Klebsiella pneumoniae Carbapenemase-producing Enterobacteria in Hospital, Singapore

To the Editor: During the past decade, enterobacteria that produce Klebsiella pneumoniae carbapenemase (KPC) have become established in the United States and countries in South America and Europe (1). In Asia, KPC was reported in the People’s Republic of China in 2007 (2) and subsequently in South Korea (3) and Taiwan (4). Public health agencies emphasize screening and strict contact precautions to control multidrug resistant Enterobacteriaceae (5). Routine testing for mechanisms of resistance facilitates detection of emerging carbapenem-resistant Enterobacteriaceae.

In Singapore’s 1,000-bed National University Hospital during November 2010–January 2011, we identified New Delhi metallo-β-lactamase 1–producing Enterobacteriaceae in 2 clinical specimens but none that produced KPC (i. Venkatachalam et al., unpub. data). We conducted a laboratory screening study to determine the prevalence and nature of carbapenem-resistant Enterobacteriaceae in April 2011. Ethics committee approval was waived for this study.

Testing of rectal swab samples is part of an established hospitalwide program for vancomycin-resistant enterococci screening. Using a scoring system to identify patients at high risk for vancomycin-resistant enterococci (6), we found that ≥2.5 specimens per 100 admissions were attained each month. During our study, we also tested these samples for carbapenemase-producing Enterobacteriaceae.

During April–June 2011, we incubated specimens for 24 h in 10 mL tryptic soy broth containing 1 mg/L imipenem, then streaked 100 μL of the broth onto CHROMagar KPC (CHROMagar, Paris, France). Colonies detected after 24 h incubation at 35°C were identified by using MALDI-TOF MS with a Microflex LT instrument (Bruker Daltonik GmbH, Leipzig, Germany). Imipenem and meropenem MICs for Enterobacteriaceae were confirmed by using Etests (bioMérieux, Marcy l’Etoile, France). Isolates with MIC ≥2 μg/mL underwent analysis with Metallo-β-Lactamase Confirmative Identification Pack (Rosco Diagnostic, Taastrup, Denmark) and Etest MBL (bioMérieux) for metallo-β-lactamase production. Isolates suspected to be producers were genotypically confirmed by PCR.

Of the 201 nonduplicate samples processed, 79 microorganisms exhibited imipenem resistance and were isolated on CHROMagar KPC (Table). Among Enterobacteriaceae, carbapenem MIC ≥2 μg/mL was present in 1 E. aerogenes, 2 E. cloacae, and 4 K. pneumoniae isolates. One isolate (K. pneumoniae) had a positive combined disk test result with a pattern suggestive of serine carbapenemase production.

We analyzed genomic DNA (DNasey Blood and Tissue Kit, Qiagen, Hilden, Germany) from this isolate by using PCR for transmissible carbapenem resistance markers: metallo-β-lactamas (VIM, IMP, and KHM-1), serine carbapenemases (KPC, GES1–5 and 7), and OXA-48. blaKPC-specific primers (forward primer 5’-CGTGGACGCCTATACCC-3’; reverse primer 5’-ACCGCTGCAGCGCTGAGC-3’ generated a 390-bp amplicon. Full gene sequencing of blaKPC (forward primer 5’-ATGTACGTATCGCGCTGCTT-3’; reverse primer 5’-CCATAATGTGACGATGTTG-3’; GenBank accession no. FJ628167.2). Further analysis showed that the isolate carried extended-
We empirically prescribed a 10-day course of piperacillin-tazobactam. On day 10 of treatment, KPC-producing *K. pneumoniae* was isolated from the rectal specimen. The patient responded to treatment and was discharged to a long-term care facility.

This case demonstrates concerns about a KPC of local community origin because no other KPC-producing *Enterobacteriaceae* were isolated during this inpatient surveillance and the patient had neither received antimicrobial drugs nor traveled in the 6 months before her May admission (7). However, she was admitted 3 weeks before sampling; an unidentified hospital source remains a possibility. Of added concern is the potential for dissemination within the facility to which she was discharged.

Resistance to third-generation cephalosporins was reported for 20% of *Escherichia coli*, 32.3% of *K. pneumoniae*, 46.2% of *Acinetobacter* spp., and 7.5% of *Pseudomonas aeruginosa* clinical isolates at 4 major Singapore hospitals during January 2006–December 2008 (9). Authors reported positive correlation between meropenem administration and carbapenem resistance development in *Acinetobacter* spp. blood isolates.

When the resistance mechanism to an antimicrobial drug is embedded in highly mobile elements like plasmids, widespread dissemination is possible. Although acute care hospitals are conducive to development of antimicrobial drug resistance, long-term care facilities facilitate spread of these organisms (10). Infection control interventions including routine screening for mechanisms of resistance and responsible use of antimicrobial drugs are increasingly critical in hospitals and long-term care facilities; a response plan coordinated between these facilities is needed.

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**References**


blaNDM-1–positive Klebsiella pneumoniae from Environment, Vietnam

To the Editor: The blaNDM-1 gene, which produces the New Delhi metallo-β-lactamase (NDM-1) enzyme, confers resistance to the carbapenem class of antimicrobial drugs and can be transferred among different types of bacteria. NDM-1 was identified in 2008 in Sweden from a patient from India who had been hospitalized in New Delhi (1). Since that report, blaNDM-1–positive bacteria have been identified from patients in several countries; most of these patients had a direct link with the Indian subcontinent (2). The spread of blaNDM-1 among bacterial pathogens is of concern not only because of resistance to carbapenems but also because such pathogens typically are resistant to multiple antimicrobial drug classes, which leaves few treatment choices available (3–5). In 2011, spread of blaNDM-1–positive bacteria in an environmental setting in New Delhi was reported (6).

The possible appearance of bacteria harboring blaNDM-1 in Vietnam is of concern because cultural and economic links between Vietnam and India are strongly established, including extensive person-to-person exchanges that could enable easy exchange of pathogens. In addition, Vietnam faces a serious problem of antimicrobial drug resistance because drugs are freely available and used in an indiscriminate fashion. Thus, once blaNDM-1–positive bacteria colonize persons in Vietnam, they would be able to spread easily and pose a serious public health threat.

During September 2011, we collected paired swab samples (1 for PCR, 1 for culture) of seepage water from 20 sites (rivers, lakes, and water pools in streets) within a 10-km radius of central Hanoi, Vietnam. Samples...