

PREVALENCE AND ANTIBIOTIC-RESISTANCE INDICES OF BACTERIAL PATHOGENS OF OTITIS MEDIA AMONG PATIENTS ATTENDING A TERTIARY HOSPITAL IN CALABAR, NIGERIA

Abstract

Background: Otitis media is linked to middle ear inflammation and sequelae, frequently occurring in infants and early childhood dealing with the accumulation of fluid behind the eardrum. It is often associated with the absence of timely and appropriate antibacterial interventions.

Aim: To investigate the identity and antibiogram of bacterial agents of otitis media among patients attending a tertiary health facility in Calabar, Nigeria.

Methods: Ear specimens collected from a total of 70 subjects were processed by conventional bacteriological methods for isolation and identification of pathogens. Antibiotic susceptibility testing was carried out on all the isolates using the Kirby-Bauer disk diffusion method. Multiple antibiotic resistance (MAR) indices of the isolates were evaluated.

Results: The prevalence of bacterial otitis media was 72.9% in the study population. A total of 51 bacterial isolates including *Pseudomonas aeruginosa* (26), *Staphylococcus aureus* (17), *Proteus mirabilis* (6), and *Klebsiella pneumoniae* (2) were found. Isolates of *P. aeruginosa* and *S. aureus* showed high susceptibility to amoxicillin-clavulanate (92.3%) and ciprofloxacin (88.3%), respectively. The prevalence of multidrug resistant (MDR) isolates was 25.4%. MDR percentages such as 100%, 33.3%, 30.7% and 29.4% were reported for isolates of *K. pneumoniae*, *P. mirabilis*, *P. aeruginosa* and *S. aureus* respectively. MAR indexing revealed high values ranging from 0.4 to 0.87 for all the isolates.

Conclusion: High susceptibility of the predominant isolates to amoxicillin-clavulanate and ciprofloxacin may underscore the drugs' potential as antibiotics of choice for prompt treatment of otitis media in the population. However, the overall high drug-resistance indices of the isolates would suggest dire implications for empiric antibacterial therapy in the population. Choice of antibiotics for treatment of bacterial infections in this population should be driven by results of microbiological drug-susceptibility tests.

Keywords: Otitis media, bacterial pathogens, antibiotic-resistance, prevalence.

INTRODUCTION

Otitis media (OM) is a set of inflammatory disease of the eardrum and middle ear, typically classified into acute otitis media (AOM), otitis media with effusion (OME), and chronic suppurative otitis media (CSOM).¹ Whereas the disease can affect persons of all ages,

children under the age of 5 years are most susceptible to OM, often due to underdeveloped immunity and Eustachian tube dysfunction.^{2,3} Although it is rarely associated with mortality, the morbidity of OM is significant with around 1.2 billion people affected by the disease worldwide⁴. Ranked second and fifth in the list of leading causes of hearing loss and global burden of diseases,⁵ respectively, otitis media recurrence is higher in low and middle income countries, with increased incidence rate from sub-Saharan Africa and South Asia.⁶

OM often occurs following bacterial infection of the upper respiratory tract, but can also be caused by allergy as well as functional and anatomical changes of the eustachian tube or middle ear.² *Streptococcus pneumoniae*, being a primary pathogen of OME, is known to colonize the nasopharynx of 27-65% children⁷. Viruses and fungi are also associated with the disease,⁸ but the major etiological agents of otitis media are pathogenic bacteria, including *Haemophilus influenzae*, *Moraxella catarrhalis*, *Staphylococcus aureus*, *Pseudomonas aeruginosa*, *Escherichia coli*, *Proteus mirabilis*, *Klebsiella species*, and anaerobic bacteria such as *Bacteroides*, *peptostreptococcus*, *Propionibacterium* and to a lesser extent *Streptococcus pyogenes*.^{9,10,11,12}

OM is the most common disease of childhood that frequently necessitates emergency visits to hospitals¹³. Although the disease may sometimes resolve without antimicrobial drug therapy, clinical intervention with antibiotics is often required for relief of symptoms and complications⁴.

While the use of broad-spectrum antibiotics for treatment of AOM has been known to reduce the frequency of ear infections and produce overall decline in the incidence of complications of OM, but it is also associated with development and spread of drug-resistant bacteria¹⁴. Whereas most studies on OM have focused largely on its prevalence and clinical diagnosis, contemporary data on microbial etiology of the disease is scanty, particularly in relation to antimicrobial drug resistance in this epidemiological setting. This study was aimed at determining the identity and antibiotic-resistance profiles of bacterial pathogens of OM in the population. This knowledge

may be crucial for prompt antimicrobial interventions of OM, particularly in emergency situations, in Calabar-Nigeria.

METHODOLOGY

This cross sectional study was carried out between November 2020 and April 2021 in Calabar, a densely populated capital of Cross River state, Nigeria. The study participants were patients of all ages, except those aged below 6 months, who presented with ear drainage or discharge at the Ear, Nose, and Throat (ENT) Clinic of University of Calabar Teaching Hospital (UCTH), Calabar. A nonprobability (convenience) sampling technique was used. A total of 70 patients were recruited into the study, following submission of assigned or thumb-printed written informed consent by all the participants including parents or guardians for underage children. All the participants were clearly informed of the purpose and potential benefits of this research study, with firm guarantee to maintain their personal information with strict confidentiality for the research purpose only. Ethical clearance for the study was sought and obtained from the Ethical Committee of UCTH, Calabar, while permission for use of the hospital facilities was also obtained from the Hospital management.

Collection and processing of specimens

Samples of ear discharge/drainage were collected by the consulting Medical Officers in the clinic using a sterile swab stick. Prior to collecting the samples, a sterile pipette was used to aspirate the drainage to avoid stirring the discharge. The specimens were placed into an AMIES transport medium and transported to the microbiology laboratory for processing within an hour of collection.

Ear specimens were inoculated onto bacteriological media including chocolate agar, blood agar, cysteine lactose electrolyte deficient agar (CLED). The inoculated plates were incubated at 37°C in a 5-10% carbon dioxide enriched atmosphere and examined for growth of bacteria after 24-

48 hours' incubation. The isolates were identified by conventional bacteriological and biochemical procedures.

Antimicrobial susceptibility testing of ear isolates

Antimicrobial susceptibility test was carried out on each bacterial isolate using the disk diffusion method on nutrient agar plates. Three to five pure colonies of each bacterium were picked and transferred to a tube containing 5ml sterile peptone water. The preparations were mixed thoroughly to make the suspension homogenous. The bacterial suspension was incubated at 37°C until its turbidity matched the opacity of 0.5 McFarland Standard (equivalent to bacterial concentration of 1.5×10^8 colony forming unit/ml). A sterile swab was dipped in the suspension and gently rubbed on the agar surface to make a uniform wet layer on the nutrient agar plate, and allowed to dry for about 15-30 minutes. Commercially available Brodisk, Nigeria-antibiotics susceptibility test discs were placed on the inoculated plate using sterile forceps, with adequate spacing (at least 24 mm) between discs to avoid overlapping zones of inhibition; the antibiotics used included amoxicillin-clavulanate (30µg), Erythromycin (15µg), Zithromax (30µg), Ciprofloxacin (5µg), Levofloxacin (5µg), Gentamicin (10µg), Ceftriaxone (30µg), and Ceftazidime (30µg). The plates were kept to dry at room temperature for 30 minutes, then incubated overnight at 37°C, and examined for zones of inhibition. Susceptibility pattern was interpreted by comparison of the zone of inhibition according to Clinical and Laboratory Standards Institute guidelines (CLSI).¹⁵

Determination of Multidrug Resistance

Multidrug resistance (MDR) was defined by resistance of an isolate to three or more classes of antibiotics tested against the same isolate¹⁶.

Determination of Multiple Antibiotic Resistance Index

Multiple antibiotics resistance (MAR) index for each isolate was calculated as a ratio of the number of antibiotics which an isolate showed resistance to the total number of antibiotics used for susceptibility testing against the isolate¹⁷.

Data analysis

The data obtained in this study were analyzed using IBM SPSS Statistics 20 computer software (SPSS for Windows 20.0; SPSS Inc, Chicago, Illinois). Proportions were presented in frequencies and percentages. Pearson's chi-square analysis was used to test the statistical significance of bacterial etiology and other variables on the prevalence of otitis media. P-values were set at ≤ 0.05 level of significance.

RESULTS

Prevalence of bacterial otitis media among the study participants

The prevalence of bacterial ear infection in the study population was 72.9%. The prevalence of infection was slightly higher in males (75.9%) than in females (70.7%). Subjects aged 1-10 years had the highest prevalence of infection (91.7%), followed by those aged 31-40 years (77.8%), while those aged 21-30 years had the least (50.0%). Neither the age nor sex of the study participants was found to be significantly associated with the prevalence of infection ($p > 0.05$) [Table 1].

Distribution of bacterial pathogens of otitis media in the study population

Out of a total of 70 ear discharge swabs that were tested for microbial growth and MDR, and analyzed in this study, 51 (72.9%) yielded the growth of pathogenic bacteria (Table 2). A total of 51 isolates comprising *Pseudomonas aeruginosa* (26),

Table 1: Prevalence of bacteria-associated OM among the Subjects

Variables	No. of subjects	Infection	P- value
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detected (%)

Age 0.22

1-10 24 22 (91.7)

11-20 13 10 (76.9)

21-30 8 4 (50.0)

31-40 9 7 (77.8)

41-50 4 3 (75.0)

>50 12 8 (66.7)

Total 70 51 (72.9)

Gender

Male 29 22 (75.9) 0.63

Female 41 29 (70.7)

Total 70 51 (72.9)

Table 2: Bacterial isolates of otitis media in the study population

Pathogens	Bacterial isolates (%)
No bacterial growth	19 (27.1)
<i>P. aeruginosa</i>	26 (37.1)
<i>S. aureus</i>	17 (24.3)
<i>P. mirabilis</i>	6 (8.6)
<i>K. pneumonia</i>	2 (2.9)
Total	70 (100)

UNDER PEER REVIEW

Staphylococcus aureus (17), *Proteus mirabilis* (6), and *Klebsiella pneumonia* (2) were obtained in the study.

Antibiotics susceptibility and resistance patterns of bacterial isolates

The susceptibility and resistance of bacterial isolates to commonly used antibiotics is shown in Table 3.

P. aeruginosa isolates were more susceptible to amoxicillin-clavulanate (92.3%), ceftriaxone (76.9%), and ceftazidime (69.2%). In decreasing order, the isolates showed high resistance to erythromycin (100%), gentamicin (69.2%), azithromycin (61.5%), levofloxacin (34.6%), and ciprofloxacin (34.6%).

The susceptibility of *S. aureus* isolates was 88.2%, 82.4%, 76.5%, 70.5%, and 64.7% to ciprofloxacin, ceftriaxone, amoxicillin-clavulanate, azithromycin and ceftazidime, respectively. The isolates were more resistant to erythromycin (82.3%), gentamicin (64.7%), and levofloxacin (41.2%) compared to other antibiotics.

The sensitivity pattern of *P. mirabilis* to ciprofloxacin, levofloxacin and ceftriaxone was 88.3%, 66.7% and 66.7%, respectively, while Augmentin and ceftazidime were 50% each; resistance to erythromycin was total (100%), while 66.7% resistance was found for both azithromycin and gentamicin.

K. pneumonia isolates showed total (100%) resistance to ceftazidime, azithromycin, erythromycin, Augmentin and gentamicin, but total (100%) susceptibility to ceftriaxone, and modest sensitivity (50%) to levofloxacin and ciprofloxacin.

Multidrug resistance and multiple antibiotic resistance index of the bacterial isolates

The overall prevalence of multidrug resistant (MDR) strains among the isolates was 33.3% (Table 4). Based on their resistance to three or more classes of the antibiotics tested, 13 (24.5%) of the total 51 isolates were categorized as MDR strains. In descending order, MDR percentages for the isolates were 100%, 33.3%, 30.7% and 29.4% for *K. pneumoniae*, *P. mirabilis*, *P. aeruginosa* and *S. aureus*, respectively. However, association between multidrug resistance and the prevalence of infection was not statistically significant ($p > 0.05$).

Table 3: Antibiotic sensitivity patterns of isolates to commonly used antibiotics

Pathogens	Status	No. of isolates (%)							
		CRO	AZI	CAZ	AUG	ERY	LEV	CIP	GEN
<i>P. aeruginosa</i>	Sensitive	20(76.9)	10(38.5)	18(69.2)	24(92.3)	0	17(65.4)	17(65.4)	8(30.8)
	Resistant	6 (23.1)	16(61.5)	8(30.8)	2 (7.8)	26(100)	9(34.6)	9(34.6)	18(69.2)
<i>S. aureus</i>	Sensitive	14(82.4)	12(70.6)	11(64.7)	13(76.5)	3(17.6)	10(58.8)	15(88.2)	6(35.3)
	Resistant	3(17.6)	5(29.4)	6(35.3)	4(23.5)	14(82.3)	7(41.2)	2(11.8)	11(64.7)
<i>P. mirabilis</i>	Sensitive	4(66.7)	2(33.3)	3(50.0)	3(50.0)	0	4(66.7)	5(83.3)	2(33.3)
	Resistant	2(33.3)	4(66.7)	3(50.0)	3(50.0)	6(100)	2(33.3)	1(16.7)	4(66.7)
<i>K. pneumoniae</i>	Sensitive	2(100)	0	0	0	0	1(50)	1(50)	0
	Resistant	0	2(100)	2(100)	2(100)	2(100)	1(50.0)	1(50.0)	2(100)

* CRO- Ceftriaxone, AZI=Azithromycin, CAZ- Ceftazidime, AUG- Amoxicillin-clavulanate, ERY=Erythromycin, LEV=Levofloxacin, CIP=Ciprofloxacin and GEN=Gentamicin

Table 4: Prevalence of multidrug resistance (MDR) among the bacterial isolates

Bacterial pathogens	*Class of antibiotics No. (%)				MDR (%)	P-value
	**R3	R4	R5	R6		
<i>P. aeruginosa</i> (n=26)	2 (7.7)	4 (15.3)	2 (7.7)	0 (0)	8 (30.7)	0.523
<i>Staph. aureus</i> (n=17)	0 (0)	2 (11.8)	3 (17.6)	0 (0)	5 (29.4)	
<i>P. mirabilis</i> (n=6)	0 (0)	0 (0)	2 (33.3)	0 (0)	2 (33.3)	
<i>K. pneumoniae</i> (n=2)	0 (0)	0 (0)	2 (100)	0 (0)	2 (100)	
Total	2 (3.9)	6 (11.8)	9 (17.6)	0 (0)	17 (33.3)	

*MDR was defined using six classes of antibiotics including, **cephalosporin** (ceftriaxone, ceftazidime), **penicillin** (amoxicillin-clavulanate), **quinolone** (ciprofloxacin), **fluoroquinolone** (levofloxacin), **macrolide** (erythromycin, azithromycin), and **aminoglycoside** (gentamicin).

**R3, R4, R5 and R6 were used to denote resistance of isolates to three, four, five and six classes of antibiotics, respectively.

Table 5: Multiple antibiotic resistant indices of the ear isolates

Bacterial isolates	No. of antibiotics tested	No. of antibiotics resisted by isolates	No. of isolates (%)	MAR index
<i>P. aeruginosa</i> (n=26)		3	4 (15.3)	0.37
		4	6 (22.5)	0.50
		5	8 (30.7)	0.62
		6	8 (30.7)	0.75
<i>Staph. aureus</i> (n=17)		4	3 (17.6)	0.50
		5	3 (17.6)	0.62
		6	7 (41.1)	0.75
		7	4 (23.5)	0.87
<i>P. mirabilis</i> (n=6)		4	1 (16.6)	0.50
		5	3 (50.0)	0.62
		6	2 (33.3)	0.75
<i>K. pneumoniae</i> (n=2)		5	1 (50.0)	0.62
		7	1 (50.0)	0.87

Multiple antibiotics resistance (MAR) indexing of all the isolates revealed values greater than 0.2; no isolate, however, had an index equal to 1 (Table 5). MAR indices found for different bacterial isolates varied as follows: *P. aeruginosa*(0.42 - 0.85), *K. pneumonia* isolates (0.62 - 0.87), *S. aureus*(0.50 – 0.87), and *P. mirabilis* (0.50 – 0.75).

DISCUSSION

Otitis media is a common disease of childhood, with about 80-90% of children likely to experience one or more episodes by the age of 10 years¹⁸. This study found the highest prevalence of the disease in subjects aged 1-10 years, while those aged 31-40 years had the least among other age groups. Although children are generally known for contracting infectious diseases more frequently because of indiscriminate playing and poor hygienic habits, vulnerability to OM has been largely associated with underdeveloped immunity and Eustachian tube dysfunction^{2,3}. In consistency with some study reports that have identified the male sex as a host-related risk factor of OM^{19,20}, the frequency of infection in this study was found to be slightly higher in male subjects than the females. In contrast, however, a number of studies carried out in Nigeria have reported a higher prevalence of OM in females than males²¹⁻²³. Variations in gender-based prevalence of OM in diverse epidemiological settings may be attributed to peculiar population dynamics that put one gender at greater risk of exposure to environmental pollution..

In relation to the microbial etiology of OM, this study confirmed the predominance of bacterial pathogens with a prevalence of 72.9% in the study population. *P. aeruginosa* was the most frequently isolated pathogen, among others including *S. aureus*, *P. mirabilis*, and *K. pneumoniae*. This finding is consistent with reports of similar studies which found *S. aureus*, *P. aeruginosa*,

Proteus species, and *K. pneumoniae* among the most common agents of OM in some parts of Nigeria and elsewhere in sub-Saharan Africa²⁴⁻²⁶.

In spite of a widely endorsed strategy for conservative management of AOM without antibiotics in patients less likely to have any therapeutic benefits²⁷, treatment with antibiotics has remained a primary tool for clinical intervention of OME¹³. This study found ear pathogens with remarkable variation in their susceptibility to commonly used antibiotic drugs in this setting. For instance, while isolates of *S. aureus* were more susceptible to ciprofloxacin, *K. pneumoniae* strains showed high susceptibility to ceftriaxone. Remarkably, *P. aeruginosa* isolates were found to be highly sensitive to amoxicillin-clavulanate, in contrast to the findings of similar studies that reported high resistance of the pathogen to the drug in other epidemiological settings of sub-Saharan Africa²⁸. Compared with other commonly used antibiotics, the high susceptibility of *P. aeruginosa* isolates to amoxicillin-clavulanate in this study may be a consequence of the discrete and appropriate usage of the drug in the population. Indiscriminate use of antibiotics has been known to play an important role in the development of drug-resistant bacterial strains²⁹.

Overall, the present study found a high proportion of drug-resistant strains with an MDR prevalence of 33.3% among the isolates. This finding is consistent with the fact that the common isolates of this study, including *P. aeruginosa*, *S. aureus* and *K. pneumoniae*, are members of the so-called 'ESKAPE' group of pathogens³⁰, widely known for their increasing resistance to commonly used antibiotics²⁸. Evaluation of the MAR index for all the isolates in this study revealed high values ranging from 0.4 to 0.8. MAR indices greater than 0.2 are known to be effective indicators of bacterial pathogens acquired from highly contaminated environments associated with indiscriminate use of antibiotics, whereas indices less than or equal to 0.2 would indicate bacteria from sources with less antibiotic usage.³¹ The high MAR indices of ear pathogens in this study may portend dire implications for empiric antimicrobial therapy of OM, with a high likelihood of treatment failures and disease complications in the

population. Treatment failures with first episodes of OM have been known to result in recurrent or chronic disease usually associated with hearing loss, decreased learning ability, and poor educational output in children^{32,33}.

Limitations: This study utilized only ear-swabs/discharge specimens for isolation of bacterial pathogens; the absence of tympanocentesis could possibly have compromised the capacity for detection of early-onset infections, particularly in children. Similarly, due to inadequate laboratory capacity, bacterial etiology was determined strictly by the isolation of pathogens on traditional bacteriological media. Reliance on solid culture isolates, in absence of more sensitive molecular methods, could potentially limit the yield of fastidious ear pathogens, including anaerobes, and possibly eliminate their etiologic contributions. Discrepancies in isolation rates and etiological data of some studies, particularly in sub-Saharan Africa, have been attributed to inadequate laboratory capacity and the quality of microbiological procedures used²⁸. Further studies on the microbiological etiology of otitis media in this setting should consider the utilization of more sensitive methods to maximize the bacterial yield and overall etiological data.

CONCLUSION

This study found a high prevalence of bacteria-associated OM, with *P. aeruginosa* and *S. aureus* as the predominant etiologic agents of the disease in the population. High susceptibility of the predominant isolate to amoxicillin-clavulanate and ciprofloxacin may underscore the potential of these drugs for prompt treatment of OM. However, given the overall high resistance indices of the study isolates, and dire implications for empiric antibacterial therapy, choice of antibiotics for clinical intervention of otitis media in this population should be driven mainly by valid results of microbiological susceptibility tests.

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