Isolation and Identification of Enterobacteriaceae from Patients with Community Acquired Urinary Tract Infection

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Abstract: The study was carried out in red sea state during the period from November 2013 to March 2014 to investigate the Enterobacteriaceae from patients suffering from community-acquired urinary tract infections and then do sensitivity test for each of isolates. In this study out of 100 specimens 52 Enterobacteriaceae species were isolated from different clinics and hospitals in Port Sudan city. The specimens were cultured on CLED media (cystine-lactose electrolyte deficiency). Identification was done by gram's stain and conventional biochemical reactions. Then the anti-microbial sensitivity tests were done as the follows: (Ampicillin-Sulbactam "AS", Co. trimoxazole "BA", Ceftriaxone "CI", Chloramphenicol "CH", Cephalaxin "PR", Tetracycline "TE", Ciprofloxacin "CP", Amikacin "AK", Sparfloxacin "SC", Gatifloxacin "GF", Norflaxcin "NX) by Kirby-Bauer disc diffusion method. The study revealed that the most part of strains are sensitive to Chloramphenicol and Amikacin and resistant to Ampicillin –Sulpectam (AS). The identified Enterobacteriaceae were as follows: Escherichia coli 34 (65%), Klebsiella pneumonia 10 (19%), Klebsiella oxytoca 3 (6%), Salmonella Para A 3 (6%), proteus mirabilis 1 (2%), Citrobacter 1 (2%).

Keywords: Enterobacteriaceae, Urinary Tract Infections, Escherichia Coli, Red Sea State

1. Introduction

Urinary tract infection represents one of the commonest bacterial infections. The Enterobacteriaceae are the most frequent pathogen detected, causing most of the urinary tract infection, Enterobacteriaceae are a group of largest, most heterogeneous collection of medically important gram –ve bacilli, being found worldwide in soil, water and are part of the normal flora in the intestine of most animal and human this family include many genera such as(Escherichia, Coli, Klebsiella, salmonella …etc). These days the main cause for concern among Enterobacteriaceae especially that cause community acquired infection is Escherichia coli. [1].

A urinary tract infection (UTI) is a condition in which one or more parts of the urinary system (the kidneys, bladder, and urethra) become infected. Although some cases of UTI are due to fungus or a virus, most are caused by one of several types of bacteria most cases of UTIs are caused by bacteria that typically multiply at the opening of the urethra and travel up to the bladder. Much less often, bacteria spread to the kidney from the bloodstream [1].

The urinary system helps maintain proper water and salt balance throughout the body and also expels urine from the body. The symptoms of urinary tract infections result from the presence and growth of bacteria or other microorganisms in the urinary tract. The urinary tract is normally a sterile environment. The bacteria, in some cases, can get flushed up into the kidneys and therefore can cause a kidney infection. Both kidney and bladder infections are more common in women because their urethras are shorter than men, making it easier for organisms to get from outside into the bladder. Most typically, a woman develops a UTI if she has been
sexually active, (hence the moniker "honeymoon cystitis"),
or has been careless with her hygiene habits (for example,
wiping from back to front after a bowel movement) [2].

Early recognition of bacteremic UTI and prompt,
appropriate treatment are critical in reducing the mortality. A
diagnosis of a urinary tract infection can easily be missed or
delayed in the elderly. This is because some symptoms, such
as fatigue and weakness, may not be noticed or might be
associated with aging. Also the extensive and inappropriate
use of antimicrobial agents has increasingly resulted in the
development of antibiotic resistance which, in recent years,
have become a major problem worldwide. Physicians can
provide empirical treatment without the benefit of a pre-
therapy urine culture. The extensive and inappropriate use of
antimicrobial agents has invariably resulted in the
development of antibiotic resistance which, in recent years,
have become a major problem worldwide. For example
Quinolones which are one of the most widely used antibiotics
in the community for the treatment of UTI, the unfortunate
excessive use of this agent that has led to a considerable and
worrying increase in the rate of E. coli resistant isolates in
many countries, and this is just a start because as more
patients use antimicrobial drugs without pre-therapy
culture more resistant bacteria will gain. [2].

Urologists have tended to ignore the clinical importance
and urologic realities of community-acquired urinary tract
infections (UTIs) despite their significant prevalence, cost,
morbidity, and increasing management problems. This is
primarily because of our perception that uncomplicated UTIs
are common but not a serious problem (patients do not die
from uncomplicated UTIs), easy to diagnose (simple
midstream urine culture), and simple to treat (short course of
antibiotics). Nevertheless, data on increasing prevalence,
cost, morbidity, antibiotic resistance, recurrence, and relapse
suggest that the urological community needs to have another
look at community-acquired UTIs. [3].

This study aimed to determine the frequency of isolated
Enterobacteriaceae, and antimicrobial susceptibility of
uropathogens in culture-positive community-acquired UTIs
over a 3 months period, community-acquired UTIs over a
four months period in order to understand the pathogenesis of UTI which may lead to better methods of
prevention and treatment. [3].

2. Materials and Method

2.1. Study Approach

Study approach is to identify and isolate the possible
causative organisms and the characterization of isolated
strains using bio typing and antibio gram.

2.1.1. Study Type and Design

Cross-sectional descriptive study.

2.1.2. Study Area

The study area is different hospitals and clinics in Red Sea
state.

2.1.3. Study Period

During the period from November 2013 to March 2014

2.2. Methodology

2.2.1. Sample Size and Collection

According to standard method all specimen were examine
to detect, and identify pathogens or their products using:
microscopic examination of specimen to detect their motility,
morphology and staining reaction. Also culture techniques to
isolate pathogens in pure form and to identify them then test
their antibiotic sensitivity and biochemical.

a. Sampling

Samples for community acquired UTI to investigate and
diagnosis of microbial diseases (urine specimen).

b. Urine Specimens (100 Samples)

Urine specimens were collected in case of urinary tract
infection as following. A mid stream urine is obtained in a
sterile container after cleaning the external genitalia with tap
water and drying. Samples should reach the laboratory within
one hour after voiding or kept refrigerated at 4°C to avoid
multiplication of bacteria in urine then we do appropriate test
to identify and isolate the causative organisms.

2.2.2. Cultivation of Specimens

Urine specimens were inoculated onto CLED medium by
using sterile loop, then incubated aerobically at 37°C over
night.

2.2.3. Examination of Bacterial Growth

The primary culture on CLED medium that showed
significant growth was examined for fermentation. The
morphological character, size, shape, colour were observed
and recorded.

2.2.4. Interpretation of Culture Growth

The culture growth obtained was interpreted as significant
(>10^5 CFU/ml). Cultured of less than (10^3 CFU/ml) of urine
was considered insignificant, while culture with no growth
were considered negative. Significant cultures were further
investigated.

2.2.5. Purification of Bacterial Growth

The isolates were streaked onto Nutrient agar and
incubated overnight at 37°C. The resultant growth was
checked for purity and stored in Bijou bottle for further
test.

2.2.6. Identification of the Isolated Bacteria

I. Colonial Morphology

Colonial characteristic were observed on CLED medium
after overnight incubation isolated organisms were growth on
CLED medium.

II. Biochemical Tests (Conventional Test)

These are called biochemical tests because they are tests
which identifythe bacteria on the basis of the presence of
certain enzymes and other biochemical properties.
III. Kliglar Iron Agar

This medium was originally designed as a multi-test medium. It provides a low degree of sensitivity for H2S production (often required when differentiating members of the Enterobacteriaceae). The medium is now used principally as a standard test for H2S. One disadvantage of multitest media is that chemical interaction—in this case acid production from fermentable sucrose—may inhibit blackening of the iron indicator. Some Citrobacter and Proteus species have this ability. KIA agar should be used in conjunction with a urease test to eliminate Proteus spp when screening for Salmonellae.

IV. Citrate Utilization Test

This is for the ability of an organism to utilize citrate as the sole carbon and energy source for growth and an ammonium salt as sole source of nitrogen.

V. Indole Test

This test demonstrates the ability of certain bacteria to decompose the amino acid tryptophan to indole, which accumulates in the medium. Indole is then tested for by a colorimetric reaction with p-dimethylaminobenzaldehyde. Add 0.5ml kovacs reagent to see result.

VI. Urease Test

Bacteria, particularly those growing naturally in an environment exposed to urine, may decompose urea by means of the enzyme urease. The occurrence of this enzyme can be tested for by growing the organism in the presence of urea and testing for alkali production by means of a suitable pH indicator. An alternative method is to test for the production of ammonia from urea by means of Nesslers reagent.

VII. Motility Test

In semi solid agar media, motile bacteria (Swarm) and give a diffuse spreading growth that is easily recognized by the naked eye. Motility may thus be detected more easily than by themicroscopical method.

VIII. Antimicrobial Sensitivity Test

All isolated microorganisms were subjected to antimicrobial sensitivity test using Modified Kirby-Bauer disc diffusion method [10].

3. Results

One hundred urine specimen were collected from patients suffering from UTI during the period from November 2013 to March 2014. Out of 100 patients (52%) were positive, while (48%) were negative. Among the positive growth 4 of them were NLF organisms (8%), and 48 (92%) were L. F organisms (Table 1).

The most frequent patients were female (75%), 38 of them were positive culture and the male were less frequent (25%) only 14 of them were positive culture (Figure 1).

The isolated Enterobacteriaceae were as followed: Escherichia coli 34 (65.4%), Klebsiella pneumonia 10 (19.2%), Klebsiella oxytoca 3 (5.7%), Salmonella Para A 3 (5.7%), proteus mirabilis 1 (2%), Citrobacter 1 (2%) (Figure 2).

For female patient the age ranged from (one year to 10 years) one patient showed positive culture, 4 urine culture were positive from the ages (11 to 20 years). Seven urine culture were positive from the ages of (21 to 30 years). From the age of 31 to 40 years old 13 of them were positive urine culture and this is the most predominant ages infected with Enterobacteriaceae, from (41 years old to 50 years) 9 patients were positive urine culture and more than (50 years) only 4 patients were positive urine culture (Figure 3).

For male patients the ages ranged from (one year to 10 years) one patient was positive urine culture, from the ages of (21 to 30 years) 4 patients were positive for urine culture, from (41 years to 50 years) 4 patients were positive for urine culture. More than (50 years) represent the most frequent infection in male (Figure 4).

The result of antimicrobial sensitivity tests revealed in (Table 2) and (Figure 5).

![Figure 1. Distribution of specimen according to gender and the number of positive culture for each gender.](image_url)
Table 1. Significant and insignificant growth.

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<th>Total Number of specimens</th>
<th>Significant growth (%)</th>
<th>Insignificant growth (%)</th>
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<td>48%</td>
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<td>4 specimens</td>
<td>8%</td>
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<td>48 specimens</td>
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Figure 2. Distribution of specimen according to gender and the number of positive culture for each gender.

Figure 3. Percent of each isolated Enterobacteriaceae.
Figure 4. Distribution of female specimens according to ages and positive culture.

Figure 5. Distribution of male specimens according to ages and positive culture.

Table 2. Number and percentage of antimicrobial sensitivity tests (S=sensitive, R=resistance).

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<th>CH</th>
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4. Discussion

This study was conducted to determine the main \textit{Enterobacteriaceae} caused infection in community acquired UTI patient and the antimicrobials sensitivity test. The results revealed that the lactose ferment \textit{Enterobacteriaceae} type represent (92\%), while non lactose fermented organisms represent (8\%) and this result agreed with the result obtained by Panahi Y., \textit{et al.} [4]. The ratio between male to female is 1:3, 25\% --75\% respectively this result is nearly similar to result 1:2 report by Sharifian \textit{et al.} [5].

The result showed that UTI cases among female of age group (31-40 years) were found more susceptible to UTI (33.4\%), that agree with results obtained by Orret and Shurland [6]. In the present study the most prevalent organisms were \textit{E.coli} (65.4\%) of all \textit{Enterobacteriaceae} isolated, this result agree that obtained by Ekweozor and Onyemenen [7], who showed that \textit{E.coli} account (62\%), the followed organism is \textit{Klebsiella Spp} this result is similar to that obtained by Gupta K., \textit{et al.} [8]. In our study the elder males (over 50 years) are more susceptible to UTI this result agree with a result obtained by Torkaman M., \textit{et al} [9]. In the present study the anti microbial sensitivity test demonstrated that Ampicillin- Sulbactam (21.2\%) and Tetracycline (36.5\%) are the lowest active agent, While Chloramphenicol (96.2\%) and Amikacin (92.3), are the highest active agent this result confirmed the resultobtained by Modarres \textit{et al}, [7].

On other hand, the result showed that \textit{E.coli} was more susceptible to Chloramphenicol (100\%), Amikacin (97\%) and Gatifloxacin (97\%), respectively, this results disagree with a result obtained by (Sharifian \textit{et al} [5], who found that \textit{E. coli} was most sensitive to Ceftizoxime.

5. Conclusions and Recommendations

5.1. Conclusions

I. The most prevalent organism in UTI infections is \textit{E.coli}.
II. Female are more susceptible to UTI than male.
III. Ages from 31-40 are the most infected among female.
IV. Men whom ages more than 50 are more susceptible to UTI than other ages.
V. Chloramphenicol and Amikacin are the highest active agents in most strains.
VI. Ampicillin-Sulbactam is the lowest active antimicrobial agents due to high resistant rate.
VII. Resistance rate of \textit{Enterobacteriaceae} increased to commonly used antimicrobial agents.

5.2. Recommendations

a. Urine specimen should investigated for culture and susceptibility test before giving the patient any therapy to decrease the resistant rate among organisms causing community acquired UTI.
b. Increase awarenessabout the hazards of using antibiotic for treatment without pre -therapy culture and how bacteria gain resistant among people with UTI infection.
c. Uses of API 20 E are recommended for investigation of all \textit{Enterobacteriaceae} in Microbiology lab for more accuracy.
d. Establishment of antimicrobial policies and treatment guidelines.
e. Uses of Chloramphenicol and Amikacin as routine treatment for community acquired UTI infections.
f. In depth studies by using modified technique (molecular methods) for precision and accuracy is recommended.
References


