E. coli Bacteremia Strains - High diversity and Associations with Age-related Clinical Phenomena

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Abstract

Advanced age is associated with an increased proportion of Escherichia coli in bacteremia as well as an increased risk of death from E. coli blood stream infection. Age-associated differences in normal flora E. coli indicate that elderly persons may be diseased by other groups of E. coli than do younger patients. We studied a historical cohort of 212 patients with community-acquired E. coli bacteremia. The bacterial strains were tested for antimicrobial resistance and analyzed by a generic Multi-Locus Variable-Tandem Repeats Analysis (MLVA).

The available 212 strains showed a great diversity, and clustered into ten different MLVA-type complexes (MTC). MTC-b, containing 97 of the strains, was associated with ≥1 comorbid illness (OR 2.02, 95% CI 1.12-3.64), and with to ≥1 atypical symptom (OR 0.46, 95% CI 0.27-0.80). MTC-c, containing 31 strains, was associated with urinary origin of infection (OR 3.28, 96% CI 1.345-8.00) and was preventive against gastrointestinal origin of infection (OR 0.11, 95% CI 0.01-0.83). MTC-g, containing only eight strains, was associated with leukaopenia (OR 6.43, 95% CI 1.15-36.00). The strains showed low level of antimicrobial resistance. Fifteen of the 212 patients (7.1%) died within 14 days after admission to hospital. Neither MTC nor antimicrobial resistance was associated with hospital mortality.

In conclusion, our study showed a great diversity of the strains and that one of the MTCs was associated with age-related clinical phenomena. Some of the MTCs were associated with outcome, indicating that patient characteristics are more important than microbial characteristics.

Keywords: E. coli, age, bacteremia, genotype, mortality

Introduction

E. coli is the most frequent Gram-negative bacillus isolated in blood stream infections [1,2]. Unlike other common pathogens seen in community-acquired blood stream infections, the proportion of E. coli isolates increases with increasing age [1]. Clinical as well as population-based studies have identified high age, in addition to certain clinical factors such as hospital acquisition, comorbid illnesses, presence of shock, non-urinary focus, and antimicrobial resistance in conjunction with inadequate treatment, as risk factors for death in E. coli blood stream infection [3,4]. Unlike commensal and intestinal pathogenic E. coli, extra intestinal pathogenic E. coli (ExPEC) derive predominantly from E. coli main phylogenetic group B2, and to a lesser extent, group D [5]. In a mouse model, phylogeny was linked to virulence [6]. However, clinical studies of E. coli bacteremia give conflicting results when comparing relative impact of host and bacterial determinants on severity of infection [7-9]. Advanced age is associated with an increased risk of severe infection, probably due to immune dysregulation and a more pronounced procoagulant state [10] as well as increased apoptosis [11]. The above-mentioned studies did not, however, evaluate whether advanced age and age-related clinical presentation were associated with different types of E. coli. Efforts are made to establish strategies other than antibiotic treatment to manage or prevent ExPEC infections, based on certain virulence traits [12], or by using more of a whole-cell approach [13]. It is therefore relevant to ask whether elderly patients fall seriously ill from other groups of E. coli than do younger patients.

A fast and easy molecular tool to discriminate different isolates of the same species is Multiplex-Variable number tandem repeats Analysis (MLVA) [14]. The National Reference Laboratory for Enteropathogenic Bacteria at the Norwegian Institute of Public Health routinely uses a generic MLVA protocol to genotype enteropathogenic E. coli of all serotypes [15]. By applying a 9-locus variant of the recently updated version [16] of the original protocol [17], the aim of the study was to determine if high age and age-linked clinical phenomena were associated with certain genotypes of E. coli found in bacteremia cases already well described [18]. Furthermore, we aimed to determine whether particular bacterial genotypes or antimicrobial resistance represented risk factors for hospital mortality.

Materials and Methods

Patients and E. coli isolates

Demographic, laboratory and clinical data for 450 adult patients with E. coli bacteremia admitted to a middle-sized Norwegian hospital between 1994 and 2004 was part of a clinical-epidemiological study described elsewhere [18]. A total of 225 E. coli strains isolated from patients admitted between 2000 and 2004 could be retrieved from the -70 degree centigrade freezer at Aker University Hospital. Of these, 212 isolates were verified as E. coli by matrix-assisted laser desorption ionization-time of flight mass spectrometry (MALDI-TOF) technology.

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Received January 20, 2014; Accepted February 17, 2014; Published February 25, 2014

Citation: Wester AL, Melby KK, Wyller TB, Dahele UR (2014) E. coli Bacteremia Strains - High diversity and Associations with Age-related Clinical Phenomena. Clin Microbial 3: 140. doi:10.4172/2327-5073.1000140

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whereas five were non-\textit{E. coli} (one \textit{Citrobacter}, three \textit{Klebsiella}, one \textit{Morganella morganii} and one not further specified) and a further five did not grow after thawing. As a result, 212 isolates and respective patients (median age 78 years, interquartile range 61-83 years) were eligible for the study.

As markers of microbial phylogeny in the molecular statistical analyses, we included 42 human strains from the \textit{E. coli} Reference (ECOR)-collection obtained from the Microbial Evolutionary Laboratory, Michigan, State University, East Lansing, USA, as well as four shiga toxin producing \textit{E. coli} (STEC) strains associated with Haemorrhagic Uremic Syndrome (HUS) from the strain collection at the Norwegian Institute of Public Health. In the analyses we also included the recently described results on the presence of the shiga toxin gene \textit{stx2} for 193 of the strains [19].

### Microbiological analyses

**Testing of antimicrobial susceptibility:** All strains confirmed to be \textit{E. coli} were tested for antimicrobial susceptibility by the EUCAST standardized disc-diffusion method version 3.0 (http://www.eucast.org/antimicrobial_susceptibility_testing/disk_diffusion_methodology/). The panel of antimicrobials tested was in accordance with the panel recommended by the Norwegian Working Group on Antimicrobials (http://www.unn.no/resistenspaneler/category19025.html). Based on millimetre zones, antimicrobial susceptibility was categorized into sensitive, intermediate sensitive and resistant according to EUCAST clinical breakpoints version 3.0 (http://www.eucast.org/clinical.breakpoints/). The strains were screened for resistance against third generation cephalosporins by cefpodoxime, and, if reduced susceptibility was found, phenotypical and molecular analyses were performed to detect Extended Spectrum Betalactamase (ESBL) activity. Resistance to one or both of the antimicrobials used as empirical treatment during the study period (ampicillin and gentamicin combined for severe infections presumably located below the diaphragm) was categorized as ampicillin-gentamicin resistant (AG-resistant), whereas multidrug resistance (MDR) and extensive drug-resistance (XDR) were categorized as ampicillin-gentamicin resistant (AG-resistant), whereas multidrug resistance (MDR) and extensive drug-resistance (XDR) were defined according to the 2011 joint ECDC/CDC definitions [20].

### MLVA analysis

Genomic DNA of \textit{E. coli} was prepared by 15 minutes of boiling of strain suspensions and used directly in the PCR reaction after centrifugation at 960g for three minutes. The isolates were MLVA genotyped in accordance with the previously described protocols [16,17]. The following loci were included: CVN001, CVN002, CVN003, CVN004, CVN007, CVN014, CVN015, CVN016, and CVN017. Repeats were amplified using Qiagen Multiplex PCR-kit (Qiagen, Hildern, Germany).

PCR products were subjected to capillary electrophoresis on an ABI 3130 Genetic Analyser (Applied Biosystems, Foster City, CA, USA). Each peak was identified according to colour and size, and allele numbers were assigned based on fragment sizes. Alleles lacking amplicons were designated as having zero alleles.

### Statistical analyses

The rate of patients lost to follow-up (i.e. from the initially available 450 isolates) was 52.9%. Chi-squared tests were used for evaluating if there were statistically significant differences in clinical and demographic variables between patients included and those lost.

Clinical and demographic variables have previously been found to be independently associated with hospital death within 14 days of admission [18]. These variables were selected for statistical analysis in the current study. For analytical purposes we dichotomized age, number of comorbid illnesses, leukopenia and fever at the same cut-off values as previously described [18]. Chi-squared tests and Fisher’s exact tests were used.

The allele numbers generated from the MLVA-analyses were entered into BioNumerics (Version 6.6, Applied Maths, Sint-Martens-Latem, Belgium) as character values and a dendrogram was constructed using categorical coefficients and the UPGMA algorithm. Numerical values were assigned for distinct MLVA type profiles, and MLVA-Type Complexes (MTCs) were assigned for related isolates with similarity>57%. Mantel-Haenzel Common Odds Ratio estimation was used to analyse whether different MTCs were associated with age, gender and different clinical variables, as well as with the presence of \textit{stx2}. Chi-squared tests were used to test whether microbial and clinical variables were associated with death within 14 days after admission to hospital. In order to explore possible grouping of clinical outcome and \textit{stx2}-status to phylogenetic groups of ECOR strains or to HUS-associated STEC, an analysis based on Minimal Spanning Tree (MST) hierarchical clustering for categorical values was performed.

### Results

There were no systematic differences with regard to the selected variables between patients included and patients from whom no strain was available. Of the included patients, 147 (69.3%) patients were 65 years or older. A total of 133 patients (62.7%) were female. Among the
patients, 55.6% had no organ failure within one day of admission to hospital, whereas 28.3%, 10.4% and 4.7% had one, two and ≥3 failing organs within one day of admittance, respectively. The MTCs were grouped into MTC a-i according to the MLV A clustering shown in Figure 1 and in Annexure 1. Figure 3 shows odds ratio (OR)-plots for the associations between MTCs and demographic and clinical variables. The largest MTC, containing 97 of the strains, was MTC-b. This MTC was associated with ≥1 comorbid illness (OR 2.02, 95% CI 1.12-3.64), and acted to prevent having ≥1 atypical symptom (OR 0.46, 95% CI 0.27-0.80). MTC-c, containing 31 strains, was associated with urinary site of infection (OR 3.28, 95% CI 1.35-8.00) and indicated reduced probability of gastrointestinal origin of infection (OR 0.11, 95% CI 0.01-0.83). MTC-g, containing only eight strains, was associated with leukopenia (OR 6.43, 95% CI 1.15-36.00). None of the MTCs were associated with early organ failure, neither when assessed as having ≥1 failing organ, nor when assessed as having ≥3 failing organs (results not shown), within one day of admission.

Fifteen of the 212 patients (7.1%) died within 14 days after admission to hospital. The results regarding age, comorbidity, clinical variables and microbial characteristics as risk factors for hospital mortality are presented in Table 1. Antibacterial resistance was not associated with hospital mortality within 14 days after admission, and none of the MTCs were associated with severity of infection, neither when assessed as having ≥3 failing organs within one day of admission.

<table>
<thead>
<tr>
<th>Total Material (212 Patients; % within groups)</th>
<th>Alive at 14 days (188 Patients; % within this group)</th>
<th>Patients that died within 14 days (24 patients; % within this group)</th>
<th>P-Value*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥65 Years</td>
<td>148 (69.8)</td>
<td>134 (68.0)</td>
<td>14 (93.3)</td>
</tr>
<tr>
<td>Comorbid illness ≥1</td>
<td>139 (65.9)</td>
<td>124 (63.3)</td>
<td>15 (100)</td>
</tr>
<tr>
<td>Fever (≥38.5°C)</td>
<td>146 (69.5)</td>
<td>138 (70.8)</td>
<td>8 (53.3)</td>
</tr>
<tr>
<td>Leukopenia (&lt;3000/µL)</td>
<td>12 (5.7)</td>
<td>5 (2.6)</td>
<td>7 (46.7)</td>
</tr>
<tr>
<td>Early Organ Failure</td>
<td>92 (44.4)</td>
<td>78 (40.4)</td>
<td>144 (100)</td>
</tr>
<tr>
<td>Antimicrobial resistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-against 3rd generation Cephalosporins</td>
<td>3 (1.4)</td>
<td>2 (1.0)</td>
<td>1 (6.7)</td>
</tr>
<tr>
<td>-against agents used as empirical treatment</td>
<td>1 (0.5)</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>(ampicillin or gentamicin)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiresistance (against ≥3 groups of agents tested)</td>
<td>48 (22.7)</td>
<td>46 (23.6)</td>
<td>2 (13.3)</td>
</tr>
<tr>
<td>MLVA-type complex (MTC only those containing at least five strains)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MTC-a</td>
<td>49 (23.1)</td>
<td>45 (22.8)</td>
<td>4 (26.7)</td>
</tr>
<tr>
<td>MTC-b</td>
<td>97 (45.8)</td>
<td>90 (45.7)</td>
<td>7 (46.7)</td>
</tr>
<tr>
<td>MTC-c</td>
<td>31 (14.6)</td>
<td>30 (15.2)</td>
<td>1 (6.7)</td>
</tr>
<tr>
<td>MTC-e</td>
<td>11 (5.2)</td>
<td>10 (5.1)</td>
<td>1 (6.7)</td>
</tr>
<tr>
<td>MTC-g</td>
<td>8 (3.8)</td>
<td>7 (3.6)</td>
<td>1 (6.7)</td>
</tr>
<tr>
<td>MTC-g</td>
<td>11 (5.2)</td>
<td>11 (5.6)</td>
<td>0</td>
</tr>
</tbody>
</table>

*Chi-Square test or Fishers test.*Comorbid illness: Malignant Disease, Chronic Atrial Fibrillation, Ischemic heart Disease, Hypertension, Heart disease, Cerebrovascular disorder, Chronic obstructive lung disease, Alcoholism, Diabetes diseases, Chronic renal Failure, *Presence of ≥1 failing organ within one day after admission.

**Table 1:** Risk factors for hospital death within 14 days after admission.

**Figure 2 (a):** Minimum spanning tree of 212 bacteremia isolates of *E. coli* (outcome in white, grey or black), 42 ECOR strains of human origin (with known phylgroup in colours) and 4 HUS-associated STEC (in red colour).
and 2003 respectively. Positive isolates were found in patients admitted to hospital in 2001–2002. The two stx2d-positive isolates, which, however, were located in completely different branches of the MST, were found in patients admitted to hospital within the same time period. The two other stx2-positive isolates, which, however, were located in completely different branches of the MST, were found in patients admitted to hospital during the winter/spring of 2002. Also, the latter is also illustrated in the MST in Figure 2a.

Additionally, Figure 2a shows that six of the nine stx2-positive bacteremia isolates were grouped together with each other, and together with the HUS-associated O103 STEC strain, as well as with ECOR strains of different phylogroups (one phylogroup A strain, five phylogroup B1 strains, and one B2 strain). Most bacteremia strains in this main branch of the MST belonged to MTC-a (Figure 2b Included as supplementary data), and the association between stx2-status and MTC-a was formally confirmed (p-value 0.002). Five of the six stx2-positive isolates were subtype stx2c, and all patients in question had been admitted to hospital during the winter/spring of 2002. Also, the other two stx2-positive isolates, which, however, were located in completely different branches of the MST, were found in patients admitted to hospital within the same time period. The two stx2-positive isolates were found in patients admitted to hospital in 2001 and 2003 respectively.

### Discussion

The global burden of disease caused by *E. coli* infections is tremendous. *E. coli* gastroenteritis alone is responsible for 800,000 deaths annually [21]. Vaccine development aiming at the most common enteropathogenic *E. coli*, the enterotoxigenic *E. coli* (ETEC), is therefore of imperative importance. Experimental studies of a second generation ETEC vaccine are promising [22]. *E. coli* causes the majority of urinary tract infections [23], a considerable part of blood stream infections [2], and is a commonly found bacterial species in infections of the central nervous system of newborns and patients with anatomic or surgical defects [24]. The amount of suffering, as well as the threat of antimicrobial resistance, has brought about efforts to develop a vaccine and alternative treatment options, also for extraintestinal infections caused by *E. coli*. The design of such strategies is challenging, among other factors because *E. coli* strains carrying ExPEC characteristics are prevalent in the feces of healthy individuals [25,26]. Complicating the matter further, advanced age may influence “normality” of fecal flora. A recent study describes the increased diversity and virulence in content of fecal *E. coli* in the elderly as compared to young adults [27], suggesting the possibility that *E. coli* in extraintestinal infections in the elderly contain more virulence factors than in younger patients. On the other hand, since advanced age is associated with immune remodeling, resulting in increased susceptibility to infectious disease [28] and since *E. coli* in extraintestinal infections in liver transplant patients are shown to carry less virulent strains [29], the opposite may also be possible. The *E. coli* virulence load in skin and soft tissue infections is not age-dependent [30], but there are few age-focused studies describing bacteremia strains. With a growing population of elderly and very old

<table>
<thead>
<tr>
<th>MTC-a  (49 strains)</th>
<th>MTC-b  (97 strains)</th>
<th>MTC-c  (31 strains)</th>
<th>MTC-e  (11 strains)</th>
<th>MTC-g  (8 strains)</th>
<th>MTC-h  (11 strains)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥ 65 years</td>
<td>Male gender</td>
<td>Comorbid illness ≥ 1</td>
<td>≥ 3 “classical symptoms”</td>
<td>≥ 1 “atypical symptoms”</td>
<td>Non specific tentative diagnosis</td>
</tr>
<tr>
<td>Decline in general health at admission</td>
<td>Fever (≥ 38.5°C)</td>
<td>Leukopenia (3,000/L)</td>
<td>C-reactive reaction ≥ 80 mg/L</td>
<td>C-reactive reaction ≥ 200 mg/L</td>
<td>New-onset atrial fibrillation</td>
</tr>
<tr>
<td>Early organ failure</td>
<td>Urinary tract origin</td>
<td>Respiratory tract origin</td>
<td>Gastrointestinal tract origin</td>
<td>Inconclusive site of origin</td>
<td></td>
</tr>
</tbody>
</table>

*Only MfCs with ≥ 5 bacteremia strains included

*Comorbid illnesses: Malignant disease, chronic atrial fibrillation, ischemic heart disease, hypertension, heart failure, cerebrovascular disorder, chronic obstructive lung disease, alcoholism, diabetes mellitus, chronic renal failure

*Classical symptoms*: fever/chills, localised pain, nausea/vomiting, diarrhea, cough, dyspnea, expectoration, urgency, painful voiding, hematuria, skin rash and coma/seizures

*Atypical symptoms*: Malaise, falls, dizziness, syncope, unsteadiness, immobility, acute incontinence of urine or feces, paresis/speaking difficulties, acute confusional state

*Non-specific tentative diagnoses: acutedeterioration of performing daily tasks, reduced general condition, confusion, dizziness, falls, fainting, question of cerebral infection

*Presence of 1 failing organ within one day after admission

*Gastrointestinal tract including liver, pancreas and biliary tract

Figure 3: Odds ratio OR plots with 95% confidence intervals of associations between clinical presentation and MLVA complex (MTC)*.
We carried bacteriophage, infecting one of six were subtype
variety of sources, including urinary tract origin. Genome Sequencing (WGS) has
as previously reported, pathotype and phylogenetic lineage, and genes are part of the core genome of this species [36]. There is no direct
coli of different genotypes. However, this study did not look into patient outcomes [32].
outside hospital had a higher virulence factor score than nosocomial
with leukopenia, whereas a third MTC was associated with urinary tract origin and acted to prevent against gastrointestinal origin. Neither antimicrobial resistance nor MTC were associated with severity of infection. Using traditional phylogenetic analyses, similar results have been reported, that is, some associations between E. coli characteristics and certain clinical and demographic variables, but no association with severity of infection. A Danish study of 196 E. coli bacteremia isolates with a urinary tract origin found that certain virulence-associated genes were associated with gender and with whether the infection was acquired outside or inside hospital, as well as to different phylogenetic groups, but no relation was found between bacterial factors and mortality [9]. An Irish study reported that bacteremia isolates acquired outside hospital had a higher virulence factor score than nosocomial strains. However, this study did not look into patient outcomes [32].

Given that the grouping of ECOR strains of main phylogenetic group A shown in Figure 2a indicates a phylogenetic relationship between group A ECOR strains and the bacteremia isolates within this MST branch, less than 3% of isolates of urinary tract origin represented phylogroup A. The statistical power in this evaluation was low, and may not be comparable to a level of 15% of isolates found in a study of 161 strains. The grouping of E. coli bacteremia isolates showed that bacteremia strains are distributed over the entire span of E. coli phylogenetic diversity and that clonal complex, in spite of not being associated with severe sepsis or unfavorable outcomes represent important direction for future research in pathogenesis and comparative genomics [33]. A selection of 60 of the 161 strains was used to induce sepsis in genetically identical mice, and the authors found strong associations between phylogenetic group, virulence factor content and observed virulence, but this did not translate into severity of infection in the patients from whom the isolates originated from in the first place. The results indicate that blood stream infection is dependent on many, often heterogeneous, host factors (for instance individual immune status), or that virulence factors effectively killing mice may not be determinants of severity in human infection [34].

The major strengths of this study are the relatively high number of strains and patients included, and the consecutive sampling over a five-year period. When considering antimicrobial resistance and associations between MTCs with low number of strains, the statistical power may be too low to detect significant microbial differences.

Conclusions

It is not known if severely infected elderly are diseased by different groups of E. coli than younger patients. In the current study of community-acquired E. coli bacteremia isolates we focused on patient age and age-associated clinical presentation as well as infection outcome. Our study revealed great diversity among the strains, and none of the genotypes as assessed by MLVA was associated with outcome. Although no genotype was associated with patient age, one of them was associated with the age-related clinical phenomena of having ≥1 comorbid illness and a clinical presentation with ≥1 “atypical symptom” of infection. This indicated that further study of the bacterial population found in the elderly with ExPEC infections is highly relevant, with a view to
designing ExPEC vaccine or novel ExPEC treatment regimens, which will also be effective in advanced age.

Ethical Considerations

The study was approved by the Regional Committee for Ethics in Medical Research and by the Norwegian Data Inspectorate, which have given permission to carry out the study without the patients’ consent.

Funding

The study was performed without specific funding.

Authors’ Contribution

ALW participated in the concept and design of the study, gathered data on bacteremia, serum markers of infection, clinical data on presentation of infection, performed the analyses and participated in the writing of the manuscript.

KKM participated in the design and the writing of the manuscript.

TBW participated in the design, the data interpretation and the writing of the manuscript.

URD participated in the design, the data interpretation and the writing of the manuscript.

Acknowledgements

Trine-Lise Stavnes and Inger Løbersli are acknowledged for excellent technical assistance.

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