Nosocomial Infections, Challenges and Threats: A Review Article

Mohammad Darvishi1, Mojgan Forootan2, Mohammad Reza Nazeri3, Ebrahim Karimi4, Majid Noori5

1- Infectious Diseases and Tropical Medicine Research Center (IDTMRC), Faculty of Aerospace and Subaquatic Medicine, AJA University of Medical Sciences, Tehran, Iran
2- Department of Gastroenterology, Gastrointestinal and Liver Diseases Research Center (RCGLD), Shahid Beheshti University of Medical Sciences, Tehran, Iran
3- Department of Infectious Diseases, Hepatitis Research Center, Lorestan University of Medical Sciences, Khorramabad, Iran
4- Department of Emergency Medicine, Basat Hospital, AJA University of Medical Sciences, Tehran, Iran
5- Infectious Diseases and Tropical Medicine Research Center (IDTMRC), AJA University of Medical Sciences, Tehran, Iran, dr.majid.nouri@gmail.com

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Introduction

Hospital- acquired infections (HAIs) are infectious diseases an individual experiences 48 hours post-hospitalization, 3 days following hospital discharge, or 30 days after a surgery. Therefore, the patients have not have the infection before hospitalization nor has the patient been in the latent period of the disease (1, 2). HAIs often develop through contaminated medical equipment at the surgical site or through antibiotic-resistant pathogens. These infections are not limited to the patient, but also affect hospital specialists and staff. According to the recent reports, only 20% of nosocomial infections are preventable (3). The World Health Organization (WHO) has identified nosocomial infections as a major cause of disability and death among patients (7). The actual rate of HAIs varies from 5-10% among modern health centers in developed countries and up to 25% in developing countries, which is about 2-20 times higher among developing...
countries compared to developed countries. This rate has been reported to be 1.9 to 25 percent in Iran (9) which is mostly due to surgery site infections (58.2%), pneumonia (26.4%) and urinary tract infections (8.8%) (10), respectively.

In this review, we will discuss the most important pathogens responsible for nosocomial infections as well as multidrug-resistant (MDR) pathogens as a major threat around the world.

**Materials and Methods**

PubM, Medline, Cochran library, WHO, Iranmedex and PsycINFO databases were searched for articles related to different aspects of nosocomial infections and bacterial resistance, published during 1980 and 2018. An evaluation regarding the association between nosocomial infections and bacterial resistance with the use of antibiotics were carried out in March 2017.

Research on nosocomial infections was conducted in two steps. The first step was to examine the aspects and issues related to nosocomial infection, and the second step was to investigate the relationship between bacterial resistance and challenges. To gather information on nosocomial infections and bacterial resistance, the following keywords were searched: resistant bacteria, nosocomial infections, antibiotics, multidrug-resistant drugs, Healthcare, Pathogens.

Out of a total of 182 articles found following the key word search, 28 articles were relevant, in terms of subject and content, and were therefore included in this article.

**Important causes of nosocomial infections**

About 90% of nosocomial infections are caused by bacteria. Bacteria that commonly cause nosocomial infections include *Staphylococcus* spp. especially *S. aureus*, *Streptococcus* spp., *Bacillus cereus*, *Acinetobacter* spp., *enterococcus* spp., *Pseudomononas aeroginosa*. *Escherichia coli*, *Proteus mirabilis*, *Salmonella* spp., *Serratia marcescens* and *Klebsiella pneumonia*, among which *E. coli*, *S. aureus*, *enterococcus* spp. and *P. aeruginosa* are the most common causes of nosocomial infections (7, 8, 13).

In hematologic infections (BSI), coagulase negative Staphylococci are common and are isolated almost twice as much as *S. aureus* among patients with BSI (13, 17).

*Enterococcus* spp. have been repeatedly isolated from surgical site and bloodstream infections, but is rarely found in the respiratory tract. *P. aeruginosa* has been isolated from one-tenth of all infections and is found equally in all areas prone to nosocomial infections with the exception of blood stream (13).

Viruses cause only 5% of nosocomial infections and are more common among infants and children. There are possibilities of transmitting nosocomial infections caused by viruses, including hepatitis B and C viruses (via dialysis, injection, endoscopy), respiratory syncytial virus (RSV), rotavirus, and enterovirus (through hand-to-mouth and mouth-to-mouth contact) in the hospital (19, 20).

Some parasites are easily transmitted between children and adults. Many fungi and parasites are opportunistic organisms that cause infections during long-term treatment with antibiotics. Environmental contamination caused by organisms that spread through the air, such as *Aspergillus* spp., is a concern during hospital construction (13, 21).

**The importance and impact of using antibiotics in nosocomial infections**

In developing countries, drugs such as antibiotics are easily available in pharmacies (12) and the overuse of a wide range of antibiotics in the hospital environment has led to the emergence of MDR microorganisms which cause fatal nosocomial infections and are difficult to treat (13, 22).

The most important MDR bacteria causing nosocomial infections include *E. faecium*, *S. aureus*, *K. pneumoniae*, *A. baumannii*, *P. aeruginosa*, and *Enterobacter* species, which are classified as ESKAPE.

In addition, in 2017, WHO published a list of the most important bacterial species and the antibiotics against which these bacteria are resistant (Table 1). This group of pathogens is responsible for most MDR nosocomial infections (12, 25).
MDR bacteria that cause nosocomial infections are able to spread and multiply rapidly not only in health care centers but around the world (12). In Europe, over four years (2014-2011), a significant increase in the mean rate of *E. coli* resistance to third-generation cephalosporins (from 9.6 to 12%), *K. pneumonia* to carbapenems (from 6.6 to 7.3%) and *P. aeruginosa* to carbapenems (from 16.8 to 18.3%) and Enterococci resistance to vancomycin (from 6.2 to 7.9) was observed. In Iran, a study found that 73.8% of the *E. coli* isolates were resistant to nalidixic acid, 54.3% to Sulfamethoxazol and 54.3% to Liprofloxacin (46).

In order to maintain the efficiency of antibiotics, many hospitals reserve certain antibiotics such as vancomycin and imipenem, only for cases in which other antibiotics have proven ineffective. The problem with this policy is the delay in the use of effective antibiotics in urgent cases. In addition, the limited use of these antibiotics has led to a decline in motivation and ultimately to defect in pharmaceutical industries due to poor investment returns. In fact, the lack of new antibiotics on the market increases the problem of antibiotic resistance (12).

Since the countdown to the emergence of resistance against the newly made antibiotics starts as soon as they are introduced to the clinical settings, the development of new antibiotics is not the ultimate solution to the antibiotic crisis. It is clear that antibiotic resistance is not a one-dimensional problem, and in addition to the sustainable development of new antibiotics, other strategies, including effective vaccines and faster and more sensitive diagnosis, can reduce the emergence of resistance to the new antibiotics (12, 23).

**Methicillin-resistant *Staphylococcus aureus* (MRSA)**

*S. aureus* is a gram-positive bacterial strain and one of the most dangerous bacterial pathogens that can cause nosocomial infections worldwide. According to the latest research, most *S. aureus* isolates have been resistant to the antibiotics Cefoxitin, Azithromycin, Cefotaxime, Tetracycline, Gentamycin, Chloramphenicol and Ciprofloxacin (Figure 2).
Since resistance to anti-MSRA antibiotics occurs through bacterial mutations, resistance to linezolide and glycoprotein antibiotics has recently become a major concern (27, 31).

Vancomycin resistant Enterococci (VRE)

Enterococci are the second leading cause of nosocomial infections worldwide and the leading cause of infections in the United States (20-30% of infections).

According to a report by the World Health Network, these pathogens cause about 12 percent of all nosocomial infections and kill 1,300 people a year (36). About 35.5% of enterococci are resistant to vancomycin which is created by the synthesis of a modified cell wall precursor that does not bind to glycopyptide antibiotics. This process occurs by the acquisition of a plasmid-dependent gene cluster (mostly vanAog and vanB genes) (36, 37). These may be transferred from enterococci to MSRA and, therefore, further complicate the treatment process of nosocomial infections.

Enterococcus species are less likely to cause nosocomial infections compared to S. aureus. Two of the most important species of Enterococci include E. faecalis and E. faecium. VRE nosocomial infections are mostly caused by E. faecium. Resistant isolates of this species usually possess the resistance genes VanA, VanB, VanD, VanN and VanM, and epidemiological studies have shown that VanA and VanB are the most common types, abundance of which is increasing (Figure 4 and Table 2) (35, 37, 39).
Multidrug-Resistant *Klebsiella pneumoniae* (MDR-KP)

*Klebsiella pneumoniae* is a gram-negative bacillus found in a variety of environments, including the human body, gastrointestinal tract, skin, and nasopharynx. Due to the specific pathogenic properties of *K. pneumoniae*, including capsule production, antibiotic resistance, and biofilm formation, the nosocomial infections caused by this species are typically chronic and difficult to treat. In recent years, MDR-KP strains have emerged due to the overuse of various antibiotics to treat nosocomial infections caused by this pathogen. MDR-KP is resistant to a wide range of antibiotics, including ampicillin and cephalosporins, which have previously been shown to be effective in treating *K. pneumoniae* isolates. The global prevalence of MDR-KP strains has become a global threat and concern due to its prevalence in hospitals and community (41, 51). Unfortunately, the optimal options for treating MDR-KP infection have not yet been identified (44, 45). Currently, a combination of colistin, phosphomycin, tigecycline, and aminoglycosides, although associated with adverse outcomes, is widely used. Recently, WHO has warned that if appropriate solutions are not adopted to prevent the development of MDR-KP, current antibiotics would completely lose their effect fail to treat these infections (55, 56).

Multidrug-resistant *Acinetobacter baumannii* (MR-AB)

*A. baumannii*, a gram-negative aerobic bacterium, is another important pathogen causing nosocomial infection. ICU is known as the main center for infections caused by *A. baumannii*, however, several studies have shown that it is possible for this species to spread it to other areas in the hospital. This pathogen is responsible for about 2-10% of infections caused by all gram-negative bacteria in European and American countries (59-57). The constant presence of *A. baumannii* in different parts of the hospital has caused this pathogen to be in constant contact with antibiotics. Such environmental conditions has imposed pressure on the selection and emergence of colonies with antibiotic resistance characteristics. Over time, the emergence if strains that are resistant to 3 or more antibiotic classes, including carbapenems which once were the treatment option of *A. baumanii* isolates, has increased (61). Due to the increasing resistance of this pathogen against carbapenems and colistin, as the last lines of treatment, therapeutic options are very limited and in some cases do not exist (61, 65).

Multidrug-resistant *Pseudomonas aeruginosa* (MDRPA)

*P. aeruginosa* is another gram-negative and aerobic bacterium which is known to be one of the leading causes of nosocomial infections, accounting for 10% of all nosocomial infections (63, 64). Resistance rates to imipenem, quinolones, and third-generation cephalosporins have increased among *P. aeruginosa* isolates by 15, 9, and 20 percent, respectively (67). Of great concern is the results of a recent study showing a significant increase in the rate of MDRPA from 2007 to 2014 (Figure 5).
### Conclusion

Studies evaluated in this review reported an important role of antibiotic resistance in imposing therapeutic challenges and mortality among infected patients. Studies have described this factor as a global threat associated with the increase in nosocomial infections among patients. Improper use of a wide range of antibiotics against pathogens responsible for nosocomial infections has led to the emergence of MDR isolates that cause fatal nosocomial infections and are difficult to treat. Therefore, nosocomial infections are still uncontrollable during antibiotic era.

Although the production of new antibiotics are needed to treat nosocomial infections, this alone cannot be a solution to overcome the problem of MDR nosocomial infections. Therefore, some scheduled programs are needed to prevent the improper use of antibiotics and the occurrence of antibiotic resistance in the hospital settings.

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### Conflicts of Interest

Authors declared no conflict of interests.

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**References**


Nosocomial infections are infections which are a result of treatment in a hospital or a healthcare service unit, but secondary to the patient's original condition. Infections are considered nosocomial if they first appear 48 hours or more after hospital admission or within 30 days after discharge. Nosocomial comes from the Greek word nosokomeion (νοσοκοµείον) meaning hospital (νοσος = disease, κοµεο = to take care of). This type of infection is also known as a hospital-acquired infection. The most common nosocomial infections are of the urinary tract, and various pneumonias. Nosocomial infections kill more Americans each year than AIDS and breast cancer combined. Keeping your medical gas systems operating properly isn't the only threat to patient safety. It is about time that these formerly Hospital Acquired Infection or Hospital Associated Infections were seriously attacked. In recent years, these infections have killed 100,000 people who were patients mostly of hospitals; but with the changes in healthcare delivery, also infected rehab and even surgery centers. 1.7 million infections have been identified in a year. Nosocomial infections kill more Americans each year than AIDS and breast cancer combined. So the counter attack was begun to save life.

Nosocomial infections, or healthcare associated infections occur when a person develops an infection during their time at a healthcare facility. Infections that appear after your hospital stay must meet certain criteria in order for it to qualify as a HAI. If new symptoms appear within 48 hours of admission, three days after discharge, or 30 days after an operation, talk to your doctor.


Sydnor, E. R. M. & Perl, T. M. (2011, January). Hospital epidemiology and infection control in acute-care settings. Clinical Microbiology Reviews, 24(1), 141-173.ncbi.nlm.nih.gov/pmc/articles/PMC3032107/. Nosocomial infections are the infections acquired in hospital. But what kind of nosocomial infections are there? How are the infections treated? What can you do to prevent them? 4 Common Nosocomial Infections and Treatments. The nosocomial infection definition states that it is any infection which arises after 48 hours of being admitted to the hospital. If the infection appears prior to 48 hours, it is assumed that it was before being admitted; however, it may not always be true. When patients are admitted for a very short period, they might experience nosocomial infections after they have left the hospital.