Neonatal sepsis: Risk factors, clinical and bacteriological profile, and antibiotic sensitivity

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ABSTRACT

Background: Neonatal sepsis (NS) is a cause of very high morbidity and mortality. Reviews of bacterial spectrum and antimicrobial susceptibility help to treat NS and to develop strategies to lower neonatal mortality. Objectives: The objectives were to study organisms causing NS, their antimicrobial susceptibility pattern, predisposing factors of NS, and the presentations of NS. Methods: This prospective study was done for 1 year from August 2016 to July 2017 at a tertiary care hospital, Hyderabad with C-reactive protein (CRP), aerobic blood cultures, and sensitivities in 300 neonates with clinical sepsis. Risk factors for NS and clinical features were recorded. Significances for sex, gestational age, birth weight, and age of onset of sepsis differences were assessed. Results: Male to female ratio was 1.65:1, 39% were preterm, 40% were <2500 g in weight, and 54% had sepsis in <72 h (early onset sepsis - EOS) (p<0.05). Prolonged labor and rupture of membranes, maternal fever within 2 weeks, foul-smelling liquor, birth asphyxia, and iatrogenic factors were the risk factors in decreasing order of frequency. Refusal to feed was the most common presentation. CRP showed good sensitivity and negative predictive value while 117 (39%) cases were blood culture positive. Organisms in decreasing order of frequency were Klebsiella pneumoniae, coagulase-negative staphylococci, enterococci, Staphylococcus aureus, Pseudomonas aeruginosa, Acinetobacter, Escherichia coli, and Group-B streptococci. Gram-negative isolates (44%) were sensitive to meropenem, amikacin, and piperacillin-tazobactam while Gram-positive isolates (56%) were sensitive to vancomycin and netilmicin and both were least sensitive to cefotaxime and ampicillin. Conclusion: Obstetric and neonatal care practices around birth need to be reviewed as EOS proportion in India is very high. Most of the isolates were resistant to cefotaxime and ampicillin, underscoring the need for the addition of penicillinase inhibitors. Timely review of antibiotics is necessary in view of widespread resistance. Focus on prevention of NS and the improvement of health systems to effectively manage it is very much needed in India.

Key words: Antibiotic sensitivity, Clinical features, C-reactive protein, Neonatal sepsis, Organisms, Risk factors

Sepsis is a major cause of neonatal morbidity and mortality. In 2013, sepsis accounted for 15.6% of 2.8 million neonatal deaths and 47.6% of late neonatal deaths [1]. Estimates of neonatal sepsis (NS) burden vary by setting. Incidence of NS in India was 30/1000 live births and culture-proven sepsis was 8.5/1000 live births and 2.3% of intramural live births according to the National Neonatal Perinatal Database (NNPD) report 2002–2003 [2]. A study (2002–2005) from rural Orissa reports the incidence of culture-confirmed neonatal (0–28 days of life) sepsis as 4.6/1000 live births, 5.5% mortality for clinical NS, and 10.3% mortality for culture-proven NS [3]. Investigators of the Delhi Neonatal Infection Study (DeNIS) collaboration found that, in the 13530 neonates who were enrolled of 88636 live births from 2011 to 2014, the incidence of total sepsis was 14.3% and of culture-positive sepsis was 6.2% of which 83% were early onset sepsis (EOS). The population attributable risks of mortality were 8.6% in culture-negative sepsis, 15.7% in culture-positive sepsis by multidrug-resistant organisms, and 12.0% in culture-positive sepsis by non-multidrug-resistant organisms [4]. The clinical manifestations range from subclinical, nonspecific to severe manifestations. The organisms differ significantly between developed and developing countries [5]. Even among developing countries, regional variation exists [6]. In EOS (Sepsis within 72 h of birth), Gram-negative organisms such as Escherichia coli, Klebsiella, and Enterobacters are the prime cause of sepsis in India [7,8]. Some studies mention Gram-positive organisms as the chief cause, among which Staphylococcus aureus, coagulase-negative staphylococci (CONS), Streptococcus viridans, and Group B Streptococci (GBS) are more common [9,10]. The organisms commonly associated with late-onset sepsis (LOS: Sepsis developing after >72 h of age) include CONS, S. aureus, Klebsiella pneumoniae, E. coli, Enterobacter spp., Pseudomonas aeruginosa, and Acinetobacter species [11]. NNPD database shows Klebsiella as the most common organism (32.5%) followed by S. aureus (13%) and E. coli (10.6%) [2].

We attempted this study as a concern about variable, and extended drug resistance is on the rise, and also treatment, policy decisions, rational use of antibiotics require updated...
Babies with birth weight <1000 g, neonates with obvious malformations/congenital anomalies were excluded. C-reactive protein (CRP) was done by latex agglutination test. Aerobic blood cultures were done and bacterial isolates, if identified were studied for antibiotic susceptibility by Kirby–Bauer disc diffusion method. Data were entered into an excel spreadsheet and group comparisons were done by applying t-test and χ² (Chi-squared) test. p<0.05 was taken as significant.

RESULTS

A total of 300 neonates were included in the study and the male to female ratio was 1.65:1. The percentage of septicemic preterm babies (39%) was higher than their proportion of 10–12% of all births. 40% had low birth weight (LBW), which was higher than their proportion of 25–30% of all births. The value of p was <0.05 (calculated by one sample t-test) for gender, gestational age, birth weight, and onset of sepsis groups. Demographic characteristics, onset of sepsis, and culture details are given in Table 1.

EOS contributed to 54% of the cases. Blood cultures were positive in 39% of the cases. Perinatal risk factors responsible for the EOS are enumerated in Table 2, which shows that a very high proportion of the babies had these risk factors making them susceptible to sepsis. There was a coexistence of more than one factor in many cases.

The presentations of the babies with sepsis are given in Table 3. Refusal to feed and lethargy were the dominant presentations. More ominous features were observed in nearly 40% of the babies.

CRP was positive in 208 babies of the total of 300, of which 114 were culture positive, and 94 were negative. In 92 babies with negative CRP, 3 were culture positive. Considering culture as the standard for diagnosis of NS, parameters for CRP derived were 97.4% sensitivity, 48.6% specificity, 54.8% positive predictive value, and 96.7% negative predictive value. Of the 39% positive blood cultures, K. pneumoniae, CONS, Enterococcus, and S. aureus were the predominant isolates as shown in Table 4. Klebsiella was relatively more common in LOS while enterococcus was more frequent in EOS.

Tables 5 and 6 give the details of the bacterial isolates’ drug sensitivity patterns. As all isolates were not tested for all drugs, number of samples tested for a particular drug is mentioned in the tables along with percentage of sensitivity.

Excepting Enterococcus and Pseudomonas, all other organisms were sensitive to aminoglycosides. While cefotaxime and ampicillin had the lowest sensitivity, drugs with added penicillinas (Cefoperazone + Sulbactam and Piperacillin + Tazobactam) had better sensitivity. Levofloxacin had better...

METHODS

This prospective observational study was conducted at Niloufer Hospital, Hyderabad, for a period of 1 year from August 2016 to July 2017. 300 neonates admitted with clinical suspicion of sepsis were included in the study. A data entry sheet was used to obtain patient details. Institutional Ethics Committee approval was obtained for the study. Clinical features of sepsis (lethargy, refusal to feed, abdominal distension, vomiting, respiratory distress, fever, hypothermia, convulsion, sclerema, apnea, and mottling) and risk factors for the sepsis (foul-smelling liquor/meconium stained liquor, unclean vaginal examination done before delivery/>3 sterile vaginal examinations, prolonged labor, prolonged rupture of membranes, maternal pyrexia within 2 weeks of labor, and birth asphyxia) were recorded.
sensitivity than ciprofloxacin. Some isolates were resistant to carbapenems and vancomycin also.

**DISCUSSION**

NS being a life-threatening condition, changes in risk factors, etiology, and growing multidrug resistance must be properly addressed at each level of care. Considering this purpose, the present study looked at the said elements of concern. We observed male-female ratio as 1.65:1 (p<0.05) similar to other works (1.2:1–1.8:1) [15-18]. In contrast to it, one study reported a ratio of 1:1 [19]. As immunoglobulin genes are on chromosome X, females may be relatively resistant to infections. Notably, 39% were preterm in the study while their proportion being 10–12%
of all births correlating with similar observations in two previous studies (32% and 39%) [19,20]. Prematurity and LBW coexist, and 40% cases were LBW which is similar to other studies [20-22]. Nearly 54% were EOS, while 46% were LOS (p<0.05) and a higher incidence of EOS was also observed elsewhere [4,23,24]. Conversely, some reported a higher incidence of LOS [6]. In developed countries, the proportion of EOS is in the range of 10–20% [25,26]. Perinatal risk factors have a significant impact on the incidence of EOS. There is a huge difference in the incidence of EOS in between India and developed countries, which clearly emphasizes the need for reduction of perinatal risk factors for sepsis in India. PROM (25 %) and prolonged labor (25.7%) were the major perinatal risk factors, which were similar to two studies [19,21]. There was the coexistence of more than one factor in several cases. Refusal to feed (76.7%) was the most common mode of presentation as seen in other studies (75–92%). Rests of the clinical features were also similar in frequencies to other works [12,19,20]. CRP was positive in 69.3% of the clinical sepsis cases. CRP had good sensitivity and negative predictive value than specificity and positive predictive value when culture is taken as standard similar to previous observations [27,28]. This implies when CRP is negative, culture is negative most of the times, but CRP positivity does not denote culture positivity.

The culture positivity rate (39%) depends on a multitude of factors. Studies showed culture positivity rates in the same range (28.6–47.5%) [2,29,30]. Klebsiella was the most frequently isolated organism in this study, whereas *E. coli* was the most common organism in the past [8,15]. GBS which is one of the most common isolates in West was not grown in significant numbers in any Indian study. Enterococcus has emerged as a major pathogen which is associated with LOS in preterms and nosocomial infections. The frequencies of bacterial isolates are comparable to studies in India and abroad, references of which are included in Table 4.

A survey of the studies reveals varying predominance of microbes at different times and places and even within the same setup. Hence, in any NICU, it is very essential to have periodic survey to define the organisms and their sensitivity pattern. Antibiotic sensitivity pattern varied among studies probably due to the antibiotic usage differences. Drugs used for sensitivity testing were also not the same in all the studies. A comparison of antibiotic sensitivity of organisms among North and South Indian studies is presented in Table 7, which illustrates the differences.

### Table 7: Comparison of antibiotic sensitivity of organisms among North and South Indian studies

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<tbody>
<tr>
<td>K. Pneumoniae</td>
<td>H</td>
<td>Meropenem (88.5%), Vancomycin and linezolid (100%)</td>
<td>Cefmetazole (100%), Amikacin (90.9%), Cefoperazone-sulbactam</td>
<td>Piperacillin tazobactam Ciprofloxacin</td>
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<tr>
<td></td>
<td>L</td>
<td>Cefotaxime (12%), Ceftazidime (0%)</td>
<td>Ampicillin (0%)</td>
<td>Imipenem third-generation Cephalosporins</td>
<td></td>
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<tr>
<td>CONS</td>
<td>H</td>
<td>Vancomycin and netilmicin (88.5%)</td>
<td>Vancomycin and amikacin (100%)</td>
<td>Vancomycin (90%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>L</td>
<td>Gentamycin (19.2%)</td>
<td>Ampicillin (0%)</td>
<td>Ceftriaxone (5%)</td>
<td></td>
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<tr>
<td>S. aureus</td>
<td>H</td>
<td>Netilmicin (100%), Vancomycin (92.8%), aminoglycosides, Vancomycin and linezolid</td>
<td>Vancomycin and amikacin (100%)</td>
<td>Vancomycin (96.15%)</td>
<td></td>
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<tr>
<td></td>
<td>L</td>
<td>Cefotaxime (25%), oxacillin</td>
<td>Ciprofloxacin (0%)</td>
<td>Cefaperazone (3.84%)</td>
<td></td>
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<tr>
<td>P. monas</td>
<td>H</td>
<td>Imipenem (100%), meropenem (87.5%)</td>
<td>second and third-generation cephalosporins, Cefoperazone-sulbactam, Amikacin and Ciprofloxacin</td>
<td>Imipenem (71.42%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>L</td>
<td>Gentamicin (90%)</td>
<td>Ampicillin (0%)</td>
<td>Amipillin (14.28%)</td>
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<tr>
<td>A. bacter</td>
<td>H</td>
<td>Amipillin and meropenem (100%)</td>
<td>Cefterazidime (100%), Cefoperazone-sulbactam, amikacin (100%)</td>
<td>Imipenem (76.15%)</td>
<td></td>
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<tr>
<td></td>
<td>L</td>
<td>Cefotaxime (0%), Gentamicin</td>
<td>Ciprofloxacin (0%)</td>
<td>Vancomycin (4.16%)</td>
<td></td>
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<tr>
<td>E. coli</td>
<td>H</td>
<td>Imipenem (85.7%)</td>
<td>Cefoperazone-sulbactam</td>
<td>Imipenem (75%)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>L</td>
<td>Cefotaxime (0%), amipillin (0%)</td>
<td>Gentamicin (0%)</td>
<td>Gantamycin (25%)</td>
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</tr>
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from center to center and differences at the same center, and also gives an idea of sensitivities across India. GBS showed 100% sensitivity to gentamicin and vancomycin while no sensitivity to cefotaxime.

A population-based study of NS in 223 villages of Odisha state recorded a very high level of resistance to penicillin and ampicillin, moderate resistance to cephalosporins, and extremely low resistance to gentamicin, amikacin, and 2nd generation cephalosporins. No resistance was seen to imipenem or vancomycin; although 27% of the S. aureus isolates were intermediate sensitive to vancomycin. High numbers of the Gram-negative organisms were extended-spectrum beta-lactamase producers and harbored multidrug resistance. Removal of an antibiotic from the therapeutic regimen may lead to a reversal of microbial resistance resulting in susceptible phenotypes [3]. Amikacin, the most widely used semisynthetic aminoglycoside, is refractory to most aminoglycoside modifying enzymes except acetylation by the aminoglycoside 6'-N-acetyltransferase Type Ib [AAC(6')-Ib] [34].

In the present study, Netilmicin and amikacin showed good sensitivity to most of the isolates except enterococcus and pseudomonas. Imipenem, meropenem, and piperacillin-tazobactam showed good sensitivity to Gram-negative organisms. Gram-positive organisms were sensitive to vancomycin. Most of the bacterial isolates were resistant to cefotaxime and ampicillin. Limitations of the study are not using fungal and anaerobic organisms’ culture methods, not testing antibiotic sensitivity of isolates with a similar set of antibiotics, and all the bacterial isolates were not tested by a given antibiotic.

Using the combination of biomarkers to shorten the response times in diagnosis and treatment is of immense value as the presentation of NS is ambiguous and there may be a delay in its detection. Modern molecular methods on the direct sample or the identification by MALDI-TOF on positive blood culture help in optimizing the antibiotic treatment and facilitating stewardship programs. Establishing a sepsis code to decrease the time to achieve diagnosis and to treat, and to improve organization, unify criteria, promote teamwork and also commitment from health administration can reduce morbidity and mortality due to NS by great degree [35,36].

**CONCLUSIONS**

This study revealed variation in antibiotic susceptibility pattern among bacterial isolates and also showed that third-generation cephalosporins and penicillins are no more effective in treating NS. Addition of penicillinase inhibitors to them is advocated. Aminoglycosides, as first-line antibiotics are still effective. Review of antibiotics every 48–72 h, in view of high drug resistance, is critical. Recognizing NS as a seriously concerning public health problem and implementing measures aimed at changes in health systems and personnel are imperative to reduce neonatal mortality.

**REFERENCES**


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