Class D OXA-48 Carbapenemase in Multidrug-Resistant Enterobacteria, Senegal
Olivier Moquet, Coralie Bouchiat, Alfred Dieudonné Kinana, Abdoulaye Seck, Omar Arouna, Raymond Bercion, Sebastien Breurec, Benoit Garin

To cite this version:

HAL Id: hal-01348289
https://hal.archives-ouvertes.fr/hal-01348289
Submitted on 26 Jul 2016

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers. L’archive ouverte pluridisciplinaire HAL, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d’enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.


Address for correspondence: Anna Papa, Department of Microbiology, Medical School Aristotle University of Thessaloniki, 54124, Thessaloniki, Greece; email: annap@med.auth.gr

---

**Class D OXA-48 Carbapenemase in Multidrug-Resistant Enterobacteriaceae, Senegal**

To the Editor: Class D OXA β-lactamas are characterized as penicillins that can hydrolyze oxacillin and cloxacillin and are poorly inhibited by clavulanic acid and EDTA. OXA-48 is one of the few members of this family to possess notable carbapenem-hydrolyzing activity (1). First described in 2004 in Turkey, OXA-48 has recently started to spread in Europe and the Middle East (2). We report the recent emergence of the plasmid-encoded blaOXA-48 gene in multidrug-resistant Enterobacteriaceae recovered from patients in Dakar, Senegal, in hospitals and in the community.

From November 2008 through October 2009, 11 Enterobacteriaceae isolates (8 Klebsiella pneumoniae, 1 Escherichia coli, 1 Enterobacter cloacae, and 1 Enterobacter sakazakii) with reduced susceptibility to imipenem were identified at the Institut Pasteur (Dakar, Senegal). Antibacterial drug susceptibility was determined by the disk diffusion method and interpreted according to the European Committee on Antimicrobial Susceptibility Testing guidelines (www.eucast.org). Nine isolates were resistant to expanded-spectrum cephalosporins and also to other antibacterial drug classes.

The isolates were recovered from 6 patients with urinary tract infections, 4 patients with surgical infections, and 1 patient with omphalitis. Nine infections were hospital acquired (Le Danec and Principal Hospitals). Because the patients died before antibacterial drug susceptibility testing could be completed, all 5 patients with surgical infections or omphalitis received only empirical therapy with amoxicillin/clavulanate. One patient with a nosocomial urinary tract infection caused by a co-trimoxazole–susceptible strain was successfully treated with this antibacterial agent. The antibacterial drug regimens of the remaining 4 patients were not known, and they were lost to follow-up. We determined the MICs of imipenem, meropenem, and ertapenem by using the Etest method (AB Biodisk, Solna, Sweden), which showed that 9 isolates were susceptible to imipenem and meropenem but either intermediate susceptible or resistant to ertapenem (Table). The 2 imipenem-nonsusceptible isolates were susceptible or intermediate susceptible to meropenem, and both were resistant to ertapenem.

We used previously described PCRs (1,3–7) to screen for carbapenem-hydrolyzing β-lactamase genes (blaVIM, blaIMP, blaAmpC, and blaOXA-48), as well as plasmid-encoded blaCTX-M1, bla AmpC, blaOXA-48, and blatem β-lactamase genes; the aac(6′)-Ib aminoglycoside resistance gene; the quinolone resistance genes qnrA, B, S; the tetracycline resistance genes tetA, B, D; and class 1 integron. The blaOXA-48, blaVIM, blaAmpC, and aac(6′)-Ib genes and the variable region of class 1 integron were then characterized by direct DNA sequencing of the PCR products. blaOXA-48 was present in all 11 isolates. blaVIM, blaAmpC, and blaKPC were not detected. The qnr genes were present in 7 isolates resistant to ciprofloxacin. The aac(6′)-Ib-cr variant was present in 7 isolates resistant to gentamicin, tobramycin, and ciprofloxacin.

The 9 isolates resistant to expanded-spectrum cephalosporins all harbored the blaCTX-M-15 gene. The E. coli isolate also harbored the plasmid-encoded bla AmpC gene ACT-1; blaOXA-48, blaCTX-M-15, blaTEM-1, blaKPC, and aac(6′)-Ib-cr were associated in 6 isolates. Long-range PCRs showed that these latter 4 genes were located in the same “multidrug resistance region,” as described in Senegal (6). Positive conjugation experiments with sodium azide–resistant E. coli J53 showed through PCR results, plasmid DNA extraction, and antibiogram patterns of the obtained transconjugants that blaOXA-48 was located on a 70-kb self-conjugative plasmid.

The genetic environment of blaOXA-48 was then investigated by PCR with primers specific for insertion sequence IS1999 and for the 5′ part of blaOXA-48 (1). blaOXA-48 found to be part of a Tn1999 composite transposon composed of 2 copies of the insertion sequence IS1999, as reported (2). Further sequencing of the IS1999 located upstream of blaOXA-48 showed that it was consistently truncated by the insertion sequence IS1999, as initially described in Turkey and more recently in Lebanon and Egypt (2,8).

XbaI pulsed-field gel electrophoresis was then used to study the genetic relatedness of the 8 K. pneumoniae
isolates. Three isolates had similar restriction profiles and had been recovered from 3 patients concurrently hospitalized at Le Dantec Hospital, suggesting nosocomial transmission. A class I integron harboring the dfrA1 trimethoprim-resistance gene was detected in the 3 clonal isolates.

Together, these findings show the recent emergence of \( \text{bla}_{\text{OXA-48}} \) in Senegal in community and hospital settings. They may also suggest the spread of the same major carrying plasmid between the Middle East and Africa. Although 9 of the 11 isolates were found to be susceptible to imipenem on the basis of their MICs, their MICs were nonetheless higher than those of \( \text{bla}_{\text{OXA-48}} \)-negative isolates. This raises 2 issues. First, these strains might go undetected during routine antibacterial drug susceptibility testing, a problem that could be overcome by using ertapenem, a compound more susceptible to carbapenemases. Second, the clinical efficacy of imipenem on such strains is uncertain. The frequency of acquired carbapenemases, which emerged early after imipenem introduction in Senegal (2008), is probably strongly underestimated, partly owing to the limited availability of reliable clinical laboratories (9). Because multidrug resistance is prevalent among \( \text{Enterobacteriaceae} \) isolated in Dakar hospitals (B. Garin, unpublished data) and in rural communities (6), the emergence of \( \text{bla}_{\text{OXA-48}} \) is a clear cause for concern.

Olivier Moquet, Coralie Bouchiat, Alfred Kinana, Abdoulaye Seck, Omar Arouna, Raymond Berclon, Sebastien Breurec, and Benoit Garin

Author affiliations: Institut Pasteur, Dakar, Senegal (O. Moquet, C. Bouchiat, A. Kinana, A. Seck, S. Breurec, O. Garin); and Hospital Principal, Dakar (O. Arouna, R. Berclon)

DOI: 10.3201/eid1701.100224

References


Address for correspondence: Olivier Moquet, Laboratoire de Biologie Medicale, Institut Pasteur, BP 220, Dakar, Senegal; email: olivier.biomed@gmail.com

---

**Table. Resistance genes and carbapenem MICs of 11 \( \text{Enterobacteriaceae} \) isolates, Senegal, 2008–2009**

<table>
<thead>
<tr>
<th>Isolate</th>
<th>Species</th>
<th>Origin†</th>
<th>( \text{bla}_{\text{OXA-48}} )</th>
<th>( \text{bla}_{\text{CTX-M-15}} )</th>
<th>( \text{bla}_{\text{OXA-48}} )</th>
<th>( \text{bla}_{\text{TEM}} )</th>
<th>aac-6'-lb</th>
<th>qnr</th>
<th>tet</th>
<th>dfr</th>
<th>IPM (μg/mL)</th>
<th>MEM</th>
<th>ERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>17176</td>
<td>( \text{Klebsiella pneumoniae} )</td>
<td>1</td>
<td>+</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>A,D</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>22184</td>
<td>( \text{K. pneumoniae} )†</td>
<td>2</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cr</td>
<td>S</td>
<td>A</td>
<td>A1</td>
<td>1</td>
<td>0.38</td>
<td>1.5</td>
</tr>
<tr>
<td>20254</td>
<td>( \text{K. pneumoniae} )†</td>
<td>3</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cr</td>
<td>S</td>
<td>A</td>
<td>A1</td>
<td>1</td>
<td>0.38</td>
<td>1.5</td>
</tr>
<tr>
<td>10243</td>
<td>( \text{K. pneumoniae} )†</td>
<td>3</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cr</td>
<td>S</td>
<td>A</td>
<td>A1</td>
<td>1</td>
<td>0.38</td>
<td>1.5</td>
</tr>
<tr>
<td>19220</td>
<td>( \text{K. pneumoniae} )</td>
<td>2</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cr</td>
<td>B</td>
<td>A,D</td>
<td>–</td>
<td>0.5</td>
<td>0.19</td>
<td>0.75</td>
</tr>
<tr>
<td>18212</td>
<td>( \text{K. pneumoniae} )</td>
<td>2</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>3</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>18220</td>
<td>( \text{K. pneumoniae} )</td>
<td>3</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>1</td>
<td>0.38</td>
<td>1.5</td>
</tr>
<tr>
<td>06003</td>
<td>( \text{K. pneumoniae} )</td>
<td>4</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>2</td>
<td>0.25</td>
<td>0.75</td>
</tr>
<tr>
<td>HPD</td>
<td>( \text{Enterobacter cloacae} )</td>
<td>3</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cr</td>
<td>B,S</td>
<td>B</td>
<td>–</td>
<td>4</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>20247</td>
<td>( \text{Enterobacter sakazakii} )</td>
<td>5</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cr</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.5</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>24246</td>
<td>( \text{Escherichia coli} )</td>
<td>4</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>cr</td>
<td>S</td>
<td>–</td>
<td>–</td>
<td>2</td>
<td>0.5</td>
<td>2</td>
</tr>
<tr>
<td>J53</td>
<td>( \text{E. coli} )</td>
<td>4</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.12</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>TC</td>
<td>( \text{E. coli} )</td>
<td>5</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>0.5</td>
<td>0.19</td>
<td>0.75</td>
</tr>
</tbody>
</table>

*IPM, imipenem; MEM, meropenem; ERT, ertapenem; TC, transconjugants.
†Origin: 1, postsurgical visceral infection; 2, postsurgical orthopedic infection; 3, nosocomial urinary tract infection; 4, community-acquired urinary tract infection; 5, omphalocoele infection.
‡Clonally related isolates.