Isolated microorganisms in plastic biliary stents placed for benign and malignant diseases

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**Abstract**

**Background** Biliary stenting is a well-established method to treat patients with malignant and benign biliary diseases. However, occlusion of plastic biliary stents is considered as a drawback and bacterial colonization seems to be the key factor in this process.

**Methods** During a 3-year period, 51 plastic biliary stents were extracted from 42 patients. Twenty-three stents were inserted for treating malignant and 28 for benign diseases. Stent samples were taken under a strict protocol, and were immediately sent to microbiological laboratory for culturing.

**Results** A polymicrobial growth was present in nearly all stents. The most frequently isolated organisms were *Enterococcus spp* (74%), *Escherichia coli* (*E. coli*) (62%), and *Klebsiella spp* (58%). *E. coli* was more frequently encountered in benign vs. malignant disease (78% vs. 43%, P<0.05). *Klebsiella spp*, *Pseudomonas spp*, and *Candida spp* were more frequently isolated in occluded vs. non-occluded stents, 68% vs. 37%, 22% vs. 0 and 40% vs. 6% respectively (P<0.05). *E. coli* and *Pseudomonas spp* had 34% and 50% resistance rate to quinolones respectively. *Enterobacter spp* expressed Amp-C derepression in 35%. *Enterococcus spp*, *Klebsiella spp* and *Pseudomonas spp* had a low resistance rate.

**Conclusion** *Enterococcus spp*, *E. coli* and *Klebsiella spp* are the most frequently associated organisms in plastic biliary stents. In occluded stents *Pseudomonas spp* and *Candida spp* should be taken into account. Quinolones may not be adequate for the treatment of cholangitis associated with stent occlusion. In patients under chemotherapy for malignancy and stent occlusion-related biliary sepsis, antifungal and enterococcal covering should be considered.

**Keywords** Biliary stents, occlusion, microorganisms, microbial growth, antibiotic resistance

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**Introduction**

Since its first application in 1968, endoscopic retrograde cholangiopancreatography (ERCP) [1] remains an effective procedure for diagnosis and mainly for treating diseases of biliary and pancreatic tracts. The evolution of other non-invasive imaging techniques, such as magnetic resonance cholangiopancreatography (MRCP) [2] and endoscopic ultrasonound (EUS) [3], has limited the diagnostic prospective of ERCP [4]. However, endoscopic sphincterotomy, stone extraction and stent placement have established ERCP as a gold standard treatment for a variety of malignant and benign diseases of biliary and pancreatic ducts [5]. When plastic stents are chosen to maintain bile duct patency, stent occlusion with consequent bile stasis and cholangitis constitutes one of the major late complications [6,7]. The elimination of the anti-microbial barrier of Oddi [8] and the low pressure in common bile duct, due to endoscopic sphincterotomy and endoprostheses insertion leads to duodenal reflux, allowing bacterial colonization and biofilm formation, resulting to stent occlusion [7,9,10]. This study was performed to identify the spectrum of microbial flora involved in endoprostheses colonization and biofilm formation, as well as to evaluate their resistance to advanced antibiotic therapy.
Patients and methods

During a 3-year period, 51 plastic biliary stents were extracted from 42 patients. There were 25 female and 17 male patients with a median age of 71 years (range 39-92). Twenty-three stents were inserted for treating malignant disease and 28 for benign disease (Table 1). A total of 31 straight polyurethane stents with side flaps (20 had a diameter of 10-Fr and 11 of 7-Fr) and 20 polyurethane pig-tail stents with side holes (7-Fr) (Wilson-Cook Medical Inc.) were extracted. Stent extraction was decided on a scheduled basis up to 3 months after placement for benign disease or if clinical signs of stent clogging such as cholangitis, recurrent jaundice or biliary colic with elevated liver function tests developed.

All patients with symptoms of stent occlusion had been administered antibiotics for various lengths of time before ERCP. Patients scheduled for stent removal were given a single dose of antibiotic before ERCP, usually cefuroxime or ciprofloxacin.

Stent preparation

Under sterile conditions (surgical gloves) the extracted stents were cannulated using a sterile 21 G vein catheter, 10 cc of normal saline was injected and the collected lavage was distilled in a sterile culture tube and was immediately sent to the microbiological laboratory for culturing.

Microbiological study

The sample was cultured in blood agar, MacConkey agar (for selective isolation of Gram negative bacterial species) and Columbia agar (for selective isolation of anaerobic bacterial species). The identification of the isolated bacterial species, as well as the minimum inhibitory concentration (MIC) specification was based on Vitek 2 Comact system (bioMerieux, France) and auxiliary on API (bioMerieux, France) and BBL Crystal (BD) systems. Additionally, the confirmation of specific resistance phenotypes (e.g., extended-spectrum β-lactamases (ESBLs), metallo-β-lactamases (MBLs), AmpC type β-lactamases) was measured by Etest (AB Biodisk, Sweden).

Statistical analysis

Data from categorical variables were compared using the chi-square test or the Fisher’s exact test. Continuous variables were compared using the Mann-Whitney test. All P-values were based on two-tailed tests. A P-value <0.05 was considered significant. Analysis was performed with Minitab 16 statistical software.

Results

Sixteen stents were schedule explanted and 35 because of clinical signs of occlusion. Fifty stents were endoscopically retrieved and one surgically during a Whipple’s procedure. The median stent time to removal was 90 days (range, 9-730).

All our samples were positive for bacterial growth. Monomicrobial growth was present in two stents, whilst polymicrobial in all the remaining.

There were 162 growths from 16 different species. The median number of bacteria per stent was 3 (range, 1-6). There was statistical correlation between stent remaining time and number of organisms isolated (P<0.05) (Fig. 1). Table 2 shows the distribution of different microbial species in the stents. The most frequently encountered organisms were Enterococcus spp (74%), Escherichia coli (E. coli) (62%) and Klebsiella spp (58%).

There were no statistical differences between the organisms isolated between straight vs. pig-tail stents (P>0.05) and 10-Fr vs. 7-Fr stents (P>0.05). E. coli was more frequently encountered in benign disease vs. malignant disease (78% vs.43%; P<0.05). There was no statistical difference in the other organisms between malignant and benign disease (P>0.05). Klebsiella spp, Pseudomonas spp, and Candida spp

![Figure 1](image_url)

Table 1 Main indication for the endoscopic intervention

| Diagnosis                             | N of stents |
|---------------------------------------|-------------|
| Malignant disease                     |             |
| Pancreatic cancer                     | 15          |
| Cholangiocarcinoma                    | 4           |
| Gallbladder cancer                    | 2           |
| Ampullary cancer                      | 1           |
| Metastatic lesion from colon cancer   | 1           |
| Benign disease                        |             |
| Choledocholithiasis                   | 21          |
| Iatrogenic injuries                   | 5           |
| Primary sclerosing cholangitis        | 2           |

![Figure 2](image_url)

Figure 1 Scatterplot of stent duration in place vs. number of organisms
Pearson correlation of remaining time (days) and N of organisms=0,449
P-Value=0.001
were more frequently isolated in occluded vs. non-occluded stents, 68% vs. 37%, 22% vs. 0% and 40% vs. 6% respectively (P<0.05) (Table 3).

There was no statistical difference between organisms, as regards stent duration in place (P>0.05) (Table 4).

The screening for potential resistance of bacteria was performed by defining specific type β-lactamases (e.g. ESBLs, AmpC), carvapenemases (e.g. MBLs, *Klebsiella pneumoniae* carbapenemase-KPC) and resistance to advanced antibiotics (quinolones and vancomycin) (Table 5). Eleven of 32 (34%) isolated *E. coli* strains, and 4 of 8 (50%) *Pseudomonas spp* strains were resistant to quinolones. Five of 14 (35%) isolated *Enterobacter spp* strains expressed Amp-C derepression and were highly resistant. *Enterococcus spp* and *Klebsiella spp* had a low resistance rate.

There was no statistical difference in the resistance rate for *E. coli* and *Enterobacter* species, between occluded and non-occluded stents (P>0.05), and between malignant and benign diseases (P>0.05).

### Discussion

The occlusion of endoscopically placed plastic biliary stents is the most frequent cause of biliary infection and recurrent jaundice, increasing morbidity and health care cost due to the need of stent exchange [9]. The occlusion mechanism is primarily based on bacterial colonization, as intestinal bacterial flora has ascending access to the biliary system due to elimination of the barrier function of the sphincter of Oddi. Subsequent biofilm formation on the inner surface of the stent by amorphous sludge from microbial byproducts, proteins, dietary fibers and biliary salts induce stent lumen encasement [11-14]. The outer surface of the distal end of the stent comes in direct contact with the duodenal lumen and our preparation technique was suggested to obtain samples from the inner surface where the bacteria are attached and the biofilm is formatted. However, a limitation is that contamination via the endoscope, when it is passed through the duodenum, or via cross-transmission between different patients cannot be excluded, despite vigilant disinfection.

A polymicrobial growth in bile or stents is quite common with an incidence ranging from 8 to 67% [15-17]. Nearly all our stents (96%) had polymicrobial growth. This high percentage may be due to the way our samples were obtained. The number of bacteria isolated per stent was in correlation with stent duration (P<0.05), and the longer duration of stent (P<0.05). On the contrary, the type of bacteria isolated was not related to stent duration (P>0.05).

Microbial organisms isolated from biliary stents include both aerobic and anaerobic species, as well as fungi [9]. *Enterococcus spp, E. coli,* and *Klebsiella spp* are the most common bacteria isolated from the sludge removed from biliary stents. However, the ratio between the isolated organisms varies in different studies, probably depending on either the portion of the stent analysed (proximal or distal part) or the protocol of sampling and microbiological analysis [9].
Another limitation in our study is that patients with symptoms of stent occlusion, and especially cholangitis, received prolonged treatments with antibiotics before stent exchange and that may influence the type of organisms cultured and their sensitivity.

Organisms isolated from the sludge of biliary stents are similar in 47% of patients to those isolated from blood in patients with biliary sepsis [17]. Isolation of similar organisms from blood and from bile shows a wide spectrum from 21-67% of the patients with bacteremia [16,18].

In our study Enterococcus spp (74%), E. coli (62%), and Klebsiella spp (58%) were also the most frequently isolated organisms. Stent diameter (10-Fr vs. 7-Fr) and shape (straight vs. pig-tail) did not play a role in the frequency of organisms. The same bacteria were isolated for benign and malignant disease, with the exception of E. coli. E. coli was more frequently isolated in benign diseases (P<0.05). Analysis of bile and stent samples of patients with gallstone disease has showed E. coli and Gram-negative bacteria to be most commonly found [17,19].

Klebsiella spp, Pseudomonas spp, and Candida spp were more frequently isolated in occluded than non-occluded stents (P<0.05). This may be due to more hospital admissions and more antibiotics used in patients with occluded stents. Pseudomonas spp was not isolated in any non-occluded stent scheduled for extraction. The incidence of anaerobes in our study was very low (2%). Isolated anaerobic bacteria rates in the literature are controversial because of the difficulties of isolation and proliferation style of some facultative-anaerobic organisms [9,20,21]. However, anaerobic bacteria are suggested to play a significant role in biliary stent clogging [22] and anaerobic therapy is suggested if a biliary-enteric anastomosis is present [23].

The clinical presentation of cholangitis associated with stent occlusion ranges from mild abdominal discomfort and pyrexia to life-threatening septic shock. Antimicrobial therapy is usually empirical. Initial therapy should cover the Enterobacteriaceae, especially E. coli and relief of biliary obstruction is mandatory. Based on pharmacokinetic studies and in vitro susceptibility findings, ciprofloxacin was suggested to be superior to other antibiotics in prophylaxis and treatment of biliary sepsis [24,18]. In our study, E. coli, Klebsiella spp, and Pseudomonas spp were found to be resistant to quinolones in 34%, 20%, and 50% respectively. There was no difference in E. coli resistance between occluded and non-occluded stents (P>0.05). Therefore, quinolones may not be adequate either for prophylaxis in patients scheduled for stent exchange, or for treatment of cholangitis associated with stent occlusion. In Europe, the quinolone resistance rate, for hospitalized patients, ranges from 6% (France) to 20% (Spain) [25]. A recent paper demonstrated that E. coli resistance to quinolones increased significantly (P<0.0005) between 2007 (20.0%) and 2011 (29.2%) in Canadian hospitals [26]. The increased and often unjustified use of quinolones in the community and in hospitalized patients may have contributed to the high resistance rate in our sample.

Interpreting our results (Table 5) we could suggest that antibiotics combined with ESBLs inhibitors like tazobactam, clavulanate or sulbactam might be the first option in patients with cholangitis associated with stent occlusion, which is in agreement with recent literature [23].

Enterococcus species were the most frequently isolated organisms (74%), but their pathogenicity in biliary tract...

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### Table 5 Antibiotic resistance of the most frequently isolated organisms

| Bacteria                | VRE|^ | ESBLs^b | AmpC-Dr^c | MBLs^d | KPC^e | QR^f |
|-------------------------|-----|--------|----------|---------|-------|------|------|
| Enterococcus spp        | 1 (2.6%) | - | - | - | - |
| Klebsiella spp          | - | 1 (3.3%) | - | 3 (10%) | 1 (3.3%) | 6 (20%) |
| Pseudomonas spp         | - | - | - | 1 (12.5%) | - | 4 (50%) |
| Escherichia coli        | - | 4 (12.5%) | - | - | - | 11 (34.3%) |
| Enterobacter spp        | - | - | 5 (35.7%) | - | - | - |

^aVancomycin resistant enterococcus, ^bExtended spectrum B-lactamases, ^cAmpC-derepression, ^dMetallo B-lactamases, ^eKlebsiella pneumoniae carbapenemase, ^fQuinolone resistant

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### Summary Box

#### What is already known:
- The main drawback of biliary stents is occlusion, usually clinically manifesting as cholangitis
- Bacterial colonization of stents and subsequent biofilm formation are considered as the primary occlusion mechanisms
- Intestinal flora usually colonizes stents by ascending access to the biliary tract

#### What the new findings are:
- Enterococcus species, Escherichia coli, and Klebsiella species are the most frequently isolated organisms in plastic biliary stents
- In occluded stents Pseudomonas species and Candida species should be taken into account
- A high resistance to quinolones has been developed
infections remains unclear [17,27]. The need for antibiotic covering against Enterococcus should be limited to immunocompromised patients with symptoms of stent occlusion and those in severe sepsis [28].

Candida species were isolated in 40% of occluded stents. Our results are consistent with Negm et al [15], where a 31% rate of candida infection in aspirated bile, was found in patients with biliary stents. Fungal infection of the biliary tract is difficult to diagnose and the isolation of fungi may represent only colonisation due to contamination or selection of patients [29]. In patients with recurrent cholangitis or sepsis associated with stent occlusion and malignant disease under chemotherapy, fungal infection has to be taken into account, when designing anti-infectious treatment.

In conclusion, Enterococcus species, E. coli, and Klebsiella species are the most frequently isolated organisms in plastic biliary stents. In occluded stents Pseudomonas species and Candida species should be taken into account. Quinolones may not to be adequate for the treatment of cholangitis associated with stent occlusion. In patients under chemotherapy for malignancy and stent occlusion related biliary sepsis, antifungal and enterococcal covering should be considered.

References

1. McCune WS, Shorb PE, Moscovitz H. Endoscopic cannulation of the ampulla of Vater: a preliminary report. Ann Surg 1968;167:752-756.
2. Fernández-Esparrach G, Ginès A, Sánchez M, et al. Comparison of endoscopic ultrasonography and magnetic resonance cholangiopancreatography in the diagnosis of pancreaticobiliary diseases: a prospective study. Am J Gastroenterol 2007;102:1632-1639.
3. Petrov MS, Savides TJ. Systematic review of endoscopic ultrasonography versus endoscopic retrograde cholangiopancreatography for suspected choledocholithiasis. Br J Surg 2009;96:967-974.
4. NIH state-of-the-science statement on endoscopic retrograde cholangiopancreatography (ERCP) for diagnosis and therapy. NIH Consens State Sci Statements 2002;19:1-26.
5. ASGE guideline: the role of ERCP in diseases of the biliary tract and the pancreas. Gastrointest Endosc 2005;62:1-8.
6. Costamagna G, Shah SK, Tringali A. Current management of postoperative complications and benign biliary strictures. Gastrointest Endosc Clin N Am 2003;13:635-648.
7. Motte S, Deviere J, Dumoncelle JM, Serruys E, Thys JP, Cremer M. Risk factors for sepsisemia following endoscopic biliary stenting. Gastroenterology 1991;101:1374-1381.
8. Sung YJ, Costerton JW, Shaffer EA. Defense system in the biliary tract against bacterial infection. Dig Dis Sci 1992;37:689-696.
9. Donelli G, Guaglianone E, Di Rosa R, Ficca F, Basoli A. Plastic biliary stent occlusion: factors involved and possible preventive approaches. Clin Med Res 2007;5:53-60.
10. Sung YJ, Leung JW, Shaffer EA, Lam K, Olson ME, Costerton JW. Ascending infection of the biliary tract after surgical sphincterotomy and biliary stenting. J Gastroenterol Hepatol 1992;7:240-245.
11. Dowidar N, Kolmos HJ, Matzen P. Experimental clogging of biliary endoprostheses. Role of bacteria, endoprosthesis material, and design. Scand J Gastroenterol 1992;27:77-80.
12. Weickert U, Venzke T, Konig J, Janssen J, Remberker L. Why do bilioduodenal plastic stents become occluded? A clinical and pathological investigation on 100 consecutive patients. Endoscopy 2001;33:786-790.
13. Moesch C, Sautereau D, Cessot F, et al. Physicochemical and bacteriological analysis of the contents of occluded biliary endoprostheses. Hepatology 1991;14:1142-1146.
14. Yu JL, Andersson R, Wang LQ, Bengmark S, Ljungh A. Fibronectin on the surface of biliary drain materials—a role in bacterial adherence. J Surg Res 1995;59:596-600.
15. Negm AA, Schott A, Vonberg RP, et al. Routine bile collection for microbiological analysis during cholangiography and its impact on the management of cholangitis. Gastrointest Endosc 2010;72:284-291.
16. Chang WT, Lee KT, Wang SR, et al. Bacteriology and antimicrobial susceptibility in biliary tract disease: an audit of 10-year's experience. Kaohsiung J Med Sci 2002;18:221-228.
17. Demirbag AE, Karademir A, Parkar E, et al. Multidrug resistance in isolated microorganisms in occluded bile duct stents. Turk J Gastroenterol 2007;18:33-40.
18. Leung JW, Ling TK, Chan RC, et al. Antibiotics, biliary sepsis, and bile duct stones. Gastrointest Endosc 1994;40:716-721.
19. Connors PJ, Carr-Locke DL. Endoscopic retrograde cholangiopancreatography—findings and endoscopic sphincterotomy for cholangitis and pancreatitis. Gastrointest Endosc Clin North Am 1991;1:27.
20. Leung JW, Ling TK, Kung IL, Vallance-Owen J. The role of bacteria in the blockage of biliary stents. Gastrointest Endosc 1988;34:19-22.
21. Dowidar N, Kolmos HJ, Lyon H, Matzen P. Clogging of biliary endoprostheses. Role of bacteria, endoprosthesis material, and pathological investigation on 100 consecutive patients. Gastrointest Endosc Clin N Am 2009;19:1-27.
22. Guaglianone E, Cardines R, Vuotto C, et al. Microbial biofilms associated with biliary stent clogging. FEMS Immunol Microbiol 2010;50:410-420.
23. Gomi H, Solomkin JS, Takada T, et al. TG13 antimicrobial therapy for acute cholangitis and cholecystitis. J Hepatobiliary Pancreat Sci 2013;20:60-70.
24. Van den Hazel SJ, De Vries XH, Speelman P, et al. Biliary excretion of ciprofloxacin and piperacillin in the obstructed biliary tract. Antimicrob Agents Chemother 1996;40:2658-2660.
25. Wenzel RP, Sahm DF, Thornsberry C, Draghi DC, Jones ME, Karlowsky JA. In vitro susceptibilities of gram-negative bacteria isolated from hospitalized patients in four European countries, Canada, and the United States in 2000-2001 to expanded-spectrum cephalosporins and comparator antimicrobials: Implications for therapy. Antimicrob Agents Chemother 2003;47:3089-3098.
26. Karlowsky JA, Adam HJ, Desjardins M, Lagace-Wiens P, Roberts GG. Changes in fluoroquinolone resistance over 5 years (CANWARD 2007-11) in bacterial pathogens isolated in Canadian hospitals. J Antimicrob Chemother 2013;68:139-146.
27. Rerknimitr R, Fogel EL, Kalayci C, Esber E, Lehman GA, Sherman S. Microbiology of bile in patients with cholangitis or cholestasis with and without plastic biliary endoprostheses. Gastrointest Endosc 2002;56:885-889.
28. Blot S, De Waee JJ. Critical issues in the clinical management of complicated intra-abdominal infections. Drugs 2005;65:1611-1620.
29. Lenz P, Conrad B, Kucharzik T, et al. Prevalence, associations, and trends of biliary tract candidiasis: A prospective observational study. Gastrointest Endosc 2009;70:480-487.