کارگاه‌های آموزشی مرکز اطلاعات علمی

مقاله نویسی علوم انسانی
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آموزش مهارت‌های کاربردی در تدوین و چاپ مقاله
INTRODUCTION

Hospital acquired pneumonia (HAP) is the second most prevalent cause of nosocomial infection, and it’s mortality rate is more than any other hospital acquired infection world-wide. Most of the HAPs occur in intensive care units (ICUs).[1] It is estimated that intubation causes 6-21 folds increase in the risk of HAP, thus a subset of HAP is defined as ventilator-associated pneumonia (VAP), which is pneumonia in patients who have been on mechanical ventilation for more than 48 h.[2]

Overall prevalence of VAP is reported 9.3%. The mortality rate for VAP varies between 20 and 50% and up to 76% when high risk pathogens are the cause. Moreover VAP is associated with increased morbidity and hospital costs, due to prolonged ICU stay and prolonged need for mechanical ventilation.[3] Many risk factors have been attributed to VAP such as duration of mechanical ventilation, trauma, prior surgery, severity of an underlying illness, prior use of antibiotics, and chronic pulmonary diseases.[3]

It is generally accepted that the etiology of VAP is typically bacterial. Opportunistic fungi such as Candida and Aspergillus spp. are rare causes of VAP that mostly occur in immunocompromised patients.[4] However, many patients in ICUs have respiratory specimens positive for Candida without clinical and pathological evidence of invasive candidiasis known as Candida colonization.[5] Detection of Aspergillus in airway secretions is not common in comparison with Candida spp., and its significance depends on immune status of the patient. In intensive immune suppression such as neutropenia, transplantation, and corticosteroid therapy detection of Aspergillus in airways suggests invasive
aspergillosis, but in immunocompetent patients, it typically represents colonization.[8] Although the clinical impact of airway colonization with these fungi is not clearly addressed, now it is obvious that in immunocompetent patients under mechanical ventilation, presence of Candida or Aspergillus in the respiratory track is associated with worse outcomes of bacterial VAP and lower survival of patients. This is greatly evident in the case of Candida colonization.[6]

It is reported that Candida colonization in airways is associated with increased risk of bacterial VAP, presence of multidrug-resistant bacteria, and increased mortality rate in patients with VAP.[7] Nseir et al. showed that antifungal therapy decreased the risk of Pseudomonas aeruginosa infection in these patients.[8] Furthermore, it is shown that isolation of Aspergillus in critically ill patients illustrates poor prognosis irrespective of invasion or colonization.[9] Because of air-born transmission of the Aspergillus, its detection in the respiratory track is usually related to environmental contamination such as polluted air ducts or unhygienic dusty ICU rooms.[6]

In the current study, we aimed to detect Candida spp. or Aspergillus fumigatus in bronchoscopic alveolar lavage (BAL) fluid of patients with VAP. Although routine detection and treatment of fungi colonization in VAP is yet under debate, however the rate of colonization for Candida spp. or A. fumigatus can specify high risk VAPs, and the A. fumigatus colonization can determine high risk environment for immunosuppressed ventilated patients in our ICU.

MATERIALS AND METHODS

Setting
This cross-sectional study was conducted in central ICU of Al Zahra Hospital, a Tertiary University Hospital in Isfahan, from April 2011 to March 2012. The hospital is an 800 bed referral hospital with a central ICU for adults. The ICU contains 20 divided patient rooms, and admits critically ill patients from both medical and surgical wards. The protocol was approved by the Research and Ethical Committees of Isfahan University of Medical Sciences, Isfahan, Iran (Research project numbers: 289146-7). Informed consent was obtained from closest relative of each patient.

Patients
All ICU patients who were intubated and mechanically ventilated were observed for signs and symptoms of VAP during the study period. A combination of clinical, laboratory, and radiologic signs were used to diagnose VAP according to the National Nosocomial Infection Surveillance (NNIS) system pneumonia definition [Table 1].[10] The NNIS has been developed by the Centers for Disease Control and Prevention as a tool to describe the epidemiology of nosocomial pneumonia, and the criteria showed acceptable sensitivity and specificity for diagnosis of VAP in some previous studies.[11]

Patients with a clinical diagnosis of VAP were undergone BAL if there was no contraindication for the procedure. The BAL fluids were used for both bacterial cultures and real time polymerase chain reaction (PCR) assays. Patients with any kind of preceding immunosuppression such as neutropenia, hematological or solid organ malignancy, bone marrow tran plantation, immunosuppressive therapy, systemic corticosteroid therapy, and human immunodeficiency virus infection were not included. A predesigned checklist was filled for each patient containing demographic and clinical data of the patient.

Deoxyribonucleic acid (DNA) extraction and real time PCR
For cell lysis, 200 μl of the BAL fluid was mixed with 200 μl of binding buffer (Roche Diagnostics) and 50 μl of Proteinase K (Roche Diagnostics). The mixture was incubated at 72°C for 20 min. Conventional phenol-chloroform method was used for DNA extraction as was explained elsewhere.[12] A predesigned TaqMan primer and the probe was used to identify A. fumigatus and the real time PCR was conducted as previously explained.[13] Candida spp. were detected by a predesigned general primer for Candida genus.[14] The Quantifast SYBR Green PCR Kit (Qiagen) was employed.

Table 1: NNIS system criteria for diagnosis of VAP

| Radiology signs                                      | Clinical and laboratory signs                                                                 |
|------------------------------------------------------|-----------------------------------------------------------------------------------------------|
| Two or more serial chest radiographs with at least 1 of the following                           | At least 1 of the following                                                                   |
| New or progressive and persistent infiltrate        | Fever (temperature >38 C)                                                                     |
| Consolidation                                        | Leukopenia (<4000 WBC) or leukocytosis (>12000 WBC)                                          |
| Cavitation                                           | Altered mental status, for adults 70 years or older, with no other recognized cause           |
|                                                      | Plus at least 2 of the following                                                             |
|                                                      | New onset of purulent sputum, or change in character of sputum                                |
|                                                      | Increased respiratory secretions, or increased suctioning requirements                        |
|                                                      | New-onset or worsening cough, or dyspnea, or tachypnea                                        |
|                                                      | Rales or bronchial sounds                                                                     |
|                                                      | Worsening gas exchange                                                                      |
|                                                      | Increased oxygen requirements                                                                |

Adopted from Miller et al. 2006; NNIS = National Nosocomial Infection Surveillance; VAP = Ventilator associated pneumonia; WBC = White blood cell
according to the kit instructions to identify the Candida spp. All real time PCR reactions were performed on a Rotor-Gene 6000 system (Corbett, Australia) and standard positive and negative controls were run parallel with each real time PCR round.

Statistical analysis
Data were analyzed using SPSS software version 16 (SPSS Inc., Chicago, IL, USA). Chi-squared test was used to determine the significance of differences between groups. $P < 0.05$ was considered as significant.

RESULTS

During the study 38 patients developed signs and symptoms of VAP whose BAL fluid samples were examined. The characteristics of patients are summarized in Table 2. Twenty one patients (55.3%) were males, and 17 (44.7%) were females. Age of the patients ranged from 20 to 86. Underlying diseases, which led to ICU hospitalization, were diverse. We arranged the underlying diseases in four groups:

1. Internal diseases such as organ failures and infectious diseases,
2. Post-surgical when a surgical procedure led to ICU admission,
3. Brain events such as cerebro-vascular accident and intracerebral hemorrhage, and
4. Trauma.

Underlying disease for most of the patients was post-surgical (12 patients) followed by internal diseases (10 patients).

| Table 2: Demographic and clinical characteristics of patients |
|-------------------------------------------------------------|
| Patients' characteristics | Candida spp. | $P$ value* | A. fumigatus | $P$ value* | Total (38) |
|---------------------------|-------------|-----------|-------------|-----------|-----------|
| Sex                       |             |           |             |           |           |
| Male                      | 3 (14.3)    | 0.77      | 3 (14.3)    | 0.81      | 21 (55.3) |
| Female                    | 3 (17.6)    |           | 2 (11.8)    |           | 17 (44.7) |
| Age                       |             |           |             |           |           |
| 20-39                     | 4 (30.8)    | 0.20      | 2 (15.4)    | 0.67      | 13 (34.2) |
| 40-59                     | 0           |           | 2 (22.2)    |           | 9 (23.7)  |
| 60-79                     | 2 (16.7)    |           | 1 (8.3)     |           | 12 (31.6) |
| 80+                       | 0           |           | 0           |           | 4 (10.5)  |
| Underlying disease        |             |           |             |           |           |
| Internal                  | 2 (20.0)    | 0.82      | 0           | 0.036     | 10 (26.3) |
| Surgical                  | 2 (16.7)    |           | 1 (8.3)     |           | 12 (31.6) |
| Brain event               | 1 (25.0)    |           | 1 (25.0)    |           | 4 (10.5)  |
| Trauma                    | 1 (16.7)    |           | 3 (50.0)    |           | 6 (15.8)  |
| Undetermined              | 0           |           | 0           |           | 6 (15.8)  |
| Duration of ventilation   |             |           |             |           |           |
| $\leq$ 4 weeks            | 5 (16.7)    | 0.77      | 2 (6.7)     | 0.022     | 30 (78.9) |
| $>$ 4 weeks               | 1 (12.5)    |           | 3 (37.5)    |           | 8 (21.1)  |
| Mortality                 | 1 (20.0)    | 0.78      | 1 (20.0)    | 0.62      | 5 (13.2)  |

*Pearson Chi-square test is used to detect significance of differences between groups; A. fumigatus = Aspergillus fumigatus

BAL fluid sample of six patients (15.8%) were positive for Candida spp. and five (13.2%) for A. fumigatus. Patients with positive results for A. fumigatus were further assessed according to the criteria from the European Organization for Research and Treatment of Cancer/Invasive Fungal Infections Cooperative Group and the National Institute of Allergy and Infectious Diseases Mycoses Study Group.[15] None of the patients were classified as proven or probable invasive pulmonary aspergillosis (IPA) and were considered colonization.

Colonization with Candida spp. or A. fumigatus was not associated with age or sex of the patients. Mortality was not more in colonized patients, and also underlying disease and duration of mechanical ventilation was not related to Candida colonization. However rate of A. fumigatus colonization was significantly different in subsets of different underlying diseases ($P = 0.036$), with the most colonization observed in traumatic patients (three of six traumatic patients (50%) were positive for A. fumigatus). The proportion of A. fumigatus colonization was significantly higher in patients ventilated more than 4 weeks ($P = 0.022$).

DISCUSSION

In the current study, two important opportunistic fungi, Candida and A. fumigatus were detected by real time PCR in BAL fluid sample of patients with a clinical diagnosis of VAP, and association of clinical data of patients with the rate of colonization was evaluated.

In this study, 15.8% of BAL fluids were positive for Candida spp. Rate of Candida colonization is comparable with
results of a large study in Canada in which totally 17.8% of patients with clinical suspicion of VAP were colonized with Candida.[16] Culture of either BAL fluid or endotracheal aspirate (ETA) was used to detect Candida in the respiratory tract and the rate of colonization was insignificantly more in BAL arm of the study (20%) than in ETA (15.6%).[16] The proportion of positive samples for Candida is higher in some other studies, for example in an investigation 26.6% of all immunocompetent critically ill patients apart from having VAP or not, had positive culture in their BAL fluid or other distal airway samples.[17] Furthermore, rate of colonization in patients suspicious of VAP was 56% in ETA culture[18] and 53% in ETA or BAL culture[5] in other surveys. Thus far, real time PCR has been used mostly to detect Candida in blood samples[19] and rarely in the respiratory track secretions.[20] We used real time PCR to detect fungi and only included the patients who were undergone BAL. While the sensitivity of real time PCR is high and the rate of false positive possibly is more than culture, rate of Candida colonization was lower than most of the previous reports. Different patient populations and different sampling methods might stand for this inconsistency. Furthermore, prior use of antibiotics can increase the rate of colonization which was not recorded in this study and made the comparison impossible.

No association between Candida Colonization and rate of mortality or length of mechanical ventilation was found, contrary to previous reports, which found an increase in median hospital stay,[16,17,21] length of mechanical ventilation[17] and hospital mortality.[16,18,21] The reason is perhaps low number of patients in this study.

Finally, 13.2% of samples were positive for A. fumigatus. Isolation of Aspergillus from respiratory samples represents either colonization or true infection. In contrast to Candida, a significant proportion of positive cases suffer from IPA that in ICU admitted patients ranges from 25% to 75% depending on the type of patients.[9] Immunosuppression is the main risk factor for development of IPA and the most frequent comorbidity in IPA patients is sever chronic obstructive pulmonary disease (COPD) and corticosteroid therapy.[9] None of our patients with positive Aspergillus sample were immunocompromised and none of them were diagnosed as proven or probable IPA. Interestingly, two of participants were admitted to ICU because of exacerbated COPD, but A. fumigatus was not identified in BAL fluid of any of them. A. fumigatus colonization was not associated with age or mortality of the patients. Although, in a survey isolation of Aspergillus in critically ill patients was higher in older patients and was attributed to worse outcomes.[22] Interestingly, half of traumatic patients in this study (three from six) were colonized with A. fumigatus. The reason for high colonization of traumatic patients is unknown and it is not reported before.

In an international survey rate of Aspergillus colonization in ICU patients was 1.4%.[23] Most of studies on Aspergillus are conducted in immunocompromised patients and investigated the incidence of IPA. Nasal colonization of Aspergillus has been examined and attributed to hospital constructions and air duct pollutions, with rates of 6% in a nephrology ward[24] and 1.5% in none ICU immunocompromised patients.[23] We examined the samples only for A. fumigatus. Although, it is established that about 80-90% of isolated Aspergillus around the world are A. fumigatus,[6] but recently an increase in incidence of other no-fumigatus species, especially A. flavus and A. terreus is noticed. For example, Zarrinfar et al. identified nine positive samples out of 30 BAL fluids by nested PCR from ICU patients from which seven were A. flavus.[12]

We would better detect other species of Aspergillus and identify Candida spp. which is a limitation for this study. Moreover, to evaluate the real time PCR technique, comparison with culture and microscopic techniques is suggested.

CONCLUSION

The rate of A. fumigatus colonization was high in our setting in comparison with other similar studies with the identical patient types. As the Aspergillus is an airborne easily transmissible infection and it causes severe invasion with high mortality rates in ICUs, specific measures should be carried out to decrease environmental pollutions. Air conditioners should be checked and regular cleaning of the ICUs must be considered. International guidelines for prevention of nosocomial pneumonia can provide useful instructions in this regard.[26] Furthermore, overall high rate of fungi colonization in our ICU might be due to unnecessary use of antibiotics which is documented in previous studies[17] and needs further evaluation.

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AUTHORS’ CONTRIBUTION

All authors have contributed in designing and conducting the study. SA, MY, FA, FF, NA, MP, and FH collected the data and FKh, BA, and SGH did the analysis. All authors have assisted in preparation of the first draft of the manuscript or revising it critically for important intellectual content. All authors have read and approved the content of the manuscript and are accountable for all aspects of the work.
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