Analysis of Intensive Care Units (ICUs) Blood stream Infections (BSI) in Kafkas University Health Research and Application Hospital

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Abstract

**Objectives:** Sepsis is one of the most important cause of admission in Intensive Care Units, probably due to the more severe illnesses of hospitalized patients and to the persistently high incidence of nosocomial infections. However, despite the availability of potential antibiotics and refined supportive care the mortality of septic patients remains high, with overall estimates of about 30% and increasing to 50% when associated with shock. In this study, our aim is to determine retrospectively the epidemiology of blood stream infections occurred in Intensive Care Units of Kafkas University Health Research and Application Hospital and to present the first data from this university hospital.

**Materials and Methods:** Total 1004 blood culture bottle were sent to Microbiology Laboratory of Kafkas University Health Research and Application Hospital between January 2013 to January 2015. All bottles were placed into Automated BACTEC 9050 Blood Culture System. After the positive bottles were detected by machine, the bacteria were identified and antibiotic susceptibility test were performed by using both BD Phoenix Microorganism Identification System and Kirby-Bauer Disk Diffusion method.

**Results:** Total 202 positive samples were detected and the biggest part of total positive samples (n:164, 81.2%) were sent by Internal Intensive Care Unit. The identified bacteria were MRCONS (n:67, 33.2%), MRSA (n:42, 20.8%), MSSA (n:29, 14.3%), E.coli (n:23, 11.3%), P.aeruginosa (n:9, 4.5%), Enterococcus spp (n:9, 4.5%), K.pneumoniae (n:4, 1.9%), Acinetobacter spp (n:1, 0.5%), Proteus mirabilis (n:1, 0.5%), Stenotrophomonas maltophilia (n:1, 0.5%), respectively. Additionally Extended Spectrum Beta-Lactamase (ESBL) were detected as positive in 7 E.coli.

**Conclusions:** Gram negative bacteria are still important. However; in recent years, coagulase negative staphylococci are the most detected bacteria in Intensive Care Units. For this reason, increased MRCONS rate may restrict antibiotic options and lead increasing the usage of glyco- peptides prophylactically. It is necessary to perform active surveillance studies, obey standard infection control measures and develop an appropriate antibiotic policy for decreasing the frequency of resistant microorganisms, due to the changes in microorganism types in ICUs and their antibiotic susceptibilities.

**Keywords:** Intensive Care Units; Blood stream Infections; Epidemiology.

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Introduction

Infection is a major problem for patients in intensive care units (ICUs) [1]. Nosocomial infections occurs in 3-18% of hospitalized patients, with the rates being upto 54% in ICUs [2]. ICU patients are at a high risk for nosocomial infections, 5 to 10 times more than those in general medical clinics [3]. Infections caused by resistant bacteria are frequently seen patients in ICUs because of using of invasive devices (e.g., mechanical ventilators, central venous catheters or urinary catheters), broad spectrum antibiotics, general poor health, long hospital stays [4, 5].

Antimicrobial agents are used in more than 60% of ICU patients for several reasons. Frequent use of antimicrobial agents contributed developing to resistant both of gram positive and gram negative bacteria. Methicillin resistant staphylococcus aureus (MRSA), vancomycin resistant enterococcus (VRE), glycopeptide-intermediate S.aureus (GISA), Extended-spectrum beta-lactamases (ESBL) positive Enterobacteriaceae spp, Azinofluoracetate spp and Pseudomonas aeruginosa are resistant microorganisms that caused various infection by using of antimicrobial agents in ICUs [6]. Especially the use of third generation cephalosporins, fluoroquinolones and carbapenem derivatives play an important role in the development of nosocomial infections caused by resistant bacteria [7].

Nosocomial blood stream infection (BSI) is a important and potentially avoidable complication of hospitalization and is a com-
mon cause of morbidity and mortality [8, 9] Nosocomial BSIs are one of the most frequent and severe infectious complications of hospitalization and medical care. Therefore understanding the origins, treatment and outcomes of nosocomial BSIs is important [10].

Early initiation of convenient antimicrobial treatment is considerable in decreasing morbidity and mortality among patients with BSI [11]. On the other hand using of inappropriate antimicrobial therapy for blood stream infections may be associated with antibiotic resistance. Especially hospital acquired BSIs which are associated with higher hospital mortality rates [12].

Factors of developing nosocomial infections in ICUs might differ between hospitals even in a different ICUs of the same hospital. Furthermore distribution of the pathogenic microorganisms for nosocomial bacteraemia may show change by passage of time [13].

In ICUs of hospitals, understanding trends in infection rates, incidence and proportion among different causative organisms and regular monitoring of antimicrobial drug resistance are important for infection control, determination of prescription and choice of drug for empirical therapy [14].

In this study, our aim is to determine retrospectively the epidemiology of blood stream infections occurred in Intensive Care Units of Kafkas University Health Research and Application Hospital and to present the first data from this university hospital.

Materials and Methods

Study Design

Total 1004 patient samples for blood culture were sent to Microbiology Laboratory of Kafkas University Health Research and Application Hospital from different ICUs of our hospital. Total 202 samples were detected. The biggest part of total positive samples (n:164, 81.2%) were sent by Internal Intensive Care Unit. Other positive samples were isolated from the blood culture which came from different ICUs such as; Surgery Intensive Care Unit (n:22, 10.9%), Cardiovascular Surgery Intensive Care Unit (n:13, 6.4%), Neurology Intensive Care Unit (n:3, 1.5%), (Table 1).

The identified bacteria were MRCNS (n:67, 33.2%), MSCNS (n:42, 20.8%), MRSA (n:29, 14.3%), E.coli (n:23, 11.3%), MSSA (n:16, 7.9%), P. aeruginosa (n:9, 4.5%), Enterococcus spp (n:9, 4.5%), K. pneumoniae (n:4, 1.9%), A. haemolyticus (n:1, 0.5%), Proteus mirabilis (n:1, 0.5%), Stenotrophomonas maltophilia (n:1, 0.5%), respectively (Table 2).

In this study all gram positive bacteria were susceptible to tetracycline, vancomycin and linezolid. Among the MRCNS, the rates of resistance to ciprofloxacin, erythromycin, clindamycin, gentamycin and tetracycline were 68.6%, 77.6%, 70.1%, 53.7% and 41.7% respectively. On the other hand at the MSCNS, ciprofloxacin, erythromycin, clindamycin, gentamycin and tetracy-
cline resistance rates were detected 54.77%, 66.6%, 50.0%, 38.0% and 19.0% respectively. Various antimicrobial resistance rate of MRSA isolates such as ciprofloxacin, erythromycin, clindamycin, gentamycin and tetracycline were 79.3%, 75.8%, 72.4%, 65.5% and 65.5% respectively. Additionally the rates of resistance to ciprofloxacin 31.2%, erythromycin 50%, clindamycin 25%, gentamycin 6.2% and tetracycline 37.5 in MSSA isolated from blood culture (Table 3).

In the present study among the E. coli, the rates of resistance to ampicillin, amoxicillin clavulonic acid, piperacillin tazobactam, ceftazidime, ceftriaxone, cefepime, ciprofloxacin, trimethoprim sulfamethoxazole, gentamicin, amikacin imipenem and meropenem were 86.9%, 21.7%, 17.3%, 43.4%, 56.5%, 30.4%, 43.4%, 34.7%, 17.3%, 0%, 8.0% and 4.3% respectively. Additionally Extended-Spectrum Beta-Lactamase (ESBL) were detected as positive in 7 E. coli. On the other hand the rates of resistance to piperacillin tazobactam 33.3%, ceftazidime 55.5%, cefepime 44.4%, ciprofloxacin 44.4%, gentamicin 22.2%, amikacin 11.1%, imipenem 11.1% and meropenem 0.0% in P. aeruginosa isolated from blood culture (Table 4).

### Discussion

#### Table 3. Antimicrobial resistance rates of gram positive bacteria isolated from blood culture in ICUs (%).

<table>
<thead>
<tr>
<th></th>
<th>MRCNS</th>
<th>MSCNS</th>
<th>MRSA</th>
<th>MSSA</th>
</tr>
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<tbody>
<tr>
<td>Ciprofloxacin</td>
<td>68.60%</td>
<td>54.77%</td>
<td>79.30%</td>
<td>31.20%</td>
</tr>
<tr>
<td>Erythromycin</td>
<td>77.60%</td>
<td>66.60%</td>
<td>75.80%</td>
<td>50%</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>70.10%</td>
<td>50.00%</td>
<td>72.40%</td>
<td>25%</td>
</tr>
<tr>
<td>Gentamycin</td>
<td>53.70%</td>
<td>38.00%</td>
<td>65.50%</td>
<td>6.20%</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>41.70%</td>
<td>19.00%</td>
<td>65.50%</td>
<td>37.50%</td>
</tr>
<tr>
<td>Teicoplanin</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Vancomycin</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Linezolid</td>
<td>0%</td>
<td>0%</td>
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</tbody>
</table>

#### Table 4. Antimicrobial resistance rates of E.coli and P. aeruginosa isolated from blood culture in ICUs (%)

<table>
<thead>
<tr>
<th></th>
<th>E.coli</th>
<th>P. aeruginosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ampicillin</td>
<td>86.9%</td>
<td>-</td>
</tr>
<tr>
<td>Amoxicillin clavulonic acid</td>
<td>21.7%</td>
<td>-</td>
</tr>
<tr>
<td>Piperacillin tazobactam</td>
<td>17.3%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Ceftazidime</td>
<td>43.4%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>56.5%</td>
<td>-</td>
</tr>
<tr>
<td>Cefepime</td>
<td>30.4%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>43.4%</td>
<td>44.4%</td>
</tr>
<tr>
<td>Trimethoprim sulfamethoxazole</td>
<td>34.7%</td>
<td>-</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>17.3%</td>
<td>22.2%</td>
</tr>
<tr>
<td>Amikacin</td>
<td>0.0%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Imipenem</td>
<td>8.6%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Meropenem</td>
<td>4.3%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
Blood stream infection (BSI) is a serious problem in hospitals because of leading to morbidity and mortality in the world [15, 16]. BSI can be seen primary or secondarily. The cause of these infections may be another localized infection at different body regions. Focus of infection are not identified at primary BSIs. Likewise BSIs are frequently seen in ICUs and associated with multisystem organ dysfunction, severe sepsis and septic shock. Therefore early suitable antimicrobial therapy and blood culture results are very important for patients with BSI [17].

Over the past 30 years, frequency of bacteraemia, etiology and epidemiology have occurred some changes especially among patients requiring intensive care treatment. The most frequently isolated pathogens in the 1970s were gram-negative bacteria but gram positive cocci began to come to the fore in the 1980s and 1990s [13]. Additionally the incidence of pathogens isolated from blood cultures may vary over the years. In study of Starnes et al, changing microbial trends was investigated among the six years period in the surgical intensive care unit. In this study, when blood culture results were evaluated, frequency of the Enterococcus species were decreased over time. In contrast, the incidence of oxacillin-resistant Staphylococcus aureus (ORSA) isolated from blood cultures was found to increase in later years [18]. In our study, the most isolated pathogens from blood culture were gram positive cocci, MRCONS, MSCNS, MRSA, MSSA, 33.2%, 20.8%, 14.3%, 7.9% respectively, different ICUs of our hospital. Several studies on this subject shows that vary the distribution of infection in the ICUs between hospitals and countries. In study of Laupland et al, total of 244 isolates were investigated from isolated to ICU acquired blood stream infections. They reported that gram positive cocci predominate as pathogens in the Calgary health region and detected major species were S. aureus, coagulase negative staphylococci and E. faecalis, 18%, 11% and 8% respectively [19]. In another study conducted in Estonia [20], they reported that Pseudomonas spp., CNS and Candida spp. isolated from blood stream infections was considerably more prevalent among ICU than non ICU cases. Also in this study, S. aureus and E.coli isolated from blood stream infections were detected more frequently in non ICU patients than ICU cases [20]. In another study conducted, 2846 positive samples isolated from blood cultures in ICU at a tertiary care hospital in North India were analysed by Wattal et al. [21] and in their study CNS was the most prevalent pathogens isolated from blood cultures in ICU patients followed by Candida spp. in 20.3% and 17.5% respectively. It was reported that the most commonly isolated pathogens were Klebsiella spp. followed by Acinetobacter spp. among gram negative bacilli [21].

Consequently, in our study we detected that CNS is the most common pathogens isolated from blood culture in ICU at our hospital. This result is found consistent with other studies [20-22]. CNS is member of the indigenous microbiota of healthy peoples. Hospitalized patients often become colonized with CNS as a result of its presence in the patient’s flora and hospital environment. Therefore when these microorganisms are detected in blood cultures, it should be examined for the purpose of pathogen or contamination. Because of difficult to make this distinction, clinicians should be warned for rules must be followed when the blood cultures are taken from patients [13]. If only one of blood cultures was positive, it was evaluated as contamination. It is considered as pathogen, if same microorganism is detected from two or more blood cultures or if microorganisms is isolated from another infectious focus (urine, sputum or wound) in addition to blood culture [23].

Bacteremia is an independent risk factor for mortality of patients in ICUs. Early initiation of appropriate antimicrobial therapy of blood stream infection with guidelines and previous knowledge is very important. Therefore initiation of empiric treatment with targeting etiologic pathogens is necessary for reduction of morbidity and mortality of patients with blood stream infection. Furthermore patients should be treated with broad spectrum antimicrobial agents when presence of risk factors of antibiotic resistance in cases with a serious infection. On the other hand using of inadequate antimicrobial therapy for blood stream infections cause to antibiotic resistance in pathogen microorganisms. Considering the insufficiency of new antimicrobial agents in the pharmaceutical industry and development of resistance to available antibiotics, restrict the choice of antibiotics for treatment of infections and the success of treatment is decreasing [17].

Multidrug resistant microorganisms including, MRSA, carbapenem resistant Enterobacteriaceae, VRE, non-fermenters pathogens and non-albicans Candida spp. are caused to blood stream infection in ICU patients. In study of Wattal et al found that in CNS strains the resistance rates topenicillin, oxacillin, clindamycin, gentamicin and vancomycin were 99.5%, 94%, 80%, 72% and 0% respectively. Also in this study resistance of S. aureus strains for these antimicrobial agents were detected as 100%, 47%, 49%, 56% and 0% respectively [21]. In our study, among the MRCNS, the rates of resistance to ciprofloxacin, erythromycin, clindamycin, gentamycin and tetracycline were 68.6%, 77.6%, 70.1%, 53.7% and 41.7% respectively. Additionally the rates of resistance to ciprofloxacin 79.3%, erythromycin 75.8%, clindamycin 72.4%, gentamicin 65.5% and tetracycline 65.5% in MRS isolates from blood culture in ICU patients. In this study, we observed that MRSA and MRCNS strains had significantly higher resistance than MSSA and MSCNS strains. In our study, there was no resistance to teicoplanin, vancomycin and linezolid in all gram positive bacteria including S. aureus, CNS and Enterococcus spp.

E. coli and P. aeruginosa for Gram negative are important in blood-stream infections of ICU patients at this and another studies [3,13,17,19,21]. In our study, especially beta-lactam group of antibiotics, we found high resistance rates in microorganisms isolated from blood culture in ICUs (Table 4).

Conclusion

In conclusion, gram negative bacteria are still important. However, in recent years, coagulase negative staphylococci are the most detected bacteria in Intensive Care Units. For this reason, increased MRCNS rate may restrict antibiotic options and lead increasing the usage of glyco-peptides prophylactically. It is necessary to perform active surveillance studies, obey standard infection control measures and develop an appropriate antibiotic policy for decreasing the frequency of resistant microorganisms, due to the changes in microorganism types in ICUs and their antibiotic susceptibilities.

References


