICU</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acinetobacter baumannii complex</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Enterobacter cloacae</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Klebsiella pneumoniae</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Klebsiella oxytoca</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

5. Discussion
Nosocomial infections are a major source of morbidity and mortality in hospitalized patients. Increasing reports of nosocomial infections due to the drug resistant strains of bacteria have drawn much attention in the last decade. Several studies have shown a relation between hospital infections and various Gram-negative pathogens (17-19); Also, contaminated surfaces play an important role in the transmission of prevalent bacteria such as A. baumannii complex and P. aeruginosa (20). It is estimated that 20 to 40% of nosocomial infections occur through the transmission of infection from the hands of hospital staff to the patients (21).

In the current study, the most prevalent Gram-negative bacteria on the surfaces of hospitals were among the non-fermenting group. However, in the study of Fazeli and colleagues (2013), Gram-negative oxidase positive bacteria was the most frequent isolates, while 22.6% of the isolates belonged to the genus Acinetobacter (22). Recent evidences suggest that environmental contamination plays a role in the transmission of Acinetobacter spp. which remains in the environment for a long time and infections might occur through contaminated surfaces of hospital and staff hands (21). In this study, A. baumannii complex and P. aeruginosa were the most common bacteria that were isolated from ICUs. These two species of non-fermentative bacteria have been reported as the most prevalent causes of nosocomial infections in the clinical samples of the patients around the world (20, 23-25). Similar to this result, another study on environmental surfaces of ICUs in India showed that P. aeruginosa and A. baumannii complex was the most prevalent isolated bacteria (26). Also, in a study on water samples of ICU in a hospital in Germany, P. aeruginosa was recovered in 60 (42%) of 143 samples (20).

In this study the frequency of nonfermenting Gram-negative bacilli (64%) was more than that of Enterobacteriaceae (36%). In contrast, in some reports, the frequency of isolated bacteria in the family of Enterobacteriaceae was more than that of nonfermenting bacteria (17). In a study from Iran, the percentage of Gram-negative bacteria of the Enterobacteriaceae family was 9.8%, following by 3.9% of Pseudomonas species and 4.51% of other bacteria (27). Possible reason might be due to the difference in sampling surface (dry vs. moist), since moist surfaces are suitable for the growth of nonfermenting bacteria including Pseudomonas spp.

In this study in the evaluation of NICU, Klebsiella pneumoniae and P. aeruginosa were isolated from different environmental surfaces. In a study on medical equipment, beds and environmental surfaces of NICUs of two hospitals in India, K. pneumoniae was the most predominant organism. In addition, P. aeruginosa and Citrobacter freundii were isolated. Overcrowding, poor ventilation and lack of detailed protocol of nursing were considered as possible reasons (28).

K. pneumoniae is medically the most important species of the genus Klebsiella. Isolation of K. pneumoniae from environmental surfaces in NICU is considered as an important risk factor for the neonatal infections, including sepsisemia, urinary tract infections, pneumonia, and soft tissue infections. It was shown that many outbreaks of K. pneumoniae infections in the NICUs have an environmental reservoir such as the hands of healthcare workers (29-31). Drug resistant K. pneumoniae was the most common isolate causing neonatal sepsis with a high mortality rate (32) and it was reported that 80% of the outbreaks (20/25) due to K. pneumoniae being involved the bloodstream and urinary tract infections, while 50% of these outbreaks occurred in NICU and person-to-person spread was the most common mode of transmission (33).
6. Conclusion
The presence of these bacteria in ICU and NICU increases the risk of transmission to patients leading to nosocomial infections. Successful prevention of the nosocomial infections needs to investigate the sources of environmental contamination and practical ways to prevent the spread of bacteria. The high frequency of genus Acinetobacter among Gram negative bacteria isolated from environmental surfaces should be considered in control programs in hospitals. There is a need for the education of health care workers in the ICU wards on the importance of these bacteria and the modes of spread. Active surveillance of K. pneumoniae in the NICUs is also important to prevent outbreaks.

Conflict of Interests
The authors declare they have no conflict of interests.

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Authors’ Contributions
Farzaneh Mehraban collected the samples; Farzaneh Mehraban and Massoumeh Dolati conducted the laboratory experiments; Masoumeh Douraghi provided laboratory protocols. Mahmoud Nateghi Rostami designed and supervised the study, established laboratory methods, and analysed the data.

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References