Colistin-Resistant *Acinetobacter baumannii*: Beyond Carbapenem Resistance

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(See the Editorial Commentary by Pogue, Cohen, and Marchaim on pages 1304–7.)

**Background.** With an increase in the use of colistin methansulfonate (CMS) to treat carbapenem-resistant *Acinetobacter baumannii* infections, colistin resistance is emerging.

**Methods.** Patients with infection or colonization due to colistin-resistant *A. baumannii* were identified at a hospital system in Pennsylvania. Clinical data were collected from electronic medical records. Susceptibility testing, pulsed-field gel electrophoresis (PFGE), and multilocus sequence typing (MLST) were performed. To investigate the mechanism of colistin resistance, lipid A was subjected to matrix-assisted laser desorption/ionization mass spectrometry.

**Results.** Twenty patients with colistin-resistant *A. baumannii* were identified. Ventilator-associated pneumonia was the most common type of infection. Nineteen patients had received intravenous and/or inhaled CMS for treatment of carbapenem-resistant, colistin-susceptible *A. baumannii* infection prior to identification of colistin-resistant isolates. The 30-day all-cause mortality rate was 30%. The treatment regimen for colistin-resistant *A. baumannii* infection associated with the lowest mortality rate was a combination of CMS, a carbapenem, and ampicillin-sulbactam. The co-colistin-susceptible and -resistant isolates from the same patients were highly related by PFGE, but isolates from different patients were not, suggesting evolution of resistance during CMS therapy. By MLST, all isolates belonged to the international clone II, the lineage that is epidemic worldwide. Phosphoethanolamine modification of lipid A was present in all colistin-resistant *A. baumannii* isolates.

**Conclusions.** Colistin-resistant *A. baumannii* occurred almost exclusively among patients who had received CMS for treatment of carbapenem-resistant, colistin-susceptible *A. baumannii* infection. Lipid A modification by the addition of phosphoethanolamine accounted for colistin resistance. Susceptibility testing for colistin should be considered for *A. baumannii* identified from CMS-experienced patients.

**Keywords.** *Acinetobacter baumannii*; carbapenem resistance; colistin resistance; molecular typing; lipid A.

*Acinetobacter baumannii* is a major hospital-associated pathogen that causes a spectrum of diseases including respiratory tract, bloodstream, urinary tract, surgical site, and wound infections [1]. *Acinetobacter baumannii* has a propensity to acquire resistance to multiple classes of antimicrobial agents, and treatment of infection by highly resistant strains can be extremely difficult [2, 3]. For this reason, the Infectious Diseases Society of America has included *A. baumannii* among the 6 antimicrobial-resistant pathogens responsible for high morbidity and mortality in patients [4].

A rise in infections due to multidrug-resistant (MDR) *A. baumannii* strains (resistant to at least 3 different classes of antimicrobial agents) has been reported in the last 2 decades [3, 5]. Carbapenems have been considered to be appropriate agents to treat infections due to MDR *A. baumannii* strains [6, 7]. However, a worldwide surge in carbapenem resistance has been observed recently, primarily driven by the spread of several international clones [8, 9]. In the United States, the rates of carbapenem resistance among *A. baumannii* clinical
strains range from 33% to 58% [10–12]. Therapy of carbapenem-resistant *A. baumannii* infection often requires the use of colistin methanesulfonate (CMS). CMS is given intravenously as an inactive prodrug, which is converted in the blood to the active drug colistin sulfate [13]. More recently, however, resistance to colistin has been reported among *A. baumannii* clinical strains [14–17]. Indeed, a surveillance study of US hospitals revealed that 5.3% of all *Acinetobacter* strains were resistant to colistin [18]. Despite the potential magnitude of the problem, data regarding the clinical, microbiological, and molecular characteristics of colistin-resistant *A. baumannii* infections remain scarce to date. The objectives of the present study were therefore to (1) evaluate the clinical characteristics and outcomes of patients with infections due to colistin-resistant *A. baumannii*, (2) determine the molecular epidemiology of the strains, and (3) elucidate the mechanism underlying colistin resistance in *A. baumannii* strains.

**MATERIALS AND METHODS**

**Patients and Bacterial Isolates**

Patients colonized or infected with colistin-resistant *A. baumannii* were identified at the University of Pittsburgh Medical Center between 2007 and 2014. Colistin susceptibility testing was performed at the request of the treating physician by broth macrodilution. Colistin minimum inhibitory concentrations (MICs) >2 µg/mL were considered resistant [19]. The colistin-resistant isolates and earlier colistin-susceptible isolates from the same patients were collected through the clinical microbiology laboratory. The study was approved by the institutional review board at the University of Pittsburgh (PRO13030021).

**Clinical Data**

Patient demographics, underlying medical conditions, types of infection, antimicrobial agents given before and after isolation of colistin-resistant *A. baumannii* isolates, intensive care unit (ICU) admission, Acute Physiology and Chronic Health Evaluation II (APACHE II) score at the time of identification of colistin-resistant *A. baumannii*, clinical outcomes at 30 days, and recurrence of infection within 90 days were extracted from electronic medical records. The types of infection were defined according to standardized definitions by the Centers for Disease Control and Prevention/National Healthcare Safety Network [20]. For pneumonia, the PNU2 (pneumonia with specific laboratory findings) and PNU3 (pneumonia in immunocompromised patients) categories were applied as appropriate. Patients who did not receive specific treatment for *A. baumannii* were considered colonized only. Clinical response to treatment was classified as success for patients who had resolution of signs and symptoms that defined the infection, and failure for patients who had persistence or deterioration of symptoms and signs of colistin-resistant *A. baumannii* infection. For pneumonia, improvement of hypoxemia, leukocytosis, fever, and reduction in secretions was considered success. For bacteremia, resolution of symptoms and clearance of blood cultures defined success. Hospital records and the Social Security Death Index were assessed to determine mortality at 30 days from the onset of colistin-resistant *A. baumannii* infection. Death was attributed to infection when the patient had persistent infection at the time of death.

**Susceptibility Testing**

MICs of colistin were confirmed by standard agar dilution methods [21]. MICs of tigecycline and minocycline were determined by Etest (bioMérieux, Durham, North Carolina). MICs of other antimicrobial agents were determined by broth microdilution using Sensititre GNX3F plates (TREK Diagnostic Systems, Oakwood Village, Ohio). Results were interpreted according to the Clinical and Laboratory Standards Institute susceptibility breakpoints [19]. Tigecycline MICs were interpreted using the breakpoints for Enterobacteriaceae defined by the US Food and Drug Administration.

**Pulsed-Field Gel Electrophoresis and Multilocus Sequence Typing**

Genetic relatedness of colistin-susceptible and -resistant isolates from the same patient was determined by pulsed-field gel electrophoresis (PFGE) using a CHEF DR III system (Bio-Rad, Hercules, California) using the *Apa* I restriction enzyme [22] and interpreted according to the criteria proposed by Tenover et al [23]. The genetic relatedness among the colistin-resistant isolates from all patients was assessed by the unweighted-pair group method using Bionumerics version 6.01 (Applied Maths, Austin, Texas). To determine the clonal lineages, the sequence types (STs) of the colistin-resistant isolates were determined by multilocus sequence typing (MLST) [24].

**Detection of Carbapenemase-Encoding Genes**

Detection of the intrinsic *bla*<sub>OXA-51-like</sub> carbapenemase gene was performed by polymerase chain reaction (PCR) using primer sets and conditions described previously [25]. A multiplex PCR was conducted to detect the *bla*<sub>OXA-23</sub>, *bla*<sub>OXA-40</sub>, and *bla*<sub>OXA-58</sub> genes, the 3 major groups of acquired carbapenemase genes [26].

**Analysis of Lipid A**

Lipid A was extracted using an ammonium hydroxide/isobutyric acid–based procedure [27]. Once extracted, 1 µL of the concentrate was spotted on a matrix-assisted laser desorption/ionization–time of flight (MALDI-TOF) plate followed by 1 µL of norharmane matrix (Sigma-Aldrich, St Louis, Missouri) and then air-dried [16]. The samples were analyzed on a Bruker AutoFlex mass spectrometer (Bruker Daltonics, Billerica, Massachusetts) in the negative-ion mode.
RESULTS

Twenty unique patients with colistin-resistant A. baumannii were identified. Nineteen of them had colistin-susceptible A. baumannii isolates identified prior to the onset of colistin resistance, and the susceptible isolates were available for further analysis in 18 patients. The remaining patient presented directly with infection due to colistin-resistant A. baumannii. Taken together, 38 isolates (18 pairs of colistin-resistant and -susceptible isolates, and 2 colistin-resistant isolates without accompanying susceptible isolates) were available for analysis.

Clinical Characteristics of Patients With Colistin-Resistant A. baumannii Infections

The clinical features and outcomes of all patients are summarized in Table 1. Overall, the patients were critically ill with a median APACHE II score of 19.5 (range, 10–28), and all patients but one were in an ICU at the time of isolation of colistin-resistant A. baumannii. The types of infection included ventilator-associated pneumonia (VAP) (13 [65%]), bacteraemia (2 [10%]), mediastinitis (1 [5%]), and hospital-acquired pneumonia (1 [5%]). The source of bacteraemia was presumed to be VAP in 2 patients. All 19 patients initially infected with colistin-susceptible A. baumannii received therapy with intravenous CMS, inhaled CMS, or both, prior to isolation of colistin-resistant A. baumannii; 18 (95%) received therapy with intravenous CMS for a median duration of 12.5 days (range, 2–76), and 16 (84%) received therapy with inhaled CMS for a median duration of 10.5 days (range, 5–84). The median interval between the isolation of the colistin-susceptible A. baumannii isolate and the colistin-resistant A. baumannii isolate was 20 days (range, 4–99).

Of the 20 patients, 17 were treated for colistin-resistant A. baumannii infections, whereas 3 patients were asymptomatic, did not receive treatment against colistin-resistant A. baumannii, and were thus classified as colonization. All 3 colonized patients had received CMS for prior infections due to colistin-susceptible A. baumannii. Specifically, the first patient completed treatment for VAP due to colistin-susceptible A. baumannii, and at the time of colistin-resistant A. baumannii detection, the patient demonstrated improved clinical and radiographic characteristics. The second patient had a mucous plugging event that improved with bronchoscopy, and otherwise lacked signs of infection at the time of the culture. The last patient had colistin-resistant A. baumannii isolated from a sputum culture in the absence of any signs or symptoms of infection. Among 17 patients who were treated for colistin-resistant A. baumannii infections, 15 received various CMS-based combination regimens. The most common regimen was a combination of CMS, a carbapenem, and ampicillin-sulbactam (n = 7). None of these 7 patients died within 30 days of the infection, compared with 6 of 10 (60%) patients who received other antimicrobial regimens (P = .03 by Fisher exact test). All-cause mortality was 30% (6/20) at 30 days. Of the 6 deaths, 4 were likely attributable to A. baumannii infection. Two patients had a recurrence of infection within 90 days. They were both treated with a combination of CMS and a carbapenem at the time of recurrence; 1 patient survived and 1 died during the hospital stay.

Antimicrobial Susceptibility and Carbapenemase-Encoding Genes

MICs of colistin-resistant A. baumannii isolates are shown in Table 2. All isolates were nonsusceptible to piperacillin-tazobactam, gentamicin, imipenem, meropenem, doripenem, and ciprofloxacin, and most isolates were nonsusceptible to trimethoprim-sulfamethoxazole (95%), tobramycin (85%), amikacin (80%), and ampicillin-sulbactam (70%). Fifty percent and 20% were nonsusceptible to minocycline and tigecycline, respectively.

Among the colistin-susceptible A. baumannii isolates, all were nonsusceptible to meropenem and doripenem, and all except 1 were nonsusceptible to imipenem (Supplementary Table). They were nominally more resistant to ampicillin-sulbactam (94.4% nonsusceptible) and tigecycline (50% nonsusceptible) compared with the colistin-resistant isolates. Apart from these agents, no differences were observed in the MICs between the colistin-susceptible and -resistant isolates. All 38 A. baumannii isolates (20 colistin-resistant and 18 colistin-susceptible) were positive for blaoxa-51-like, the intrinsic carbapenemase gene in A. baumannii. Additionally, all 38 isolates were positive for blaoxa-23 by multiplex PCR, accounting for the carbapenem resistance. None of the isolates was positive for the blaoxa-40 and blaoxa-58 genes.

Molecular Typing

PFGE was performed on all 38 isolates. Within the 18 pairs of colistin-susceptible and -resistant isolates from the same patients, 12 pairs shared indistinguishable restriction profiles (0 band difference), 4 pairs were within a 3-band difference (considered closely related), and 2 pairs had 5- and 6-band differences (considered possibly related). Using a cutoff of 80% similarity, the 20 colistin-resistant isolates were grouped into 9 clusters (Figure 1). In contrast with the high level of relatedness observed between the susceptible and resistant isolates from the same patients, there was considerable interpatient variability of the restriction profiles.

By MLST, 16, 3, and 1 isolates belonged to ST92, ST282, and ST451, respectively. All these STs belong to clonal complex 92 (CC92; CC2 by the alternative MLST protocol proposed by Diancourt et al [28]), which corresponds to part of the international clone II and is commonly observed among carbapenem-resistant A. baumannii in hospitals worldwide [29].
<table>
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<th>Prior Inhaled CMS, d&lt;sup&gt;a&lt;/sup&gt;</th>
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Abbreviations: AMS, ampicillin-sulbactam; APACHE II, Acute Physiology and Chronic Health Evaluation II; BAL, bronchoalveolar lavage specimen; CMS, colistin methansulfonate; COPD, chronic obstructive pulmonary disease; CVA, cerebrovascular accident; DOR, doripenem; F, female; HAP, hospital-acquired pneumonia; ICU, intensive care unit; M, male; MEM, meropenem; RIF, rifampin; TIG, tigecycline; VAP, ventilator-associated pneumonia.

<sup>a</sup> Days of therapy between isolation of colistin-susceptible and colistin-resistant isolates.

<sup>b</sup> Subsequent aspiration event and bowel ischemia were deemed to be the causes of their deaths, respectively.

<sup>c</sup> The patient did not have a prior colistin-susceptible isolate, so did not receive CMS before the onset of bacteremia with the colistin-resistant isolate.
Lipid A Profiles of Colistin-Resistant and -Susceptible Isolates

To determine the presence or absence of this lipid A modification, MALDI-TOF mass spectrometry was performed on all 38 isolates (20 colistin-resistant and 18 colistin-susceptible). The lipid A from colistin-resistant isolates typically showed 2 major [M-H]⁻ ions at a mass-to-charge ratio (m/z) of 1910 and 2034 (Figure 2). The most prominent ion at m/z 1910 corresponds to a biphosphorylated hepta-acylated lipid A. The ion at m/z 2034 corresponds to the hepta-acylated lipid A (m/z 1910) modified with phosphoethanolamine addition. The ion at m/z 1910 was present in all 38 isolates. The ion at m/z 2034 was present in all 20 colistin-resistant isolates, but in none of the colistin-susceptible isolates (Table 2).

DISCUSSION

Colistin, or its prodrug CMS, is a key therapeutic option for treatment of carbapenem-resistant A. baumannii, alone or in combination with other agents such as tigecycline, ampicillin-sulbactam, rifampin, and carbapenems [8]. Nevertheless, increased exposure has led to the emergence of colistin resistance, further limiting the therapeutic options against this pathogen [18]. Our study involved 20 unique patients with infection or colonization due to colistin-resistant A. baumannii. To our knowledge, this study represents the largest series describing detailed clinical and molecular characteristics of colistin-resistant A. baumannii. Our data highlight an emerging clinical problem that may be underappreciated by centers not routinely performing colistin susceptibility testing against A. baumannii.

A distinguishing factor associated with isolation of colistin-resistant A. baumannii among patients at our center was prior drug exposure. Indeed, all patients except 1 received CMS therapy (intravenous and/or inhaled) prior to the identification of a colistin-resistant isolate. This finding is consistent with a recent report of colistin-resistant A. baumannii from the US military health system [14] and is supported by the genetic relatedness of colistin-susceptible and -resistant isolates by PFGE. Moreover, only 2 pairs of patients (in 2007 and 2010, respectively) resided in the same ICU for overlapping periods of time in our study. There were no identifiable transmission
opportunities among the remaining 16 patients. Taken together, we hypothesize that colistin resistance predominantly emerges under selective pressure during CMS therapy in individual patients, rather than through patient-to-patient transmission in the hospital. Identification of prior CMS exposure should be considered in selecting appropriate therapy for patients with A. baumannii infection. Overall, 30% of patients died by 30 days; however, mortality rates were lower among patients receiving a 3-drug combination of CMS, a carbapenem, and ampicillin-sulbactam compared with other regimens. These data support recent in vitro data that demonstrated rapid bactericidal activity of the combination by time-kill analysis against colistin-resistant A. baumannii [30]. Thus, in treating patients with prior exposure to CMS, colistin susceptibility testing should be considered to best guide effective therapy. In addition, future studies should focus on how to best utilize CMS to minimize the risk of developing resistance.

The dissemination of carbapenem-resistant A. baumannii in hospitals worldwide is now understood as a highly clonal process, with the international clone II being the most prevalent clone [31]. Within the international clone II, CC92, as defined by the original MLST protocol [24], has been shown to have global distribution [32]. We previously documented the predominance of CC92 among carbapenem-resistant A. baumannii isolates identified in US hospitals [33]. All the colistin-resistant A. baumannii isolates in our study belonged to CC92. This makes our findings on the development of colistin resistance relevant to locales where carbapenem-resistant CC92 isolates are widespread.

Finally, lipid A analysis provided insights into the mechanism of colistin resistance. Colistin is a cationic amphiphilic

Figure 1. Pulsed-field gel electrophoresis dendrogram of colistin-resistant Acinetobacter baumannii isolates from 20 patients. The isolates were grouped into 9 clusters with a cutoff of 80%, demonstrating substantial diversity.
antimicrobial agent that interacts with the lipid A component of outer membrane lipopolysaccharide (LPS), resulting in its disruption and thereby causing cell death [34]. Modification of lipopolysaccharide outer membrane by addition of phosphoethanolamine to the hepta-acylated lipid A structure has been suggested as a major mechanism of colistin resistance in A. baumannii [16, 35, 36]. We observed this modification in all colistin-resistant A. baumannii isolates, but none of the corresponding colistin-susceptible isolates. Our data strengthen the contention that resistance to colistin is strongly associated with lipid A modification by phosphoethanolamine [14, 16]. Colistin resistance among A. baumannii may also be attributed to the complete loss of LPS [37]; however, we were able to identify the lipid A species intrinsic to A. baumannii (bisphosphorylated hepta-acylated lipid A) in all colistin-resistant isolates. Nevertheless, colistin MICs ranged from 4 µg/mL to >256 µg/mL, suggesting that resistance is likely multifactorial, and other factors cannot be excluded on the basis of our study.

Our data come from a single center in the United States, so the findings may not be generalizable to other institutions. Colistin susceptibility was not routinely tested on all A. baumannii isolates; thus, it is possible that some colistin-resistant A. baumannii cases were not identified. In addition, the lack of a comparison group with colistin-susceptible A. baumannii cases precludes our ability to make definitive conclusions on clinical outcomes. In terms of microbiological investigations, all isolates belonged to the international clone II and produced OXA-23 carbapenemase, which is a common combination observed among carbapenem-resistant A. baumannii worldwide [31]. Also, our investigation of colistin resistance mechanism was limited to lipid A profiles, which accounted for colistin resistance categorically, but not the levels of resistance.

In conclusion, colistin-resistant A. baumannii occurred almost exclusively among patients who had received CMS therapy for carbapenem-resistant, colistin-susceptible A. baumannii infection. Treatment with a combination of CMS, a carbapenem,
and ampicillin-sulbactam was associated with lower mortality in comparison to other treatment regimens in this study. However, the numbers of cases were small, and this signal requires confirmation in a larger study. All isolates belonged to the globally epidemic international clone II, and lipid A modification was the mechanism underlying colistin resistance in all isolates. Susceptibility testing for colistin should be considered for 

**Supplementary Data**

Supplementary materials are available at *Clinical Infectious Diseases* online (http://cid.oxfordjournals.org). Supplementary materials consist of data provided by the author that are published to benefit the reader. The posted materials are not copyrighted. The contents of all supplementary data are the sole responsibility of the authors. Questions or messages regarding errors should be addressed to the author.

**Notes**

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Potential conflicts of interest. R. K. S. has received research funding from Astellas Pharma and Merck & Co for studies unrelated to this work. R. K. E. has received research funding from MedImmune for a study unrelated to this work. Y. D. has served on an advisory board for Shionogi Inc, consulted for Melinta Therapeutics, and received research funding from Merck & Co for a study unrelated to this work. All other authors report no potential conflicts.

All authors have submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Conflicts that the editors consider relevant to the content of the manuscript have been disclosed.

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