Original Research Article

A study of microbial gamut and antibiograms in chronic suppurative otitis media

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ABSTRACT

Background: The aim of the study was to discern the patterns in microbial diversity and the resistogram among the patients suffering from CSOM.

Methods: A total number of 100 ear swabs were investigated for the present study. Their gram staining, direct microscopy with KOH, culture sensitivity, and biochemical tests were carried out to identify the organisms and to know their sensitivity pattern. All the swabs were collected from clinically diagnosed cases of chronic suppurative otitis media visiting otolaryngology outpatient department of tertiary care hospital. The study period was one year, from January 2016 to December 2017.

Results: Out of total 100 cases, 90 were culture positives, 6 showed no growth and 4 were skin contaminants (mircococi). Out of 90 culture positives, fungal culture was positive in 5 (5.5%) while combined bacteria and fungi obtained in 18 (20%) cases and only bacteria in 67 (74.4%) cases. Among the aerobic bacterial isolates, Pseudomonas aeruginosa was the most common bacteria isolated from the bacterial culture (n=36; 34.95%) followed by Staphylococcus aureus (n=28; 27.18%) and Proteus (n=13; 12.62%). Among the fungal isolates, Aspergillus niger was predominant followed by Candida albicans & Aspergillus flavus. Amikacin and imipenem were found to be the most effective antibiotics with low resistance rates.

Conclusions: The present study gave an insight into the bacteriological profile of the cases of CSOM and their antibiotic sensitivity patterns. This in turn will ensure rational and judicious use of antibiotics and thus prevent emergence of resistant bugs and also the complications associated with CSOM.

Keywords: Chronic suppurative otitis media, Microbiology, Antibiotic resistance

INTRODUCTION

Chronic suppurative otitis media (CSOM) is an ignominious infection and a major health issue in developing world causing serious local morbidity and life threatening complications. Early and effective treatment based on the knowledge of causative micro-organisms and their antimicrobial sensitivity ensures prompt clinical recovery and possible complications can thus be avoided.

CSOM is considered a multifactorial disease resulting from a complex series of interactions between environmental, bacterial, host and genetic risk factors.1 It is a chronic inflammatory process in the middle ear space that results in long term or permanent changes in the tympanic membrane including atelectasis, dimeric membrane formation, perforation, tympanosclerosis, retraction pocket or cholesteatoma.2 Most common manifestations of CSOM are ear discharge, perforation and hearing impairment.
Incidence of CSOM is higher in developing countries especially among low socioeconomic society because of malnutrition, overcrowding, poor hygiene, inadequate health care, and recurrent upper respiratory tract infection. It is one of the most important causes of preventable hearing loss in India and other developing countries.

CSOM in infants and children can result in conductive hearing loss which may in turn lead to delayed development of speech and language in children. The infection may occur during the first 5 years of child’s life, with a peak around 2 years.

The disease usually occurs after upper respiratory viral infections followed by invasion of pyogenic organisms. The aerobic microorganisms most frequently found in CSOM are Pseudomonas aeruginosa, Staphylococcus aureus, and Gram negative organisms such as Proteus spp, Klebsiella spp, Escherichia coli, Haemophilus influenza, and Moraxella catarrhalis. The most commonly isolated fungal isolates are Aspergillus spp especially Aspergillus niger and Candida spp.

CSOM can cause severe adverse effects like intra and extra-crianal complications which can be life threatening. Infection can spread from middle ear to vital structures such as mastoid, facial nerve, labyrinth, lateral sinus, meninges and brain leading to mastoid abscess, facial nerve, paralysis, deafness, lateral sinus thrombosis, meningitis and intracranial abscess. Intracrani

Complications like brain abscess and meningitis are the most common causes of death in CSOM patients.

The complications of CSOM have been curtailed to a large extent owing to the discovery of antibiotics. But irrational and indiscriminate use of antibiotics has led to the emergence of resistant organisms to the commonly used drugs. Among Gram-negative bacteria, the most resistant pathogens are E. coli, Klebsiella species and Pseudomonas aeruginosa, with increasing trends observed for all major anti-Gram negative agents (betalactams, fluoroquinolones and aminoglycosides).

Microbial drug resistance has emerged as a growing global problem. There is a need to understand the epidemiology and microbiology of CSOM in order to develop effective strategies for primary prevention and better management of the disease. Therefore an intelligible knowledge about the bacterial flora causing the infection and their antibiotic susceptibility pattern is very important for avoiding the imperilment of injudicious use of anti-bacterial agents and prevention of emergence of resistant strains.

The objective of our study is to determine the microbial diversity and the resistogram among the patients suffering from CSOM who attended ENT OPD of our hospital, a tertiary care centre located in the Vale of Kashmir. To the best of our knowledge no such data is available from this part of India. Treatment of the cases after studying the antimicrobial susceptibility pattern will help in preventing the emergence of resistant strains in the community.

METHODS

This descriptive, cross sectional study was conducted in Department of Otorhinolaryngology of a tertiary care hospital in Srinagar, Jammu & Kashmir, India for a period of 12 months from January 2017 to December 2017 and 100 clinically diagnosed cases of CSOM were included in this study after the approval of Institutional Ethics Committee.

A detailed clinical history regarding name, age, sex, address and socioeconomic status, history of onset and duration of ear discharge, other associated symptoms and antibiotic therapy were taken from the patients.

Inclusion criteria

Inclusion criteria were patients of any age, both genders, discharge from unilateral or bilateral ears; patients with active ear discharge of more than 3 months duration; patients with tubo-tympanic type of CSOM with central perforation.

Exclusion criteria

Exclusion criteria were history of antibiotic use within preceding 2 weeks (topical or systemic); patient with attico-antral type of CSOM; acute suppurrative otitis media; patients with draining ears but intact tympanic membrane (otitis externa); recent ear surgery, mastoid surgery or tympanostomy tube insertion.

Pus specimens from draining ears were taken on the first day of contact with the patient. The ears were inspected first; pus from the outer part of the ear canal was then cleaned by suction. Ear discharge was obtained from the diseased ear of the patients under strict aseptic precautions using two sterile cotton swabs with the help of aural speculum. Pus swabs collected were immediately sent to Microbiology department for further processing. The first swab was used for direct Gram stain and KOH mount. The second swab was cultured in nutrient agar, blood agar and MacConkey agar plates and incubated at 37°C for 24–48 hrs. The second swab was also inoculated onto Sabouraud’s Dextrose Agar (SDA) for isolation of fungal pathogens and was incubated at room temperature. In the case of yeast, germ tube fermentation test was employed for identification of Candida Albicans. The organisms isolated underwent antibiotic susceptibility testing (AST) on Mueller-Hinton agar by Kirby-Bauer disc diffusion method according to National Committee for Clinical Laboratory Standards (NCCLS) criteria.

Data was entered in excel sheet and analysis was done using SPSS v23 and expressed as percentage.
RESULTS

In our study of 100 patients, 53.0% patients (n=53) were males and 47.0% (n=47) were females. Male to female ratio was 1.32:1 (Table 1).

Table 1: Gender wise distribution of cases.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>53</td>
<td>53</td>
</tr>
<tr>
<td>Female</td>
<td>47</td>
<td>47</td>
</tr>
</tbody>
</table>

Age group of the patients ranged from 3 yrs to 64 yrs. The mean age of individuals participating in the study was 19.47±6.42. There was no statistically significant sex or age predilection for a sample to become culture positive in our study.

Out of total 100 cases, 90 were culture positives, 6 showed no growth and 4 were skin contaminants (micrococci) (Table 2).

Table 2: Growth pattern of CSOM cases.

<table>
<thead>
<tr>
<th>Growth pattern</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive growth</td>
<td>90</td>
<td>90</td>
</tr>
<tr>
<td>No growth</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Skin contaminants</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Out of 90 culture positives, fungal culture was positive in 5 (5.5%) while combined bacteria and fungi obtained in 18 (20%) cases and only bacteria in 67 (74.4%) cases (Table 3).

Table 3: Growth results in culture positive swabs

<table>
<thead>
<tr>
<th>Growth Type</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacterial growth</td>
<td>67</td>
<td>74.4</td>
</tr>
<tr>
<td>Fungal growth</td>
<td>5</td>
<td>5.5</td>
</tr>
<tr>
<td>Bacterial and fungal growth</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>90</td>
<td>100</td>
</tr>
</tbody>
</table>

Out of 90 culture positives, 116 aerobic organisms were isolated, of which 103 were bacterial and 13 were fungal isolates.

Among the aerobic bacterial isolates, *Pseudomonas aeruginosa* was the most common bacteria isolated from the bacterial culture (n=36; 34.95%) followed by *Staphylococcus aureus* (n=28; 27.18%) and *proteus* (n=13; 12.62%) (Table 4).

Among the fungal isolates, *Aspergillus niger* was predominant followed by *Candida albicans* & *Aspergillus flavus* (Table 5).

Table 4: Distribution of aerobic bacterial organisms causing CSOM.

<table>
<thead>
<tr>
<th>Bacterial Isolate</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pseudomonas Aeruginosa</td>
<td>36</td>
<td>34.95</td>
</tr>
<tr>
<td>Staphylococcus Aureus</td>
<td>28</td>
<td>27.18</td>
</tr>
<tr>
<td>Proteus</td>
<td>13</td>
<td>12.62</td>
</tr>
<tr>
<td>Klebsiella Spp</td>
<td>10</td>
<td>9.7</td>
</tr>
<tr>
<td>Escherichia coli</td>
<td>8</td>
<td>7.76</td>
</tr>
<tr>
<td>Streptococcus Pneumoniae</td>
<td>5</td>
<td>4.85</td>
</tr>
<tr>
<td>Enterococcus Avium</td>
<td>3</td>
<td>2.91</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 5: Distribution of Fungal Organisms causing CSOM

<table>
<thead>
<tr>
<th>Fungal Isolate</th>
<th>Number</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspergillus Niger</td>
<td>5</td>
<td>38.46</td>
</tr>
<tr>
<td>Aspergillus Flavus</td>
<td>2</td>
<td>15.38</td>
</tr>
<tr>
<td>Aspergillus Fumigatus</td>
<td>1</td>
<td>7.69</td>
</tr>
<tr>
<td>Candida Albicans</td>
<td>5</td>
<td>38.46</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>100</td>
</tr>
</tbody>
</table>

Figure 1: Antibiotic susceptibility pattern for *P. Aeruginosa*.

The antibiotic susceptibility pattern of *Pseudomonas aeruginosa* showed that the isolates were 100% sensitive to amikacin and imipenem followed by gentamicin, piperacillin, meropenem, and ciprofloxacin. They were less sensitive to cefuroxime, cefipime & levofloxacain (Figure 1).

*Staphylococcus* isolates were 100% sensitive to vancomycin. They were highly sensitive to linezolid and amikacin, followed by gentamicin and amoxycyclav. They showed less sensitivity against cotrimoxazole, chloramphenicol and cefotaxime. They were resistant to piperacillin, ciprofloxacin & erythromycin (Figure 2).

Gram negative isolates other than *Pseudomonas* showed highest sensitivity to imipenem and amikacin. They were
highly sensitive to colistin, meropenem and gentamicin followed by aztreonam, amoxiclav & ciprofloxacin. They were less sensitive towards cefoperazone, cefipime and erythromycin (Figure 3).

In our study, fungal culture was positive for 5 (5.5%) swabs, while combined growth of fungi and bacteria was seen in 18 (20%) swabs, only bacteria were isolated from 67 (74.4%) swabs.

In this study, Pseudomonas aeruginosa (34.95%) was found to be the most common organism followed by Staphylococcus aureus (27.18%), Proteus (12.62%), Klebsiella spp (9.7%) and E.coli (7.76%). These results are in harmony with various other studies that showed pseudomonas to be the most common bacteria cultured from CSOM cases.20-25 Prakash et al reported Staphylococcus aureus to be the most predominant organism which is the second common isolate in our study.26 Other isolates were E. coli, Enterococcus spp, and streptococcus pneumonia. The observations made from different studies indicate that there can be variation in causative organism based on ethnicity and geography.

The most commonly isolated fungi in CSOM are Aspergillus and Candida species. In our study, fungal etiology was found in 5 cases, out of which 61.53% were Aspergillus species, followed by Candida (38.46%). Among Aspergillus species maximum strains isolated was Aspergillus niger 5 (38.46%) followed by Aspergillus flavus 2 (15.38%) and Aspergillus fumigatus 1 (7.69%). Our findings correlated with studies of Loy et al. & Rejitha et al. wherein Aspergillus Niger was the predominant isolate following by Candida albicans.27, 28

Thus clinician routinely prescribing anti-bacterial agents for COM, without performing antibiotic susceptibility tests is totally unjustified. Therefore a clear knowledge about the bacterial flora causing the infection and their susceptibility pattern is very important. The isolates are gradually becoming more resistant and the bacteriological as well as susceptibility pattern is changing from time to time requiring continuous surveillance of AST for effective management of COM.

Antibiotic susceptibility patterns serve as a useful guideline for choosing the appropriate antibiotic and it was employed for all the isolated organisms. The anitbiotic susceptibility pattern of Pseudomonas aeruginosa showed that the isolates were 100% sensitive to amikacin and imipenem followed by gentamicin, piperacillin, meropenem and ciprofloxacin. They were less sensitive to cefuroxime, cefipime and levofloxacin. Our findings correlate with the study done by Harvinder Kumar et al. wherein amikacin was found to be the most effective drug followed by ciprofloxacin, piperacillin and cotrimoxazole. Other studies have also corroborated these findings.29-31

Staphylococcus isolates were 100% sensitive to vancomycin. They were highly sensitive to linezolid and amikacin, followed by gentamicin and amoxyclov. They
showed less sensitivity against cotrimoxazole, chloramphenicol and cefotaxime. They were resistant to piperacillin, ciprofloxacin & erythromycin.

Gram negative isolates showed highest sensitivity to imipenem and amikacin. They were highly sensitive to colistin, meropenem and gentamycin followed by aztreonam, amoxiclav & ciprofloxacin. The findings of our present study are in accordance with studies conducted by Poorey and Iyer, Bansal et al.31,32 In the present study gram negative bacilli were less sensitive to cefoperazone, cefipime and erythromycin. The resistant pattern towards most commonly used antibiotics in the present study could be because of indiscriminate use of antibiotics.

The salient gospel that the clinician needs to remember is that the antibiotic susceptibility pattern of the CSOM causing organisms keeps changing and routine antibiotic susceptibility testing before treatment is imperative. Routine use of antibiotics for CSOM as empirical therapy must be reviewed and antibiotics need to be used judiciously. Relevant antimicrobial drugs should be prescribed after proper diagnosis of the causative organism and its antimicrobial susceptibility pattern. The patients need to be educated about the advantages of taking the drugs according to proper dosage and for prescribed duration without discontinuing midway. This will halt the progression of complications at an early stage and will also forestall the emergence of resistant organisms.

CONCLUSION

The isolation of causative organisms and their resistogram pattern is important for appropriate treatment to prevent morbidity and mortality associated with CSOM. It is prudent for any health center catering to a defined area of population to conduct periodically the microbiological study of CSOM in order to install effective treatment protocols for the population. As CSOM cases are more common in day to day practice, the general practitioners should be aware of the changing patterns of microbial etiology and their susceptibility pattern to antibiotics.

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Ethical approval: The study was approved by the Institutional Ethics Committee

REFERENCES