Original Research Article

Antibiotic Susceptibility profile and prevalence Pattern of of Gram negative pathogens in Tertiary Care Hospital

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Abstract

Background and objective

Large amounts of antibiotics consumed by the human population has resulted in the culmination of pathogenic bacteria resistant to multiple drugs. The resistance profile of pathogens differ from one geographical location to another and keeps on changing continuously.

Methods

A retrospective observational analysis of antibiogram data was performed to characterize the susceptibility pattern of different pathogen isolates from various clinical sources. A total of 213 clinical isolates identified from the period June 2015 to June 2016 were included in the study.

Results

Of the 213 Gram negative isolates, 36.6% were from urine, 23.9% from respiratory specimens, 11.74% from blood, 10.33% from pus whereas 17.37% were from other sources. *E. coli* (42.25%) was most predominant pathogen isolated followed by *K. pnuemoniae* . (25.35%) and *Pseudomonas spp.* (15.96%) while other Gram negative pathogens contributed 16.4%. Antibiogram analysis has shown CSE-1034 as the most susceptible drug exhibiting 91.1%, 77.8%, 82.4% and 82.3% susceptibility against *E. coli, K. pneumoniae*, *A. baumannii* and *P. aeruginosa*. Among carbapenems, both meropenem and imipenem-Cilastin were most effective against *E. coli*. Meropenem was least effective against *K. pneumoniae* (50%) and imipenem against *P. aeruginosa* (32.35%). Like imipenem, Piperacillin-Tazobactam was highest effective against *E. coli* (20%) and lowest against *P. aeruginosa* (26.47%).

Conclusion

Susceptibility profile indicates CSE-1034 (a novel antibiotic resistance breaker) as the most effective ~~susceptible~~ drug among all the classes of antibiotics against the Gram-negative pathogens. A high resistance to piperacillin-tazobactam and penems, advocates use of CSE-1034 as empiric drug of choice in treatment of bacterial infectious diseases where the pathogen isolates are suspected resistant towards β-lactam and β-lactamase inhibitor combinations.

Keywords: Antibiotic, Clinical isolates, CSE-1034, Prevalence, Susceptibility, Resistance.

1. Introduction

The emergence of resistance among pathogenic bacteria towards potent antimicrobial agents has become a critical problem in modern medicine [1]. WHO has warned that the level of resistance to drugs used to treat common infectious diseases is arriving at a crisis point and if not controlled, entire population could be wiped out by these superbugs [2]. The developing resistance towards currently available drugs increases the economic burden on the community by increasing the rates of hospitalization, length of hospital stays and cost of treatment [3] [4][5]. The rising antimicrobial resistance among the most common opportunistic Gram negative pathogens, are also associated with increased mortality and morbidity rates [2].

β-lactam antibiotics used to be the most common treatment for bacterial infections but the constant exposure of bacteria to β-lactams drugs has created a selective pressure leading to ESBL and ~~MBL~~ carbapenemase producing strains including MBLs. [6]. In past few years, a significant increase in the prevalence of ESBL ~~, MBL and~~ and Carbapenemase producing strains including MBLs has been observed throughout the

74 globe [7]. These beta-latamase producing Gram-negative pathogens are reported resistant
75 to other classes of antibiotics also [12,13].
76 Taking into account such a situation, there is a need to optimize the antibiotic therapy
77 against multidrug-resistant pathogens which may vary from one geographical locale to
78 another. Surveillance data and hospital antibiogram profiles help clinicians in the
79 prescription of appropriate antimicrobial therapy. Therefore, we aimed to study the
80 susceptibility profile of clinical isolates collected from Noble Hospital, Pune towards
81 commonly used 2nd line antibiotics including Ceftriaxone/Sulbactam/EDTA, β-lactam and
82 β-lactamase inhibitor combination (Piperacillin-tazobactam) and Carbapenems
83 (meropenem and imipenem-cilastatin) drugs.

84 **2. Materials and Methods**

85 ***2.1 Sample collection***

86 Various clinical specimens used for pathogen isolation included urine, stool, blood, pus,
87 endotracheal tube secretions (ETT), tracheal tube (TT) secretions, sputum, wound, , gall
88 bladder specimens, abscess, drain, ear swab, vitreous eye, abdominal fluid, vitreous fluid,
89 semen, peritoneal fluid and tissue specimens collected from 347 infected patients at Noble
90 Hospital, Pune (India), during the period of July 2016 to February 2017. The collection
91 and processing of the samples were done as per common standard operating procedures of
92 hospital.

93 ***2.2 Isolation and Identification of microbes***

94 All the samples were collected aseptically in sterile containers and inoculated on the
95 different selective and non-selective culture media as per the standard microbiological
96 techniques. Details of the culture media used for the isolation of pathogens from various
97 clinical samples are given in Table 1. Blood samples were collected in Bactec bottles and
98 incubated in Bactec machine. These samples were further sub-cultured on the selective or

non-selective media and incubated aerobically overnight at 37°C. Organisms were identified on the basis of colony morphology, gram staining, motility and biochemical reactions. Biochemical reactions were performed by inoculating the bacterial colony in a nutrient broth at 37°C for 2– 3 hours [15].

The identification of pathogenic *E.coli* in stool was done by PCR method.

2.3 Antibiotic susceptibility testing

Antimicrobial susceptibility study was performed by Kirby–Bauer disk diffusion method as recommended by the Clinical Laboratory Standards Institute (CLSI) guidelines [16]. In brief, inoculum of 0.5 McFarland standards turbidity was prepared in a Mueller-Hinton broth (MHB, Hi-Media, Mumbai, India) from isolated colony of pathogens selected from 18–24 hour agar plates. A sterile cotton swab was dipped into the inoculum and streaked many times on the dried surface of a Mueller-Hinton agar (MHA) plate. After 5 minutes, antibiotic discs were applied and pressed down to check absolute contact with agar surface. The discs were apportioned in a minimum distance of 24 mm from the center. The plates were then incubated for 16-18 hrs aerobically at 37° C. The discs of meropenem (10 µg), imipenem-cilastatin (20 µg) and piperacillin-tazobactam (110 µg) were obtained from Microexpress Goa, India and CSE-1034 (45 µg) was obtained from third party.

For sensitivity of Imipenem-Cilastatin combination, we refer to the zone diameter chart given for Imipenem in CLSI guidelines.

Breakpoints for CSE-1034: Enterobacteriaceae; >23mm - S, 20–22-I, and ≤19-R and Gram-negative bacilli; >21 mm - S, 14–20-I, and ≤13-R.

3. Results

A total of 347 clinical specimens were obtained from the suspected patients out of which 213 (61.38%) clinical samples tested positive for Gram negative pathogens. Out of

these 213 Gram negative isolates, the maximum isolates were obtained from urine specimens (36.62%) followed by respiratory specimens (13.62%), blood (11.74%), pus (10.33%) and wound (6.10%) while all other samples contributed a total of 6.58% (Table 2).

On the basis of morphological and biochemical screening, eight bacterial species were obtained including *E. coli*, *K. pneumoniae, P. aeruginosa*., *A. baumannii*, along with other less prevalent Gram negative bacilli such as *Proteus spp.*, *Salmonella spp.*, *Serratia spp*. and *Enterobacter spp*. which contributed 8.45% (% cumulatively) to the total clinical isolates. The detailed profile of various pathogens isolated from clinical specimens is shown in Table 3.

Table 2 represents the prevalence of different clinical isolates in different samples. Data revealed the maximum prevalence of *E. coli* in urine samples, pus and stool samples. *K. pneumoniae* was mostly isolated from blood and respiratory specimens whereas *P. aeruginosa* isolates were mostly retrieved from wound and respiratory specimens. *A. baumannii* was least prevalent in all the specimens.

Susceptibility profile of pathogens isolated from clinical specimens is presented in Table 4. Overall, 85.4% (182) of the total number of isolates were reported susceptible to CSE-1034, 59.6% (127) to Pip-taz, 66.2% (141) to Meropenem and 64.8% (138) to Imipenem. The susceptibility rates of CSE-1034 were *E. coli* (91.9%), *K. pneumoniae* (77.8%), *A. baumannii* (82.4%) and *P. aeruginosa* (82.3%). Among all the antibiotics tested, the least susceptibility was reported to Pip/Taz. *E. coli* exhibited the highest susceptibility (80%) to Pip-taz whereas the lowest was reported by *P. aeruginosa* (26.47%). Among Carbapenems, almost similar activity of meropenem and imipenem-cilastin was reported against *E. coli* (77-82%) and *K. pnuemoniae* (48-50%). The meropenem was marginally better than imipenem-cilastin against *A. baumannii* (58.8% vs

52.9%) whereas was reported significantly better than imipenem-cilastin against *P. aeruginosa* (58.8% vs 32.3%).

4. Discussion

The predominant species isolated was *E. coli* (42.2%) followed by *K. pneumoniae* (25.3%). A good number of studies have reported *E. coli* and *K. pneumoniae* as most common and opportunistic clinical pathogens [17, 18]. Similar results with high prevalence of *E coli* (54.9%) were reported by Sikka *et al.* [19]. Sachdeva [20] has also reported the prevalence of *E. coli* to a tune of 51.7%. A similar prevalence of *K. pneumoniae* has been reported by Makkar *et al.* [21] who demonstrated 22% of *K. pneumoniae* from clinical isolates. Sahu *et al.* [22] reported the prevalence of *K. pneumoniae* to a tune of 32% which sustains our data. *Pseudomonas spp*. (15.9%) also contributed significantly to the isolated pool of pathogens. As compared to other studies, less number of *A. baumannii* isolates were identified in this study. The similar prevalence pattern of *Proteus spp.*, *Salmonella spp.*, *Serratia spp.* and *Enterobacter spp* is also reported by many other studies. [17, 24, 25]

Similar to our observations, Ruppe *et al.* [14] have also reported 90% prevalence of *E. coli* in stool samples. Majority of *E. coli* (54%) isolates were recovered from urine during the study performed by Kumar *et al.* [17]. Ibrahim *et al.* [26] have also reported 40-50% prevalence of *E. coli* in pus samples. *K. pneumoniae* isolates were mostly isolated from blood and respiratory specimens whereas *P. aeruginosa* was mostly isolated from wound and respiratory specimens.

Among all the antibiotics tested, the least susceptibility was reported to Pip/Taz and highest was reported towards CSE-1034. A high rate of resistance observed to Pip/taz which

is normally recommended second line of treatment in our hospital could be possibly the indiscriminate consumption of pip-taz. The AMR surveillance study conducted in India has shown resistance against pip-taz has risen to 65-70% [19]. Among carbapenems, the average susceptibility rates were 65% against all the pathogen isolates. The emergence of carbapenem-resistant strains, which ranges from 18-68% in different isolates is a matter of big concern as carbapenems are considered as the last resort drugs for MDR bacterial infections. Singh *et al*. [11] have reported that MBLs to a tune of 15-22% among the Gram-negative isolates in their study.

The high rate of carbapenem resistant strains reported in this surveillance study is a matter of grave concern and needs to be addressed on priority at the global level. One of the approaches that the clinicians have adopted to reduce selective pressure on last resort drugs is by pumping in the use the antibiotic resistance breakers "ARBs" along with antibiotics to revive them for clinical purposes. CSE-1034 is one such combination of beta-lactam/beta-lactamase inhibitor (BL/BLI) combination with ARB "EDTA". Interestingly, a significant number of isolates were sensitive to CSE-1034 i.e., *E. coli* (98.8%), *K. pneumoniae* (90.5%), *P. aeruginosa* (89.9%) and *Acinetobacter spp* (81%). Surprisingly, 131 isolates reported as Meropenem resistant were susceptible to CSE-1034 (Table 4). The higher susceptibility of Gram-negative pathogens to CSE-1034 has been reported by several other studies also. CSE-1034 is a novel combination of Ceftriaxone, Sulbactam and disodium edetate and the high susceptibility of CSE-1034 could be attributed to the synergistic effect of Ceftriaxone, disodium edetate and Sulbactam. The non-antibiotic adjuvant, EDTA mediates various antimicrobial effects by enhancing the penetration of antibiotic into cell membrane, decreases over-expression of efflux pumps, bio-film eradication, de-activates carbapenemases-MBL by chelating Zinc ions.

About last line therapy agents for MDR infections, our study has shown Carbapenems as the most active agent only against *E.coli* (82%). Around 36-45% of *P. aeruginosa* and 45% of *Acinetobacter* spp. were Carbapenem resistant. Resistance to meropenem was found highest in *Klebsiella spp.* (54%). Chauhan *et al.* [19] have reported a Carbapenem resistance of 14.6% in *E. coli* and 29.6% in *Klebsiella spp.* in hospital isolates from various in and outpatient areas. Gupta *et al*. [21] have reported a Carbapenem resistance ranging from 17-22% in different strains of Enterobacteriaceae from North India.

Based on pathogen type, *E. coli* exhibited the highest susceptibility rate whereas the lowest was reported against *P. aeruginosa. E. coli* was found to be most susceptible clinical isolate among major pathogens which displayed 80%, 75.5% and 82.2% sensitivity against piperacillin-tazobactam, meropenem and imipenem-cilastatin respectively. Correspondent results were observed by many authors who reported 100%, 90% and 96.5% sensitivity of *E. coli* against meropenem, piperacillin-tazobactam and imipenem-cilastatin respectively [35,36]. *Klebsiella spp*. exhibited intermediate susceptibility i.e. 44.4%, 50% and 48.1% towards piperacillin-tazobactam, meropenem and imipenem-cilastatin. Similar results were noted by many authors who revealed 40-60% sensitivity of *Klebsiella spp.* against piperacillin-tazobactam, meropenem and imipenem-cilastatin [37,38]. As reported earlier also, *Acinetobacter spp*. experienced highest susceptibility (96.3%) towards CSE-1034CSE-1034 only while extreme resistance (96.3% each) against rest of the antibiotics which is due to sulbactam (a β-lactamase inhibitor) which owns intrinsic whole-cell activity against *Acinetobacter spp.* [39]. Surprisingly, contrary to expectations, *Pseudomonas spp.* documented 73.5%, 73.5% and 67.6% resistance against piperacillin-tazobactam, meropenem and imipenem-cilastatin respectively. Mohammadi and Feizabadi [37] reported >60% resistance of piperacillin+tazobactam against gram negative bacilli isolated from clinical samples which supports our data. Similarly, Hout *et al.* [40] revealed 70-100% resistance of

meropenem towards *Acinetobacter spp.* and *Pseudomonas spp.*. Likewise, Shour and El-Sharif, [36] and Eldomany and Abdelaziz noticed significant resistance (>50%) of imipenem-cilastatin in *Acinetobacter spp.* and *Pseudomonas spp.* which is in accordance with our present data [41].

The emergence of antimicrobial resistance against BL-BLI and carbapenem drugs is due to numerous elements which assists the scattering of resistance among clinical pathogens which includes production of MBL enzymes, biofilm formation, over expression of efflux pumps and accumulation of the drug [42,43]. None of these mechanisms are dressed by either piperacillin-tazobactam, meropenem or imipenem-cilastatin and probably this could be one reason for CSE-1034 super performance that it is supplemented with EDTA as ARB. The progressive and relentless resistance towards BL-BLI and carbapenem antibiotics is probably the result of overuse of antibiotics, improper processing and inappropriate prescribing [44]. In the light of above discussion it is evident that Antibiotic adjuvant therapy which has ARB can be used as the prime choice of therapeutics to overcome the resistance raised among gram negative pathogens towards β-lactam and β-lactamase inhibitor combinations and penems in the treatment of bacterial infectious diseases.

5. Conclusion

This retrospective study indicates the rise in resistance among most prevalent and opportunistic gram negative pathogens against β-lactam and β-lactamase inhibitor combinations and penems. Present data strongly advocates precedence of CSE-1034 over β-lactam and β-lactamase inhibitor combinations and penems as CSE-1034 has scored 85-100% susceptibility which excels the antimicrobial activity of rest of the drugs. Therefore, CSE-1034, a novel product with antibiotic resistance breaker can be used as an empirical and alternate choice of drug over potent therapeutics in encountering multidrug resistance among healthcare-associated pathogens.

Ethical Approval:

As per international standard or university standard written ethical approval has been collected and preserved by the author(s).

References

1. Gelband H, Miller-Petrie M, Pant S, Gandra S, Levinson J, Barter D, et al. The State Of The World's Antibiotics 2015. Center For Disease Dynamics, Economics & Policy Washington DC and New Delhi. https://cddep.org/sites/default/files/swa_2015_final.pdf

2. Neill JO. Review on antibiotic resistance. Tackling drug resistant infections globally. 2016.

3. Peleg AY, Hooper DC. Hospital-Acquired Infections Due to Gram-Negative Bacteria. N Engl J Med. 2010;362(19):1804=13.

4. Zalewska-Piatek BM. Urinary tract infections of Escherichia coli strains of chaperone-usher system. Pol J Microbiol. 2011;60(4):279-85.
5. Neill JO. Review on antibiotic resistance. Tackling drug resistant infections globally. Tackling a crisis for the health and wealth of nation. 2014.
6. Sethuraman S, Arunachalam A, Karthikeyan M, Kumar SA, Manidipa S, Senthilraj R. Antimicrobial Sensitivity Profile of Serratia Marcescens strain isolated in

Government General hospital, Nagapattinam, Tamilnadu, India. Int J Preclin Pharm Res. 2011;'2(1):7-11.

7. Meeta S, Sati P, Preeti S. Prevalence and antibiogram of extended spectrum β-lactamase (ESBL) producing Gram negative bacilli and further molecular characterization of ESBL producing *Escherichia coli* and *Klebsiella* spp. J Clin Diag Res. 2013;7(10):2168–2172.
8. Singh N, Pattnaik D, Neogi DK, Jena J, Mallick B. Prevalence of ESBL in *Escherichia coli* Isolates Among ICU Patients in a Tertiary Care Hospital. J Clin Diagn Res. 2016;10(9):DC19–DC22.
9. Bora A, Sanjana R, Jha BK, Mahaseth SN, Pokharel K. Incidence of metallo-beta-lactamase producing clinical isolates of *Escherichia coli* and *Klebsiella pneumoniae.* BMC Res Notes. 2014;7:557.
10. Kontopidou F, Plachouras D, Papadomichelakis E, Koukos G, Galani I, Poulakou G, et al. Colonization and infection by colistin-resistant Gram-negative bacteria in a cohort of critically ill patients. Clin Microbiol Infect. 2011;17(11):E9–E11.
11. Parveen RM, Khan MA, Menezes GA, Harish BN, Parija SC, Hays JP. Extended-spectrum β-lactamase producing Klebsiella pneumoniae from blood culture in Puducherry, India. Indian J Med Res. 2011;134(3):392-395.
12. Datta S, Wattal C, Goel N, Oberoi JK, Raveendran R, Prasad KJ. A ten year analysis of multi-drug resistant blood stream infections caused by *Escherichia coli* & *Klebsiella pneumoniae* in a tertiary care hospital. Indian J Med Res. 2012;135(6):907–12.
13. Center for Disease Dynamics, Economics & Policy (CDDEP). 2015b. ResistanceMap. Accessed on August 20, 2015.

14. Ruppe E, Woerther P-L, Barbier F. Mechanisms of antimicrobial resistance in gram-negative bacilli Ann Intensive Care. 2015;5:21.
15. Cheesbrough M. Biochemical tests to identify bacteria. In: District laboratory practice in tropical countries. 2nd edition. Cambridge University Press, UK; 2000: 178-187.
16. Clinical and Laboratory Standards Institute. Performance Standards for Antimicrobial Susceptibility Testing; Twenty-sixth Informational Supplement. Wayne, PA 19087 USA: CLSI Document M100-S26; 2016.
17. Kumar M, Chaudhary S, Makkar DJ, Garg N, Chugh S. Comparative antimicrobial efficacy evaluation of a new product CSE-1034 against Meropenem of gram negative isolates. Asian J Pharm Clin Res. 2015;8(4):251-54.
18. Akter J, Chowdhury AMMA, Al Forkan M. Study on Prevalence and Antibiotic Resistance Pattern of Klebsiella Isolated from Clinical Samples in South East Region of Bangladesh. American Journal of Drug Discovery and Development. 2014;4:73-79.
19. Sikka R, Mann JK, Deep, Vashist MG, Chaudhary U, Deep A. Prevalence and antibiotic sensitivity pattern of bacteria isolated from nosocomial infections in a surgical ward. Indian J Clin Pract. 2012;22:519-25.
20. Sachdeva N. Antibiotic sensitivity pattern of bacterial pathogens in Rajeev Gandhi Cancer Hospital, Delhi. Int J Rec Sci Res. 2016;7(1):8480-8485.
21. Makkar DK, Kumar M, Chaudhary S, Goyal S, Aggarwal P, Garg N. Prevalence and Susceptibility Analysis of Gram negative Pathogens. J Pharm Bio Sci. 2015;10(3):58-65.
22. Sahu M, Sanjith S, Bhalekar P, Keny D. Waging War Against Extended Spectrum

316 Beta Lactamase and Metallobetalactamase Producing Pathogens- Novel Adjuvant
317 Antimicrobial Agent Cse1034- An Extended Hope. J Clin Diagn Res.
318 2014;8(6):DC20-DC23.
319 23. Shaikh S, Fatima J, Shakil S, Mohd S, Rizvi D, Kamal RA. Prevalence of multidrug
320 resistant and extended spectrum beta- lactamase producing Pseudomonas aeruginosa
321 in a tertiary care hospital. Saudi J Biol Sci. 2015;22:62-64.
322 24. Ejaz H, Zafar A, Anwar N, Cheema TA, Shahzad H. Prevalance of bacteria in urinary
323 tract infections among childern. Biomedica. 2006:22.
324 25. Mohammed MA, Alnour TMS, Shakurfo OM, Aburass MM. Prevalence and
325 antimicrobial resistance pattern of bacterial strains isolated from patients with urinary
326 tract infection in Messalata Central Hospital, Libya. Asian Pac J Trop Med.
327 2016;9(8):771-76.
328 26. Ibrahim ME, Bilal NE, Hamid ME. Increased multi-drug resistant Escherichia coli
329 from hospitals in Khartoum state, Sudan. African Heal Sci. 2012;12(3):368-75.
330 27. Sharma S, Srivastava P, Kumar A. Respiratory Tract Infection (RTI) and its
331 Treatment. Sch J App Med Sci. 2015;3(8E):3118-3122.
332 28. Subhedar V, Bandookwala S, Jain SK. Prevalence of multi drug resistant Klebsiella
333 pneumoniaee infections, causing a HAVOC in intensive care units of a tertiary care
334 hospital. Sch J App Med Sci. 2016;4(11):1054-1059.
335 29. Nahar A, Anwar S, Saleh AA, Miah MRA. Isolation of Acinetobacter species and
336 their antimicrobial resistance pattern in an Intensive care unit (ICU) of a tertiary care
337 hospital in Dhaka, Bangladesh. Bangladesh J Med Microbiol. 2012; 06(01):03-06.
338 30. Gupta N, Gandham N, Jadhav S, Mishra RN. Isolation and identification of
339 *Acinetobacter* species with special reference to antibiotic resistance. J Nat Sci Biol
340 Med. 2015;6(1):159–62.

31. Patel H, Garala RN. Antibiotic susceptibility pattern of Pseudomonas aeruginosa isolated at SSG hospital Baroda. J Resi Med Dent Sci. 2014:2(1):84-87.
32. Senthamarai S, Reddy SK, Sivasankari S, Anitha C, Somasunder V, Kumudhavethi MS et al. Resistance Pattern of *Pseudomonas aeruginosa* in a Tertiary Care Hospital of Kanchipuram, Tamilnadu, India. J Clin Diagn Res. 2014;8(5):DC30–DC32.
33. Prasad RR, Shree V, Sagar S, Kumar S, Kumar P. Prevalence and Antimicrobial Susceptibility Pattern of Proteus Species in Clinical Samples. Int J Curr Microbiol App Sci. 2016;5(4):962-968.
34. Menon D. A case report of community acquired Pneumonia due to multidrug resistance Pseudomonas aeruginosa treated wit Elores. Int J Med Pharm case reports. 2016;6(1):1-5.

35. Guillou M-L, Kempf M, Cavallo J-D, Chomarat M, Dubreuil L, Maugein J, et al. Comparative *in vitro* activity of Meropenem, Imipenem and Piperacillin/tazobactam against 1071 clinical isolates using 2 different methods: a French multicentre study. BMC Infect Dis. 2010;10:72 (1-9).
36. Abuhandan M, Guzel M, Oymak Y, Ciftci H. Antibiotic sensitivity and resistance in children with urinary tract infection in Sanliurfa. Turk J Urol. 2013;39(2):106–10.
37. Mohammadi MM, Feizabadi MM. Antimicrobial resistance pattern of Gram-negative bacilli isolated from patients at ICUs of Army hospitals in Iran. Iranian J Microbiol. 2011;3(1):26-30.
38. Eldomany R, Abdelaziz NA. Characterization and antimicrobial susceptibility of gram negative bacteria isolated from cancer patients on chemotherapy in Egypt. Arch Clin Microbiol. 2011; 2(6):2.
39. Penwell WF, Shapiro AB, Giacobbe RA, Gu RF, Gao N, Thresher J et al. Molecular

Mechanisms of Sulbactam Antibacterial Activity and Resistance Determinants in *Acinetobacter baumannii.* Antimicrob Agents Chemother. 2015;59(3):1680–1689.

40. Hout B, Oum C, Men P, Vanny V, Supaprom C, Heang V et al. Drug resistance in bacteria isolated from patients presenting with wounds at a non-profit Surgical Center in Phnom Penh, Cambodia from 2011–2013. Trop Dis, Travel Med Vacc. 2015;1(4):1-11.
41. Shour HM, EL-Sharif A. Species distribution and antimicrobial susceptibility of gram negative aerobic bacteria in hospitalized cancer patients. J Transl Med. 2009;7:14.
42. Fair RJ, Tor Y. Antibiotics and Bacterial Resistance in the 21st Century. Perspect Medicin Chem. 2014;6:25–64.
43. Singh J, Shukla SK. A New Threat of Bacterial Resistance towards Life Saving Carbapenem Antibiotics. Res J Chem Sci. 2015;5(4):85-88.
44. Ventola CL. The Antibiotic Resistance Crisis Part 1: Causes and Threats. Pharm Therapeut. 2015;40(4):277-83.

Table 1: Selective culture medium used for isolation of different pathogens.

Pathogen	Selective media
Klebsiella spp.	Hicrome Klebsiella selective agar base medium
E. coli	Eosine Methylene Blue (EMB) agar medium
Acienetobacter spp.	Leeds acinetobacter agar base medium
Pseudomonas spp.	Citrimide agar medium
Proteus spp.	EMB agar medium
Salmonella spp.	Wilson and Blair bismuth sulphite medium
Serratia spp.	Caprylate-thallous agar medium
Enterobacter spp.	EMB agar medium

Table 2: A profile of clinical samples used as a source of the pathogenic isolates.

Sr. No.	Name of clinical samples	Total no. of samples collected	Number of samples showing growth of pathogens (%)	Number of samples not showing growth of pathogens
1	Urine	94	78 (36.62%)	16
2	Respiratory specimens	84	51	
3	Blood	39	25 (11.74%)	14
4	Pus	34	22 (10.33%)	12
5	Wound	22	13 (6.10%)	9
6	Stool	19	10 (4.69%)	9
7	Other samples	55	14 (6.58%)	41
	Total	**347**	**213 (61.38%)**	**134**

Table 3: Prevalence of different clinical isolates in different samples.

	Clinical Isolates					
Samples	**No. of isolates**	***E. coli* (%)**	***Klebsiella spp.* (%)**	***Acinetobacter baumannii* (%)**	***Pseudomonas aeruginosa* (%)**	**Other pathogens (%)**
Urine	78	59 (75.64)	11 (14.10)	0	7 (8.97)	1 (1.28)
Respiratory specimens	51	6 (3.45)	17 (31.03)	10 (44.83)	12 (23.52)	6 (11.76)
Blood	25	2 (8)	10 (40)	4 (36)	5 (20)	4 (16)
Pus	22	10 (45.45)	6 (27.27)	2 (9.09)	2 (9.1)	2 (9.1)
Wound	13	2 (15.38)	3 (23.08)	1 (7.69)	5 (38.46)	2 (15.38)
Stool	10	8 (80)	0	0	0	2 (20)
Other samples	14	3 (21.43)	7 (50.0)	0	3 (21.43)	1 (7.14)
Total	**213**	**90**	**54**	**17**	**34**	**16**
Total (%)		**42.25 %**	**25.35 %**	**7.98 %**	**15.96 %**	**8.45%**

Table 4: Susceptibility pattern of clinical isolates.

Susceptibility (%)									
Clinical isolates	**No. of isolates**	**Antibiotic adjuvant entity**		**BL-BLI**		**Carbapenem**			
		CSE-1034		**Piperacillin-tazobactam**		**Meropenem**		**Imipenem-cilastatin**	
		S	**R**	**S**	**R**	**S**	**R**	**S**	**R**
E. coli	**90**	91.1 (82)	8.9 (8)	(80) 72	(20) 18	77.7 70	22.3 22	82.22 74	17.78 16
Klebsiella spp.	**54**	77.8 (42)	22.2 (12)	(44.44) 24	55.56 30	50 27	50 27	48.15 26	51.85 28

Acinetobacter baumannii	**17**	82.4 (14)	17.6 (3)	35.3 6	64.7 11	58.8 10	41.2 7	52.9 9	47.1 8
Pseudomonas aeruginosa	**34**	82.3 (28)	17.7 (6)	26.47 9	73.53 25	58.8 20	41.2 14	32.35 11	67.65 23
Other pathogens	**18**	(88.9) 16	(9.91) 2	88.9 16	9.91 2	88.9 16	9.91 2	100 18	0
Total	**213**	(85.4) 182	(14.5%) 31	(59.6) 127	(40.4) 86	(66.2) 141	(33.8) 72	(64.8) 138	(35.2) 75

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