Antimicrobial Drug Resistance in Pathogens Causing Nosocomial Infections at a University Hospital in Taiwan, 1981–1999

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To determine the distribution and antimicrobial drug resistance in bacterial pathogens causing nosocomial infections, surveillance data on nosocomial infections documented from 1981 to 1999 at National Taiwan University Hospital were analyzed. During this period, 35,580 bacterial pathogens causing nosocomial infections were identified. Candida species increased considerably, ranking first by 1999 in the incidence of pathogens causing all nosocomial infections, followed by Staphylococcus aureus and Pseudomonas aeruginosa. Candida species also increased in importance as bloodstream infection isolates, from 1.0% in 1981-1986 to 16.2% in 1999. The most frequent isolates from urinary tract infections were Candida species (23.6%), followed by Escherichia coli (18.6%) and P. aeruginosa (11.0%). P. aeruginosa remained the most frequent isolates for respiratory tract and surgical site infections in the past 13 years. A remarkable increase in incidence was found in methicillin-resistant S. aureus (from 4.3% in 1981-1986 to 58.9% in 1993-1998), cefotaxime-resistant E. coli (from 0% in 1981-1986 to 6.1% in 1993-1998), and cefotaxime-resistant Klebsiella pneumoniae (from 4.0% in 1981-1986 to 25.8% in 1993-1998). Etiologic shifts in nosocomial infections and an upsurge of antimicrobial resistance among these pathogens, particularly those isolated from intensive care units, are impressive and alarming.

The emergence of resistance to antimicrobial agents is a global public health problem, particularly in pathogens causing nosocomial infections (1-5). Antimicrobial resistance results in increased illness, deaths, and health-care costs (1,2,6-10). The distribution of pathogens causing nosocomial infections, especially antimicrobial-resistant pathogens, changes with time and varies among hospitals and among different locations in the same hospital (11-15). The increasing number of immunocompromised patients and increased use of indwelling devices, as well as widespread use of antimicrobial agents in hospital settings, particularly in intensive care units (ICUs), contributes to antimicrobial resistance among pathogens causing nosocomial infections (1,4,6,10).

Surveillance data reported by the National Nosocomial Infections Surveillance (NNIS) System for 1993-1997 compared with January-November 1998 show a continuing increase in antimicrobial-resistant pathogens associated with nosocomial infections in ICU patients from U.S. hospitals (2). The increase is particularly marked for vancomycin-resistant enterococci (VRE) (55%), methicillin-resistant Staphylococcus aureus (MRSA) (31%), third-generation cephalosporin-resistant Escherichia coli (29%), imipenem-resistant Pseudomonas aeruginosa (32%), and quinolone-resistant P. aeruginosa (89%) (2). Studies since 1990 have clearly demonstrated that Candida species continue to be an important cause of nosocomial infections, particularly of bloodstream infections (BSI). Furthermore, the proportion of BSI caused by Candida species other than C. albicans is increasing (14,16-20).

We describe the distribution of major bacterial pathogens causing nosocomial infections from 1981 to 1999 in National Taiwan University Hospital and demonstrate the emergence of antimicrobial drug resistance among these pathogens during this period.

Materials and Methods

Data Collection

National Taiwan University Hospital is a 2,000-bed tertiary referral center in Taipei, northern Taiwan. Available data for inpatient-days at the hospital ranged from 294,946 in 1990 to 566,165 in 1999. The number of ICU beds increased from 40-50 before 1993 to 100-120 in 1998-99. The Nosocomial Infection Control Committee of the hospital was established in 1980 to identify pathogens causing nosocomial infections and to obtain and analyze antimicrobial susceptibility results of these pathogens from the hospital’s clinical microbiology laboratory. NNIS definitions were used for nosocomial infections (e.g.,
bloodstream; respiratory tract, including lower respiratory tract and pneumonia; urinary tract; and surgical site infections) (21,22). Isolates were considered nosocomial if the culture was dated >2 days after admission. All isolates were identified by standard methods and confirmed by using Vitek or API products (bioMerieux Vitek, Inc., Hazelwood, MO). For determining the percentage of resistance, the same organisms from multiple blood cultures or from the same sources with identical antibiotic were considered a single isolate. The amount of use for each indicated antimicrobial agent (including oral and parenteral forms) was expressed in grams per 1,000 inpatient-days.

**Antimicrobial Susceptibility Testing**

Antimicrobial susceptibility testing of the bacterial isolates was performed by the disk diffusion method as described by the National Committee for Clinical Laboratory Standards (NCCLS) (23). *S. aureus* ATCC 25923, *E. coli* ATCC 25922, and *P. aeruginosa* ATCC 27853 were included as control strains. Interpretive criteria for susceptibility or resistance followed NCCLS guidelines (23). For this report, we present susceptibility data for penicillin, oxacillin, vancomycin, gentamicin, cefotaxime, ceftazidime, imipenem, and ciprofloxacin. The susceptibility data for imipenem and ciprofloxacin were available only since 1993; those for other agents were available from 1981 to 1999.

Antifungal susceptibility testing of amphoterinic B and fluconazole against 150 blood isolates of *Candida* species collected from October 1997 to September 1999 was performed by the E test (AB BIODISK, Solna, Sweden) according to the manufacturer’s instructions. Quality control was performed by testing *C. parapsilosis* ATCC 2019 and *C. krusei* ATCC 6258. MIC results were interpreted in accordance with NCCLS guidelines (24).

**Results**

During the 19-year period, 35,580 bacterial pathogens causing nosocomial infections were identified. The hospital’s overall rate of nosocomial infections during the 19-year period ranged from 3.9% to 6.1%. For the four major sites of nosocomial infections, data are presented as numbers of infection per 10,000 patient-days at National Taiwan University Hospital from 1991 to 1999. BSI, bloodstream infection; UTI, urinary tract infection; SSI, surgical site infection; RTI, respiratory tract infection.

Gram-negative bacteria remained the predominant pathogens (66.1% in 1981, 51.3% in 1993, and 53.4% in 1999); however, incidences of fungal infections have increased recently (Table 1). In a comparison of data grouped into four time periods (1981-1986, 1987-1992, 1993-1998, and 1999), *E. coli* decreased from 12.1% of all nosocomial infections in 1981-1986 to 9.5% in 1993-1998; however, infections caused by *S. aureus* increased from 5.2% (1981-1986) to 12.1% (1993-1998). *Candida* species showed a considerable increase (from 3.7% in 1981-1986 to 16.2% in 1999) and have ranked first since 1993, followed by *S. aureus* and *P. aeruginosa* (Table 1).

*Candida* species, *S. aureus*, and *Acinetobacter* species were also important bloodstream isolates (Table 1), increasing from 1.0%, 5.2%, and 6.1%, respectively, in 1981-1986 to 16.2%, 13.0%, and 7.6%, respectively, in 1999. Although *E. coli* was also a frequent isolate, it declined in percentage of all BSI from 18.7% in 1981-1986 to 9.0% in 1999. Other pathogens declining in percentage of BSI from 1981-1986 to 1999 included *K. pneumoniae*, *P. aeruginosa*, and *Enterococcus* species.

From 1992 to 1999, 1,065 isolates of *Candida* species were recovered from patients with nosocomial BSIs. *C. glabrata* (8.8%) ranked fourth in incidence behind *C. albicans* (59.3%), *C. tropicalis* (17.6%), and *C. parapsilosis* (8.2%) in 1999. Only four blood isolates of *C. krusei* were identified during the 8-year period.

The most frequent isolates from urinary tract infections in 1993-1998 were *Candida* species (23.6%), followed by *E. coli* (18.6%) and *P. aeruginosa* (11.0%). However, in 1999, *E. coli* (18.4%) replaced *Candida* species (14.3%) as the top-ranking pathogen causing urinary tract infections. *P. aeruginosa* remained the most frequent isolate for respiratory tract and surgical site infections in the past 13 years. *Candida* species increased in incidence in surgical site infections, from 1.8% in 1981-1986 to 6.4% in 1999. Among pathogens causing respiratory tract infections, *Acinetobacter* species ranked fifth in
The distributions of selected antimicrobial drug-resistant pathogens causing all nosocomial infections and BSIs of patients hospitalized in intensive care units or general wards is shown in Table 2. Antimicrobial drug-resistant pathogens causing nosocomial infections and BSIs of patients admitted to ICUs, and 6 of these 12 isolates were recovered in enterococci is shown in Figure 3. Among these VRE isolates, 4 were from blood, 15 from urine, and the rest were pus or drainage fluid. Only 12 (15%) of these isolates were from patients admitted to ICUs, and 6 of these 12 isolates were recovered in 1999. The incidence of VRE in enterococci causing nosocomial infections in ICUs was 7.0%. The relationship of increasing vancomycin use and the increase in vancomycin resistance in enterococci is shown in Figure 3.

The incidences of imipenem-resistant A. baumannii (1993 to 1998) and imipenem-resistant Acinetobacter baumannii (1999) isolated from ICUs were five- to ten-fold higher than isolates recovered from non-ICU settings. However, this was not the case with imipenem-resistant P. aeruginosa in 1999 or imipenem-resistant A. baumannii in 1993-1998 (Figure 4).

All 150 isolates of Candida species were inhibited by 1 µg/mL of amphotericin B (MIC range 0.03 to 1 µg/mL). The MIC<sub>50</sub> and MIC<sub>90</sub> of C. glabrata were 16 µg/mL and >32 µg/mL, respectively. Twenty-one isolates (70%) of these isolates were from patients admitted to ICUs, and 6 of these 12 isolates were recovered in 1999. The incidence of VRE in enterococci causing nosocomial infections in ICUs was 7.0%. The relationship of increasing vancomycin use and the increase in vancomycin resistance in enterococci is shown in Figure 3.

The first clinical isolate of VRE was recognized in 1995 (25,26). Since then, 80 isolates of VRE (49 of E. faecalis and 31 of E. faecium) have been recovered from hospitalized patients. The incidence of VRE in isolates causing nosocomial infection increased from 1.8% in 1995 to 6.7% in 1997 and 25.2% in 1999 (Figure 3). Among these VRE isolates, 4 were from blood, 15 from urine, and the rest were pus or drainage fluid. Only 12 (15%) of these isolates were from patients admitted to ICUs, and 6 of these 12 isolates were recovered in 1999. The incidence of VRE in enterococci causing nosocomial infections in ICUs was 7.0%. The relationship of increasing vancomycin use and the increase in vancomycin resistance in enterococci is shown in Figure 3.

The incidences of imipenem-resistant P. aeruginosa (1993 to 1998) and imipenem-resistant Acinetobacter baumannii (1999) isolated from ICUs were five- to ten-fold higher than isolates recovered from non-ICU settings. However, this was not the case with imipenem-resistant P. aeruginosa in 1999 or imipenem-resistant A. baumannii in 1993-1998 (Figure 4).

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### Table 1. Incidences of 10 top-ranking pathogens causing nosocomial infections and infections from four body sites at National Taiwan University Hospital, 1981 to 1999

<table>
<thead>
<tr>
<th>Pathogen</th>
<th>All</th>
<th>BSI</th>
<th>RTI</th>
<th>UTI</th>
<th>SSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candida spp.</td>
<td>3.7/9.1/14.4/16.2</td>
<td>1.0/9.2/16.4/16.2</td>
<td>2.0/5.8/2.1/2.2</td>
<td>8.4/16.0/23.6/14.3</td>
<td>2.4/5.1/5.9/6.4</td>
</tr>
<tr>
<td>Staphylococcus aureus</td>
<td>5.2/9.1/12.1/12.0</td>
<td>5.2/9.3/11.5/13.0</td>
<td>4.0/8.4/16.9/12.6</td>
<td>1.4/2.6/3.3/2.1</td>
<td>5.5/5.2/13.0/15.4</td>
</tr>
<tr>
<td>Pseudomonas aeruginosa</td>
<td>12.7/14.0/11.1/11.8</td>
<td>10.0/9.4/27.8</td>
<td>19.6/21.9/23.8/25.7</td>
<td>11.7/11.2/11.0/10.4</td>
<td>11.1/17.4/14.3/16.0</td>
</tr>
<tr>
<td>Escherichia coli</td>
<td>12.1/18.4/9.5/9.9</td>
<td>18.7/9.7/8.7/9.0</td>
<td>4.8/2.4/3.5/3.7</td>
<td>19.1/19.9/18.6/18.4</td>
<td>11.7/5.8/5.8/6.8</td>
</tr>
<tr>
<td>Klebsiella pneumoniae</td>
<td>8.1/5.5/7.2/6.8</td>
<td>11.6/6.6/7.7/7.6</td>
<td>10.9/9.4/11.5/10.8</td>
<td>9.0/7.0/8.6/8.2</td>
<td>6.9/3.5/4.2/4.6</td>
</tr>
<tr>
<td>Enterobacter spp.</td>
<td>6.0/7.6/7.4/6.4</td>
<td>8.0/8.6/7.3/6.9</td>
<td>5.2/8.1/11.8/8.6</td>
<td>9.0/8.4/6.7/6.3</td>
<td>4.5/7.9/7.8/5.8</td>
</tr>
<tr>
<td>Enterococcus spp.</td>
<td>8.8/7.8/6.7/6.2</td>
<td>8.7/6.2/6.3/7.6</td>
<td>11.6/9.7/8.1/6.5</td>
<td>10.1/12.6/8.6/7.9</td>
<td></td>
</tr>
<tr>
<td>Acinetobacter spp.</td>
<td>4.4/5.1/9.5/4.1</td>
<td>6.1/8.8/7.2/7.6</td>
<td>11.0/13.4/9.3/13.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CoNS</td>
<td>2.8/6.9/6.6/5.1</td>
<td>2.7/8.5/7.9/4.9</td>
<td>7.4/6.5/4.4/2.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other NFGNB</td>
<td>5.7/6.1/4.8/4.1</td>
<td>5.9/7.7/6.8/6.7</td>
<td>12.3/13.1/7.8/8.2</td>
<td>3.2/1.9/1.6/8.3</td>
<td></td>
</tr>
<tr>
<td>S. marcescens</td>
<td>3.5/1.9/3.7/4.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proteus spp.</td>
<td>3.2/2.2/2.4/1.1</td>
<td>3.8/3.8/3.8/3.7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citrobacter spp.</td>
<td>5.9/4.4/2.4/2.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Viridans streptococci</td>
<td>5.2/5.8/4.2/3.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bacteroides spp.</td>
<td>9.7/4.7/5.0/3.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Abbreviations: BSI = bloodstream infection; RTI = respiratory tract infection; UTI = urinary tract infection; SSI = surgical site infection; CoNS = coagulase-negative staphylococci; NFGNB = nonfermentative gram-negative bacilli.*
Discussion

Hospitals worldwide are continuing to face the crisis of the upsurge and dissemination of antimicrobial-resistant bacteria, particularly those causing nosocomial infections in ICU patients (1,27-29). Among resistant bacteria, MRSA, MRCoNS, VRE, third-generation cephalosporin-resistant Enterobacteriaceae, and imipenem- or ciprofloxacin-resistant P. aeruginosa and A. baumannii are of great concern because these bacteria have spread worldwide and ultimately will compromise the antimicrobial therapy of infections caused by these organisms (2,25-28,30).

This report describes trends in major nosocomial pathogens and shifts in antimicrobial resistance during a 19-year period in a large teaching hospital in Taiwan. In a comparison of data from a recent NNIS study and other surveillance systems (2,4,9,31), our results suggest four conclusions. First, Candida species, rather than P. aeruginosa, E. coli, or staphylococci, now are the most frequent pathogens causing overall nosocomial infections and BSIs in this hospital. The upward trend in coagulase-negative staphylococci, which was the leading cause of BSI in the recent NNIS study, was not confirmed in our study. Second, we observed a remarkably high incidence of MRSA, especially in ICUs, contrasted with a relatively low incidence of VRE. Third, we report an increase in incidence of cefotaxime-resistant Enterobacteriaceae, especially in the incidence of cefotaxime-resistant K. pneumoniae in ICUs. Fourth, although the overall incidence of imipenem resistance among P. aeruginosa and A. baumannii in recent years has remained

Table 2. Selected antimicrobial resistant pathogens associated with nosocomial infection at National Taiwan University Hospital from 1981 to 1999

<table>
<thead>
<tr>
<th>Resistant pathogen</th>
<th>% resistance (all patients/in intensive care unit patients/in patients in general wards)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methicillin-resistant Staphylococcus aureus</td>
<td>20.2/27.8/19.5 31.4/58.5/26.6 64.8/86.9/56.7 69.3/87.4/60.2</td>
</tr>
<tr>
<td>Methicillin-resistant CoNS&lt;sup&gt;a&lt;/sup&gt;</td>
<td>72.2/88.2/70.8 74.0/83.9/77.1 79.0/88.7/75.1 90.6/90.9/89.0</td>
</tr>
<tr>
<td>Penicillin-resistant enterococci</td>
<td>5.9/6.8/5.8 20.7/30/19.6 19.5/22/18.7 35.9/40.9/27.8</td>
</tr>
<tr>
<td>Gentamicin-resistant enterococci</td>
<td>0.0/0.0/0.0 71.0/71/70.9 61.5/67/60.0 50.0/39.3/55.2</td>
</tr>
<tr>
<td>Cefotaxime-resistant Escherichia coli</td>
<td>1.6/0.0/1.7 2.8/8.6/2.5 6.8/13.1/6.2 12.3/10.3/12.7</td>
</tr>
<tr>
<td>Cefotaxime-resistant Klebsiella pneumoniae</td>
<td>4.9/8.8/3.9 7.4/16.9/5.6 22.8/50.5/15.6 16.5/40.0/9.3</td>
</tr>
<tr>
<td>Cefotaxime-resistant Enterobacter spp.</td>
<td>35.8/52.4/32.4 49.7/55.7/47.7 57.6/67.0/53.6 50.9/61.8/46.2</td>
</tr>
<tr>
<td>Cefotaxime-resistant Pseudomonas aeruginosa</td>
<td>24.2/20.0/25.0 16.1/24.3/12.1 10.2/16.9/7.8 11.2/17.6/8.1</td>
</tr>
<tr>
<td>Imipenem-resistant P. aeruginosa</td>
<td>NA NA 8.5/18.2/4.9 6.7/4.5/7.7</td>
</tr>
<tr>
<td>Ciprofloxacin-resistant P. aeruginosa</td>
<td>NA NA 8.7/11.6/5.8 14.0/18.2/2.9</td>
</tr>
<tr>
<td>Imipenem-resistant Acinetobacter baumannii</td>
<td>NA NA 6.7/9.1/4.4 12.5/23.3/7.6</td>
</tr>
</tbody>
</table>

<sup>a</sup>CoNS = coagulase-negative staphylococci; NA = not available.
and from April 1995 to June 1996, the incidences of candidemia due to non-\textit{albicans} were similar to that (48%) reported in the United States 
importance (31,33). Although the proportion (40%) of \textit{C. albicans}, \textit{C. glabrata} (12,19,20,31,32). Among the species of resistance and potential outbreaks (clonal dissemination or even to \textit{Candida} species with fewer options for therapy. These shifts continue to present challenges for nosocomial infection control and prevention.

Dr. Hsueh is an assistant professor in the departments of Laboratory Medicine and Internal Medicine, National Taiwan University College of Medicine. His research interests include epidemiology of emerging and nosocomial infections and mechanisms of antimicrobial drug resistance. He is actively involved in developing a national research program for antimicrobial drug resistance (Surveillance for Multicenter Antimicrobial Resistance in Taiwan).

**References**


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