INTRODUCTION

Hospital acquired infection (HAI) also called nosocomial infection is a kind of infection which is acquired in the hospital by a patient in whom the infection was not present at the time of admission but emerged after discharging and it also includes occupational infections among the staff of the organization [1,2]. Nosocomial infections are mostly caused by Gram-negative organisms and are one of the major issues in patient safety. HAI’s are one of the major causes of death [3] which have worldwide prevalence and affect developed, developing and resource-poor countries. The rate of morbidity and mortality is significantly increased and cause financial losses for health-care system. The study has revealed that within hospital it is mostly prevalent is intensive care units (ICU) followed by acute surgical and orthopedic wards [4]. Approximately 30% patients in ICU are affected by at least one nosocomial infection [5]. Acinetobacter is Gram-negative coccobacillus who has become the most prevalent cause of HAI. It has been identified to cause sporadic infections in health-care settings and has a significant role in colonization in critically ill patients [6]. The species Acinetobacter are associated with healthcare-related outbreaks [7-9]. Advance medical interventions and various surgical procedures increase the rate of nosocomial infections. Among all species of Acinetobacter, Acinetobacter baumannii has been found to cause approximately 80% of reported Acinetobacter infections [10]. Their rapid ability to acquire resistant genes, minimal nutritional requirement, adherence to inanimate objects and long-term survival on them, biofilm production made them a successful nosocomial pathogen that is associated with respiratory tract infections, abscesses, bloodstream infections, meningitis, urinary tract infections, pleural effusion, etc. They resist mostly all common antibiotics through a number of different mechanisms which includes production of enzymes (β-lactamases, aminoglycosides-modifying enzymes), alteration in outer membrane proteins and penicillin-binding proteins, efflux pumps, e.g., multidrug efflux pump, i.e., AdeABC, MATE pump AdeM, Tet (A), and Tet (B). Lower respiratory tract infections were more prevalent (4.07%) in hospital facility followed by abscess (6.72%), septicemia (2.52%), urinary tract infections (0.84%), and soft tissue infections (0.84%). Males were most commonly affected with Acinetobacter infections [64.70%] when compared with females (35.30%). Among frequent visit to the hospital might be the possible cause of infections for the males [11]. Colistin was the most promising drug followed by tigecycline and minocycline. Imipenem, aztreonam, and ticarcillin-clavulanic acid were most resistant. Good housekeeping, sterilization of equipment, hand hygiene, water purification, isolation procedures and maintaining of the hospital environment, use of infection control practices should be implemented to control the rate A. baumannii infection.
The study was conducted at the department of microbiology from January 2016 to April 2016. A total of 2582 clinical specimens were collected from patients of different units of the hospital by maintaining universal precautions and standard microbiological protocols. The specimens include lower respiratory tract samples, i.e., endotracheal secretions, tracheal secretions, bronchoalveolar lavage, sputum, bronchial wash, and endotracheal tract tips, pus and pus swabs, blood, cerebrospinal fluid, pleural fluid, ascitic fluid, and tissues. All specimens were cultured on MacConkey agar and sheep blood agar (except

| Gender   | Total cases | Positive cases n (%) |
|----------|-------------|----------------------|
| Male     | 1718        | 77 (64.70)           |
| Female   | 864         | 42 (35.30)           |
| Total    | 2582        | 119 (100)            |

*Table 1: Gender wise distribution of *A. baumannii* infections*

**Fig. 1: Distribution of *Acinetobacter baumannii* infections**

**Fig. 2: Effect of antibiotics on *Acinetobacter baumannii* isolates**
were obtained from 2582 clinical specimens. The most common nosocomial pathogen found is Acinetobacter baumannii, which is a strong producer of biofilm that helps them adhere to surfaces and survives for a long time on surfaces of inanimate substances which play a key role in their pathogenesis. They are a strong producer of biofilm which helps them in trapping and concentrating all essential requirements from the environment and also provide a gate for horizontal gene transfer. Their ability of rapid acquiring genes that encoded drug resistant property has made them a potent pathogen in a hospital environment.

In this study, a total of 119 (4.60%) A. baumannii isolates were isolated using Vitek2 compact which is based on advanced colorimetry and MIC technique, respectively.

The most common infection A. baumannii was found as lower respiratory tract infection (89.07%) followed by abscess (67.2%), septicemia (25.2%), urinary tract infections (8.84%), and soft tissue infections (8.84%) (Table 1).

Out of 2582 specimens processed 1718 (66.54%) were from male patients with positive A. baumannii infections 77 (64.70%) and 656 (53.46%) specimens were from female with 42 (35.30%) positive A. baumannii infections. Males (64.70%) were more commonly infected with A. baumannii than females (35.30%) (Table 1).

The maximum sensitivity of A. baumannii isolates were seen to colistin (119, 100%) followed by tigecycline (63, 52.9%) and minocycline (27, 22.6%) whereas the sensitivity to cepaperazone-sulbactam was 11.8% Isolates were appeared to be intermediate sensitive to tigecycline (35, 29.41%), cefoperazone-sulbactam (28, 26.8%), minocycline (16, 13.45%), and ceftazidime (1, 0.84%). The maximum resistant was observed for imipenem, aztreonam, and ticarcillin-clavulanic acid (119, 100%), followed by ciprofloxacin (118, 99.16%), meropenem (118, 99.16%), piperaclillin-tazobactam (117, 98.32%), cefepime (117, 98.32%), doripenem (117, 98.32%), gentamicin (117, 98.32%), and levofloxacin (117, 97.48%) (Fig. 2).

A. baumannii is Gram-negative coccobacillus that has emerged as a successful nosocomial pathogen in past two decades. Its ability to resist drug, minimal nutrition requirements and ubiquitous distribution in nature made it a superbug. They are ubiquitous inhabitants of soil, water, and sewage environments. It is a communal flora of human and animal skin that eases its transmission to critically ill patients in a hospital facility. Advance facilities in treatment and use of broad-spectrum antibiotics increase the rate of morbidity and mortality of Acinetobacter infections. Acinetobacter adheres to surfaces and survives for a long time on surfaces of inanimate substances which play a key role in their pathogenesis. They are a strong producer of biofilm which helps them in trapping and concentrating all essential requirements from the environment and also provide a gate for horizontal gene transfer. Their ability of rapid acquiring genes that encoded drug resistant property has made them a potent pathogen in a hospital environment. Biofilm prevents bacteria from host immune defense and also diminish the action of antibiotics. The ratio of multi-drug resistant A. baumannii is increased, particularly in ICU patients [12]. In last two decades, the incidence of Acinetobacter infections has increased at a high rate that makes them be ranked as 2nd most common nosocomial pathogen found in all clinical specimens after Pseudomonas aeruginosa and 4th according to the frequency of infections after P. aeruginosa, Staphylococcus aureus, and Klebsiella pneumoniae [13].

In this study, a total of 119 (4.60%) A. baumannii isolates were isolated using Vitek2 compact from a total of 2582 processed clinical specimens including lower respiratory samples, blood, urine, body fluids, and tissues. Respiratory tract infections (89.07%) were most common infection observed followed by abscess (67.2%), septicemia (25.2%), urinary tract infections (8.84%), and soft tissue infections (8.84%) (Figure 1). The reason for the respiratory infections to be more frequent is may be because of the use of mechanical ventilators and intubations. Tripathi et al. reported a total number of 107 (1.02%) Acinetobacter isolates from all processed clinical specimens and Mal-Warid and Thahab reported 11 (2.40%) isolates of A. baumannii from a total of 458 clinical samples which is well comparable with our study.

In this study, A. baumannii infections were common in males (64.70%) as compared with females (35.30%). A more frequent visit to the hospitals might be the possible cause of infections for the males [11].

The notorious nature of A. baumannii to acquire resistant genes is accounting for drug resistance to most common antibiotics. This has created a major challenge in patient safety. Acinetobacter spp. is universally resistant to penicillin, ampicillin, and cephalothin. [11]. Acinetobacter resists mostly all the classes of drug including β-lactams, aminoglycosides, quinolones, and tetracyclines. Through the production of enzymes (β-lactamases, aminoglycosides-modifying enzymes), changes in their OMPS, using of multidrug efflux pumps and alteration in the affinity or expression of PBPs Acinetobacter spp. resist β-lactams and carbapenems. In this study, IMI, azithromycin, and TIC have shown maximum resistance (100%) followed by CIP (99.16%), MER (99.16%), PT (98.32%), CPM (98.32%), DOR (98.32%), GEN (98.32%), and LEV (97.48%). Colistin was the most sensitive drug (100%) obtained. Sensitivity to tight glyceric control (TGC) and MIN was 52.94% and 22.69%, respectively. Isolates were appeared to be intermediate sensitive to TGC (29.41%), CFS (28.6%), MIN (13.45%), and CAZ (0.84%). Development of new therapies, well-managed clinical trials of existing antibiotics for combination therapy, prevention of transmission of the hospital-associated infections, hospital hygiene are essential to control Acinetobacter infections.

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