Prevalence of Multidrug Resistant Uropathogenic E. coli: Role of β-lactamase

Nawal Salama Gouda¹* and Mayada Sabry Zeid²

¹Department of Medical Microbiology and Immunology, ²Nutrition and Infectious Disease Unit, Department of Pediatrics, Faculty of Medicine, Mansoura University, Mansoura, Egypt

*Corresponding author

A B S T R A C T

Urinary tract infection (UTI) is one of the most frequent health problems in clinical settings. E. coli is the most prevalent organism causing both community as well as hospital acquired UTI. Uropathogenic E. coli shows increasing rates of resistance to various antibiotics. The frequent and improper usage of antibiotics resulted in the development of resistant strains of bacteria. To determine antimicrobial susceptibility pattern of uropathogenic E. coli isolates and evaluate the production of ESBL (Extended Spectrum β-Lactamases) and AmpC by the multidrug resistant strains. Uropathogenic E. coli strains, over the period of the study, were collected and studied. Antibiotic susceptibility testing was done. Phenotypic detection of ESBL production was done among the multidrug resistant (MDR) strains using the Modified Double Disc Synergy Test (MDDST). All the isolates which showed a synergistic effect with cefepime were further assessed for the production of AmpC enzyme by AmpC disc test. Two hundred non duplicate E. coli strains were recovered during the period of the study. Out of them 139 (69.5%) strains were MDR, of which 129 (64.5%) isolates were found to be ESBL producers (P < 0.001). Pure ESBL production was seen in 98 (49%) isolates, while 31 (15.5%) isolates were co-producers of ESBL and AmpC. MDR uropathogenic E. coli becomes prevalent in clinical setting. This is attributed to both ESBLs and AmpC production. It is essential to limit antibiotic consumption and to establish protocol for routine and regular monitoring of ESBL production among clinical isolates.

Keywords
Urinary tract infection, E. coli, AmpC, β-lactamase, Extended-spectrum β-lactamase.

Article Info
Accepted: 30 October 2017
Available Online: 10 November 2017

Introduction

Urinary tract infection (UTI) is major health concern, it is one of the most common infection managed in clinical setting. It is associated with a high risk of morbidity and mortality, especially in the elderly, and account for significant health care costs (Dembélé et al., 2015). It is caused by wide variety of micro-organisms; both Gram-negative as well as Gram-positive bacteria. E. coli is the most predominant pathogen isolated from both community as well as hospital acquired UTI; More than 50% of UTI infections is caused by E. coli (Belanger et al., 2011).

Uropathogenic E. coli (UPEC) encode a number of virulence factors, which enable the bacteria to colonize the urinary tract and resist highly effective host defense and antibiotics (Niranjan and Malini, 2014). Various drug resistance mechanisms help the bacteria to resist drug action making the treatment options limited. One of the most common ways to resist the actions of antimicrobial
agents is the production of enzymes that inactivate a drug. The production of β-lactamase is the classic example of this phenomena, this enzyme inactivates the β-lactam antibiotics by opening β-lactam ring present in penicillins, cephalosporins, and monobactams (Madigan et al., 2015).

The widespread use of broad spectrum antibiotics favors the development of bacterial resistance. Extended-spectrum β-lactamases (ESBLs) are those enzymes that hydrolyze beta lactam antibiotics including third and fourth generation cephalosporins and aztreonam. Most ESBLs do not break down cephemycins or carbapenems and are susceptible to β-lactamase inhibitors as clavulanic acid. ESBLs are plasmid-mediated enzymes which may be transferable from one bacterial strain to other and between different species (Rupp and Fey, 2003).

The production of ESBLs limit the therapeutic options as it is usually associated with co-resistance to other classes of antimicrobial agents as fluoroquinolones, cotrimoxazole, tetracyclines, and aminoglycosides (Paterson and Bonomo, 2005).

New kinds of β-lactamase enzymes appeared. Various bacteria use these enzymes to resist the newest β- lactam antibiotics (Queenan and Bush, 2007).

AmpC enzyme is an example of these new β-lactamases that able to hydrolyze wide range of β-lactam antibiotics especially broad-spectrum cephalosporins like ceftazidime, ceftiraxone, cefepime, cephamycins and monobactams. AmpC enzyme cannot be inhibited by clavulanic acid (Jacoby, 2009). The worldwide emergence of antimicrobial resistance becomes a major public health problem that significantly narrows down the treatment options and result in poor outcomes.

UPEC shows high resistance to the usual treatment of UTI so we evaluate the susceptibility pattern of these uropathogenic strains with special concern about ESBL and AmpC production specially among MDR isolates.

**Materials and Methods**

**Setting**

The study was carried out from January 2017 to June 2017 at the Microbiology Diagnostics and Infection Control Unit at the Medical Microbiology and immunology Department, Faculty of Medicine, Mansoura University.

**Specimen**

Mid-stream urine specimens were collected aseptically from clinically suspected patients of UTIs attending outpatient and inpatient departments during their standard patient care investigation. Urine specimens were transported to laboratory and processed immediately.

**Identification of the isolates**

Urine samples were inoculated onto CLED agar plates and incubated at 37°C for 24-48 hours and the colonies identified based on colony morphology, Gram staining and the biochemical reactions.

**Antimicrobial susceptibility testing**

E. coli isolates were tested for their antimicrobial susceptibilities by the disc diffusion method according to the CLSI guidelines (CLSI, 2011). Ampicillin (10μg), ceftriaxone (30μg), cefotaxime (30 μg), cefepime (30μg), amikacin (30μg), ciprofloxacin (5μg), norfloxacain (10μg), nitrofurantoin (100μg), piperacillin/tazobactam (100/10μg), cefuroxime (30μg),
cotrimoxazole (25μg), and imipenem (10μg) antibiotics were used. Quality control was done using E. coli ATCC 25922.

**Testing for the ESBL Production (Kaur et al., 2013)**

All the strains which showed a diameter less than 27mm for cefotaxime and less than 25mm for ceftriaxone, were selected for testing ESBL production by the Modified Double Disc Synergy Test (MDDST) by using a disc of amoxicillin-clavulanate (20/10 μg) along with four cephalosporins; third generation cephalosporins -cefotaxime, ceftriaxone, cefpodoxime and fourth generation cephalosporins -cefepime. A lawn culture of the organisms was made on a Mueller-Hinton agar plate. A disc which contained amoxicillin-clavulanate was placed in the center of the plate. The discs of third generation cephalosporins and cefepime were placed 15mm and 20mm apart respectively, center to center to that of the amoxicillin-clavulanate disc. Any distortion or increase in the zone towards the disc of amoxicillin-clavulanate was considered as positive for the ESBL production. Multidrug resistant E. coli was defined as resistance to at least three classes of antibiotics.

**AmpC Detection (Black et al., 2005)**

All the isolates which showed a synergistic effect with cefepime only in MDDST were further tested for the production of AmpC enzyme by AmpC disc test. AmpC disk test is based on the use of Tris-EDTA which allows the cell to release β- lactamases. The Mueller-Hinton agar plate was inoculated with a lawn culture of cefoxitin - susceptible E. coli ATCC 25922. A cefoxitin disc (30 μg) was placed on the agar. Tris-EDTA disc (6mm) inoculated with several colonies of test organism was placed almost touching the cefoxitin disk. The plate was then incubated overnight at 37°C. An indentation or flattening of zone of inhibition indicated inactivation of cefoxitin which indicated the enzyme inactivation of cefoxitin (positive result). Absence of a distortion indicated no significant inactivation of cefoxitin (negative result).

**Statistical analysis**

Statistical analyses will be performed using IBM-SPSS version 22.0 for Windows 10 (SPSS Inc., Chicago, IL, USA). The susceptibility pattern of ESBL producers and non-producers was evaluated. Results were calculated on the basis of number and percentages. P values were calculated using a 2 test. P<0.01 were considered to be statistically significant.

**Results and Discussion**

Out of the 412 processed midstream urine samples, 300 (72.8%) samples were culture positive. Gram-negative bacilli were the most frequent isolated organisms; E. coli recovered from 200 samples (66.7%) (Table 1). Patients infected by UPEC had different ages ranged from 8 years up to 67 years. The patients were 80 males and 120 females. Seventy-three patients had UTI for the first time, while 127 patients had recurrent UTI.

Antibiotic susceptibility testing was done for the 200 consecutive non-duplicate E. coli isolates. High level of resistance was seen with ampicillin (96%), ciprofloxacin (80%), nitrofurantoin (80%), cotrimoxazole (78.5%), ceftriaxone (78%), cefotaxime (74%) and cefuroxime (71%). Sensitivity to imipenem was 62.5%. Up to 42% of the isolates were resistant to cefepime (Table 2).

There was a wide spectrum resistance to different antibiotics. MDR isolates represented 69.5% (139/200), while
susceptible strains detected in 61 (30.5%) isolates (Figure 1). The difference between susceptible and MDR isolates was highly significant (p < 0.001).

Among these MDR strains, ESBLs positive strains were 129 (64.5%) isolates while, the number of AmpC positive strains were 31 (15.5%) isolates. All AmpC producer were co-producers of ESBL, the remaining 98 (49%) isolates were pure ESBLs (Figure 1).

ESBLs positive isolates were found to be more resistant than ESBLs negative isolates to other classes of antimicrobials (Table 3). None of the ESBL positive strains were sensitive to all the antimicrobial agents tested.

The difference between the resistance pattern of ESBL-producing and non-ESBL-producing strains was highly significant (P < 0.0001).

Urinary tract infection is a serious health problem affecting human both in community and clinical settings. It is encountered in different age groups and both sexes. Although the majority of UTI episodes are attended at primary care settings, they also a frequent cause of admission to some hospitals (Niranjan and Malini 2014). Among the etiologic agents of UTI, *E. coli* were the most common isolated organism (66.7%). Other studies were in accordance with our study, in which *E. coli* was the predominant uropathogen accounting for more than 50% of UTI (Islam and Yusuf, 2014; Farzana et al., 2013). In study conducted in Egypt by Elsayed et al., (2017), they stated that *E. coli* account for only 38.2% of UTI cases which was lower than that of our study indicating that the etiological agents of UTI varies from one locality to another even within the same country.

Antimicrobial resistance is of special concern in treating UTI. The antimicrobial susceptibility testing showed high level of resistance to different β- lactam antibiotics mainly ampicillin (96%), ceftriaxone (78%) and cefuroxime (71%). Resistance to other classes of antibiotics was detected as ciprofloxacin (80%), norfloxacin (62%), nitrofurantoin (80%) and cotrimoxazole (78%). These results were in consistent with that observed in other studies (Niranjan and Malini, 2014; Elsayed et al., 2017; Gupta et al., 2013; Fody et al., 2017; Guessennd et al., 2008). Such level of resistance could be due to prescription of antibiotics in health care setting without prior microbiological investigations (Yandaı et al., 2014).

Our study showed a susceptibility of 62.5% for imipenem, this frequency was dissimilar with other studies in which susceptibility varied from 95 up to 100% for imipenem (Niranjan and Malini 2014; Fody et al., 2017).

| Bacteria                        | No.  | (%)   |
|--------------------------------|------|-------|
| *E. coli*                      | 200  | 66.7% |
| Other Gram negative bacilli    | 76   | 25.3% |
| Gram positive cocci            | 24   | 8.0%  |
| **Total**                      | **300** | **100%** |
Table 2: Resistant pattern of E. coli isolates

| Antibiotic         | No. (%) of sensitive isolates | No. (%) of resistant isolates |
|--------------------|-------------------------------|------------------------------|
| Ampicillin         | 8 (4%)                        | 192 (96%)                    |
| Ciprofloxacin      | 40 (20%)                      | 160 (80%)                    |
| Nitrofurantoin     | 40 (20%)                      | 160 (80%)                    |
| Cotrimoxazole      | 43 (21.5%)                    | 157 (78.5%)                  |
| Ceftriaxone        | 44 (22%)                      | 156 (78%)                    |
| Cefotaxime         | 52 (26%)                      | 148 (74%)                    |
| Cefuroxime         | 58 (29%)                      | 142 (71%)                    |
| Norfloxacin        | 76 (38%)                      | 124 (62%)                    |
| Piperacillin/tazobactam | 96 (48%)          | 104 (52%)                    |
| Amikacin           | 104 (52%)                     | 96 (48%)                     |
| Cefipime           | 116 (58%)                     | 84 (42%)                     |
| Imipenem           | 125 (62.5%)                   | 75 (37.5%)                   |

Table 3: Antibiotic resistance of ESBL producers and non-producers to various non β-lactam antibiotics

| Antibiotics          | ESBL producers (N= 129) No. (%) | Non ESBL producers (N= 71) No. (%) |
|----------------------|---------------------------------|-----------------------------------|
| Ciprofloxacin (160)  | 121 (75.63%)*                   | 39 (24.37%)                       |
| Nitrofurantoin (160) | 116 (72.5%)*                    | 44 (27.5%)                       |
| Cotrimoxazole (157)  | 122 (77.7%)*                    | 35 (22.3%)                       |
| Norfloxacin (124)    | 113 (91.1%)*                    | 11 (8.9%)                        |
| Amikacin (96)        | 88 (91.7%)*                     | 8 (8.3%)                         |

*P value <0.001

Fig. 1: Extended spectrum beta-lactamase (ESBL) detection
ESBL producing bacteria is one of the most encountered causes of treatment failure and prolonged stay in hospitals.

The widespread use of antibiotics to treat bacterial infections has rapidly increased the emerging multidrug resistance strains specially ESBL producing ones (Bush, 2001).

Our study was designed to determine the prevalence of ESBL and AmpC production among MDR strains of uropathogenic E. coli isolates.

In the present study, there were 139 (69.5%) MDR isolates, which was relatively high prevalence. A comparable MDR rates of 83% and 76.51% were reported in other studies done in Pakistan and India respectively (Ullah et al., 2009; Niranjan and Malini, 2014).

In our study we investigated the prevalence of ESBL production by uropathogenic E. coli. More than half (64.5%; 129/200) of isolated E. coli strains were ESBL producer. Lower prevalence was detected in other studies carried out in other African countries such as in Benin (22%) (Ahoyo et al., 2007), Nigeria (20%) (Onwuezobe and Orok, 2015), Niger (26.3%) (Fody et al., 2017), Tanzania (15.1%), (Mshana et al., 2016), Chad (20.09%) (Yandaï et al., 2014) and the Libyan community (13.4%) (Ahmed et al., 2014).

Our results showed that out of (64.5%) ESBL producing E. coli, 49% (98/200) were pure ESBL producers and 15.5% (31/200) were both ESBL and AmpC co-producers.

This result was in agreement with another study conducted by Gupta et al., (2013) who showed that of 52.6% of the isolates were ESBLs producer strains and 10% of strains were AmpC producer. Another investigation from Egypt revealed that 57.7% of isolates were Amp C enzyme producer (Fam et al., 2013).

Different studies detected much higher level of AmpC production among E. coli isolates as in studies carried by Shanti and Balagurunathan (2014) (76%), Rudresh and Nagarathnamma (2011) (52.2%), Getzlaft et al., (2011) (41%) and Shubha (2003) (37.5%), while other studies showed lower level of AmpC production as revealed by Mansoori et al., (2009), Niakan et al., (2008) and Singhal et al., (2005), who reported 5.7%, 5.9%, and 7% of the isolate were AmpC producer respectively.

Gupta et al., (2013) found that not all AmpC positive strains were co-producer of ESBL and AmpC, but only 8% of the strains were co-producers of ESBL and AmpC, but in our study all AmpC positive isolates were co-producers of ESBL and AmpC.

ESBL producers were more resistant than susceptible strains to classes of antibiotics rather than beta lactams. Resistance to quinolones was recorded to be 91.1% to norfloxacin and 75.6% to ciprofloxacin. This was in consistent with Farzana et al., (2013), Gupta et al., (2013) and Chander and Shrestha (2013), who reported high level of resistance to quinolones more than 90%. Elsayed et al., (2017) reported similar resistance to ciprofloxacin (72.2%) but less resistance to norfloxacin (59%).

The reason for that is the widespread empirical treatment with quinolones for treatment of UTI in our locality. Another notable resistance was to nitrofurantoin. In ESBL producing strains, resistance was 72.5%. This relatively high rate of resistance was reported in another studies carried by Elsayed et al., (2017) and Gupta et al., (2013), however Chander and Shrestha (2013) stated a lower resistance rate (11.7%).
Amikacin was another non beta lactam antibiotic which was used frequently in treatment of UTI. More than 90% of the ESBL isolates were resistant to amikacin, this result was very high as compared with other study in which resistance rate was 6.6 % (Chander and Shrestha, 2013).

Our study concluded that E. coli was the most common organism isolated from UTI. There were increasing incidence of MDR E. coli which showed resistance against different groups of antimicrobial agents such as β-lactams, aminoglycosides and fluoroquinolones. We detected high prevalence of ESBL producing uropathogenic E. coli, so a rational use of antibiotics, surveillance together with strict hospital infection control policies should be applied to reduce the emergence of ESBL producing E. coli in urinary isolates.

References

Ahmed, S.F., Ali, M.M.M., Mohamed, Z.K., Moussa, T.A., Klena, J.D. (2014): “Fecal carriage of extended-spectrum β-lactamases and AmpC producing Escherichia coli in a Libyan community”. Ann. Clin. Microbiol. Antimicrob. 13(1):22.

Ahoyo, A.T., Baba-Moussa, L., Anago, A.E., Avogbe, P, Missihouna, T.D., Loko, F., Prévost, G., Sanni, A., Dramane, K. (2007): “Incidence of Escherichia coli infections Producer of extended-spectrum beta lactamases at the Zou and Collines Hospitals in Benin”. Méd. Mal. Infect. 37:746-752.

Belanger, L., Garenaux, A., Harel, J., Boulianue, M., Nadeau, E., Dozois, C.M. (2011): “Escherichia coli from animal reservoirs as potential source of human extra-intestinal pathogenic E. coli “. FEMS Immunol Med Microbiol; 62:1–10.

Black, J.A., Moland, E.S., Thomson, K.S. (2005): “AmpC Disk Test for Detection of Plasmid Mediated AmpC Beta-Lactamases in Enterobacteriaceae Lacking Chromosomal AmpC Beta-Lactamases”. J. Clin. Microbiol., 43(7): 3110-3113.

Bush, K. (2001): “New beta-lactamases in gram-negative bacteria: diversity and impact on the selection of antimicrobial therapy”. Clin. Infect. Dis. 32:1085-1089.

Chander, A., Shrestha, C.D. (2013): “Prevalence of extended spectrum beta lactamase producing Escherichia coli and Klebsiella pneumoniae urinary isolates in a tertiary care hospital in Kathmandu, Nepal “. BMC Res Notes. 2013 Nov 25;6:487

Clinical Laboratory Standards Institute(2011): “Performance standards for antimicrobial susceptibility testing”; Twenty First informational supplement (M 100-S21) Wayne PA: Clinical and Laboratory Standards Institute.

Dembélé, R., Bonkoungou, I.O., Konaté, A., Tchamba, G.B., Bawa, H.I. Bako, E., Bagré, T.S., Kagambèga, A., Zongo C., Traoré, A.S., Barro, N. (2015): “Serotyping and antimicrobial resistance enteropathogenicEscherichia coli and enterohemorrhagicE. coli O157 isolated from children under five years of age with diarrhea in rural Burkina Faso”. Afr. J. Microbiol. Res. 9(14):1053-1059.

Elsayed, T.I., Ismail, H.A., Elgamal, S.A., et al., (2017): “The Occurrence of Multidrug Resistant E. coli which Produce ESBL and Cause Urinary Tract Infections”. J ApplMicrobiolBiochem. Vol. 1 No. 2:8

Fam, N., Gamal, D., El Said, M., Aboul-Fadl, L., El Dabei, E., El Attar, S., et al., (2013): “Detection of plasmid-mediated AmpC beta-lactamases in clinically
significant bacterial isolates in a research institute hospital in Egypt”. Life Sci J;10(2):2294-304.

Farzana, R., Shamsuzzaman, S.M., Mamun, K.Z., Shears, P. (2013): “Antimicrobial susceptibility pattern of extended spectrum b-lactamase producing gram-negative bacteria isolated from wound and urine in a tertiary care hospital Dhaka city, Bangladesh. Southeast Asian”. J Trop Med Public Health 44: 96-103.

Fody, M.A., Laouali, B., Ali, M., Bawa, I.H., Ali, K., Chaibou, Y., Cheikna, Z., Chaibou, S., Alhousseini, D., Ramatou, S., Traore, S.A., Nicolas, B. (2017): “Phenotypic detection of extended spectrum beta-lactamase in multidrug-resistant Escherichia coli from clinical isolates in Niamey, Niger” African journal of microbiology research 11(18):712-717.

Getzlaff, P.S., Polsfuss, S., Poledica, M., Hombach, M., Giger, J., Bottger, E.C., Zbinden, R., Bloemberg, G.V. (2011): “Detection of AmpC Beta-Lactamase in Escherichia coli: Comparison of Three Phenotypic Confirmation Assays and Genetic Analysis”. J. Clin. Microbiol., 49(8): 2924–2932.

Guessannd, N., Kacou-N’douba, A., Gbonon, V., Yapi, D., Ekaza, E., Dosso, M., Courvalin, P. (2008): “Prevalence and resistance profile of beta lactamase enterobacteria A Broad spectrum (ESBL) In Abidjan Côte d’Ivoire from 2005 to 2006”. J. Sci. Pharma. Biol. 9:63-70.

Gupta, V., Rani, H., Singla, N., Kaistha, N., Chander, J. (2013): “Determination of Extended-Spectrum β-Lactamases and AmpC Production in Uropathogenic Isolates of Escherichia coli and Susceptibility to Fosfomycin”. J Lab Physicians; 5(2): 90–93.

Islam, M.S., Yusuf, M.A. (2014): “Extended spectrum beta lactamase producing uropathogenic E. coli infection in Dhaka Bangladesh”. Journal of Bacteriology Research 7: 1-7.

Jacoby, G.A. (2009): “AmpC Beta-Lactamases”. Clin. Microbiol. Rev., 22: 161-182.

Kaur, J., Chopra, S., Sheevani, Mahajan, G.J.(2013) : “Modified Double Disc Synergy Test to Detect ESBL Production in Urinary Isolates of Escherichia coli and Klebsiella pneumoniae”. ClinDiagn Res. ;7(2):229-33.

Madigan, T., Johnson, J.R., Clabots, C., Johnston, B.D., Porter, S.B., Slater, B.S., Banerjee, R. (2015): “Extensive Household Outbreak of Urinary Tract Infection and Intestinal Colonization due to Extended-Spectrum β-Lactamase-Producing Escherichia coli Sequence Type 131”. Clin Infect Dis; 61:e5.

Mansouri, S., Chitsaz, M., Haji, H.R., Mirzaei, M., Gheyni, M. (2009): “Determination of resistance pattern of plasmidmediated AmpC β–lactamases producing isolate of Escherichia coli”. Daneshvar Medicine; 16: 61-70.

Mshana, S.E., Falgenhauer, L., Mirambo, M.M., Mushli, M.F., Moremi, N., Julius, R., Seni, J., Imirzalioglu, C., Matee, M., Chakraborty, T. (2016): “Predictors of blCTX-M-15 in varieties of Escherichia coli genotypes from humans in community settings in Mwanza, Tanzania”. BMC Infect. Dis. 16(1):187.

Nikan, M., Chitsaz, M., Metwaei, A. (2008): “Prevalence of AmpC type extended spectrum beta lactamases genes in clinical isolates of Klebsiella pneumoniae”. Iranian J Med Microbiol;2(2):1-8.

Niranjan, V. and Malini A. (2014): “Antimicrobial resistance pattern in
Escherichia coli causing urinary tract infection among inpatients”. Indian J Med Res.;139(6): 945–948.

Onwuezobe, A.I. and Orok, F.E. (2015): “Extended spectrum beta-lactamase producing uropathogens in asymptomatic pregnant women attending antenatal care in an urban community secondary Health facility”. Afr. J. Clin. Exp. Microbiol.16(1):49-53.

Paterson, D.L. and Bonomo, R.A.(2005):” Extended spectrum β-lactamases: a clinical update”. ClinMicrobiol Rev ;18(4):657–686.

Queenan, A.M. and Bush, K. (2007): “Carbapenemases: the versatile â-lactamases”. ClinMicrobiol Rev;20(3):440-58.

Rudresh, S.M. and Nagarathnamma, T. (2011): “Two simple modifications of modified three-dimensional extract test for detection of AmpC β-lactamases among the members of family Enterobacteriaceae”. Chron Young Sci., 2(1): 42-6.

Rupp, M.E., Fey, P.D.(2003): “Extended spectrum β-lactamase (ESBL)-producing Enterobacteriaceae: considerations for diagnosis, prevention and drug treatment”. Drugs. ;63(4):353–365.

Shanthi, J. and Balagurunathan, R.(2014): “Characterization of heteroresistant subcolonies for MBL, AmpC genes in Klebsiella pneumoniae and Acinetobacterbaumannii”. Indian J Med Microbiol;32(2):210-1.

Singhal, S., Mathur, T., Khan, S., Upadhyay, D.J., Chugh, S., Gaind, R., Rattan, A. (2005): “Evaluation of Methods for AmpC beta lactamase in Gram negative clinical isolates from Tertiary Care Hospitals”. Indian J. Med. Microbiol., 23(2): 120-124.

Subha, A., Renuka Devi, V., Ananthan, S. (2003): “AmpC β-lactamase producing multidrug resistant strains of Klebsiella spp. And Escherichia coli isolated from children under five in Chennai”. Indian J. Med. Res.,117: 13-18.

Ullah, F., Malik, S.A., Ahmed, J.(2009):” Antibiotic susceptibility pattern and ESBL prevalence in nosocomial Escherichia coli from urinary tract infections in Pakistan”. AfrJ Biotechnol. ;8(16):3921–3926.

Yandaï, F.H., Zongo, C., Moussa, A.M., Bessimbaye, N., Tapsoba, F., Savadogo, A., Barro, N., Ndoutamia, G., Traoré, A.S. (2014): “Prevalence and antimicrobial susceptibility of faecal carriage of Extended- Spectrum β-lactamase (ESBL) producing Escherichia coli at the “Hôpital de la Mère et de l’Enfant” in N’Djamena”. Chad. Sci. J.Microbiol. 3(2):25-31.