

Short Communication

Bacteria Causing UTI in Patients at Abu Ghraib, Iraq: Isolation and Identification

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A B S T R A C T

This study aimed to detect the most pathogenic bacteria causing UTI in the Abu Ghraib region in Iraq. A cross-sectional study was done in the clinic to investigate the most common bacterial cause of UTI in patients suffering from UTI symptoms. Patients who visited clinics and whose UTI signs and symptoms were verified by the attending clinician were included in the study. All patients had given their consent to participate in the trial and had no prior history of receiving antibiotics for UTIs in the previous two weeks. Patients who were currently menstruating, had a history of taking an antibiotic within the previous two weeks, or who did not give their consent were not included in the study. Two hundred thirteen midstream urine samples were included in this study obtained from 137 females and 76 males. The age of these patients ranged between 18 and 72 years. The collected urine was examined within 3 hours in the bacteriology laboratory. These samples were cultured on primary media, and then the identification of these unknown bacteria was done. The current study showed that the infections in males were significantly higher than in females. Infection was found to be significantly higher in the age group of 31-50 years than in the other age groups, followed by the age groups of 18-30 years. This study showed that *E. coli* is the most prevalent bacteria isolated from UTI patients, followed by *K. pneumonia*. In conclusion, UTIs are caused mainly by *E. coli* and *K. pneumonia*. They occur mainly in females as compared to males, especially in the age group between 31 and 50 years.

Keywords: UTI, *E. coli*, *K. pneumonia*, Abu Ghraib, Bacteria

Introduction

In most nations around the world, urinary tract infections are the second most prevalent health issue after respiratory tract infections.¹ UTIs can affect both males and females of any age. According to Chen et al., one of the biggest causes of newborn mortality is prostate infection, it was have affected of older men that makes it harder for the bladder to release from the arteries and induces inflammation of the urinary system.^{2,3} The main causes of urinary tract infections in older women are hormonal changes brought on by ageing, immunosuppression,³ pregnancy, and chronic conditions like diabetes or cancer, or HIV which cause immunosuppression and weakened immune systems. All these factors increase the risk of urinary tract infections.³

In the cardiac care unit, UTIs account for 20 to 30% of all hospital nosocomial infections.^{4,5} Bacteria, which often reside in the gastrointestinal tract, vagina, or the region surrounding the urethra which is at the start of the urinary tract are the primary causes of 95% of UTIs. The majority of these germs pass through the urethra and end up in the kidneys as well as the bladder. Despite fungi, viruses, and parasites, gram-positive bacteria are typically what cause clinical harm.⁶ It may also result from a typical source of urinary tract infection. Haemorrhagic cystitis, for instance, caused by viruses like adenovirus, is one example of a non-bacterial haemorrhagic infection.⁷

Widespread harmful gram-negative bacteria including *Klebsiella*, *Escherichia*, *Proteus*, *Pseudomonas*, *Enterobacter*, and *Serratia spp.* as well as gram-positive bacteria such as *Enterococcus sp.*, *Streptococci*, and *Staphylococcus* are among the pathogens found in critical care units.⁸

Escherichia coli is the primary cause of uropathogenic infections worldwide, accounting for 80%-85% of cases, according to Kariuki et al.⁹ It is now well-recognised that the bacteria that cause urologic infections are becoming resistant to antibiotics, particularly those that are often used; because of this, bacteria have evolved defences to fend off these antibiotics, and there is a link between rising resistance and patient antibiotic usage. The presence of the catheter is associated with the production of virulence factors like biofilm because it creates an environment that is conducive to the formation of the biofilm.¹⁰

This study aimed to detect the most pathogenic bacteria causing UTIs in Abu Ghraib, Iraq.

Materials and Methods

A cross-sectional study was done in the clinic to investigate the most common bacterial cause of UTI in patients suffering from UTI symptoms.

Patients who visited clinics and whose UTI signs and symptoms were verified by the attending clinician were

included in the study. The included participants had given their consent to participate in the trial and had no prior history of receiving antibiotics for UTIs within the previous two weeks.

Patients who were currently menstruating, had a history of taking an antibiotic in the previous two weeks, or who did not give their consent were not included in the study.

Two hundred thirteen midstream urine samples were included in this study from 137 females and 76 males. The age of these patients ranged between 18 and 72 years. The collected urine was examined within 3 hours in the bacteriology laboratory. These samples were cultured on primary media, after which the identification of these unknown bacteria was done according to Cheesbrough.¹¹

RESULTS AND DISCUSSION

The current study showed that the infections in males were significantly higher than in females (Figure 1).

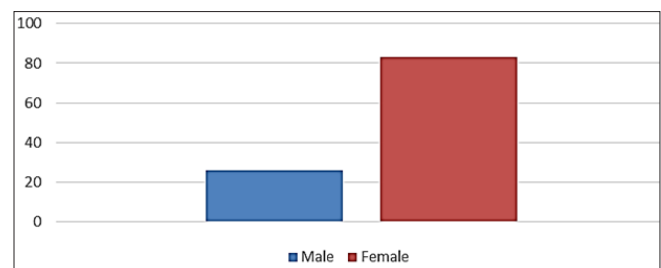


Figure 1. Number of Infected Males and Females

This finding is consistent with many studies as well as local research conducted in Baghdad City, which revealed that females were more likely to have UTIs (81.8%) as compared to males (18.2%).¹² Another study by Ibrahim et al. also showed that infection of UTI in females was significantly higher than in males.¹³

The higher incidence of UTIs in females may be due to the proximity of the urethra to the anus, the broader and shorter urethra, sexual activity, incontinence, vaginal surface's less acidic pH, and unsanitary living situations.¹⁴

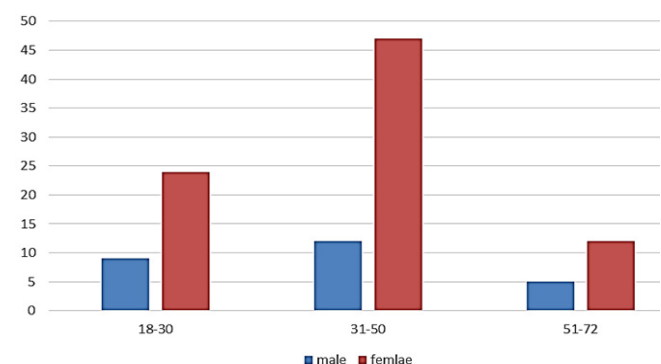


Figure 2. Distribution of Infected People as per Age Groups

The present study showed that among males and females, the age group of 31-50 years had the highest number of infected people, followed by the age group of 18-30 years (Figure 2).

There were very few studies about infections among different age groups. According to Almkhhtar,¹⁵ 58.4% of patients were in the age range of 21-30 years, followed by 26% of patients in the age range of 31-40 years. Additionally, Al-Gasha'a et al.¹⁶ discovered that the prevalence of bacterial UTIs was greater in the age group of 30-39 years (25.40% of the study population).

This study also showed that *E. coli* is the most prevalent bacteria isolated from UTI patients, followed by *K. pneumoniae* (Table 1).

Table 1. Bacterial Pathogens isolated from UTI Patients

Bacterial Name	Number of Isolates	Percentages
<i>Escherichia coli</i>	47	41.6
<i>Staphylococcus aureus</i>	14	12.4
<i>Klebsiella pneumoniae</i>	34	30.0
<i>Proteus spp.</i>	8	7.1
<i>Pseudomonas aeruginosa</i>	10	8.9
Total	113	100

Many studies reported that the *Enterobacteriaceae* family was the most prevalent cause of UTI in humans.^{17,18} These studies are in agreement with the present findings. Many variables help *Enterobacteriaceae* adhere to uroepithelium. Such bacteria cause adhesion pili and fimbriae to form on the uroepithelial mucosa.^{19,20} Additionally, research done in Irbil, Iraq, found that *Klebsiella pneumoniae* (28%) and *E. coli* (16.8%) were the two most prevalent causes of UTI in children.²¹ According to Ramalingam et al.,²² *Klebsiella spp.* constitutes 50% of bacterium isolates that cause UTI. According to Muharram et al.,²³ *Klebsiella spp.* was the most prevalent microorganism in UTI patients. Asymptomatic Bacteriuria (ASB) caused by *Klebsiella pneumoniae* in a pregnant woman was described by Garnizov.²⁴ *Escherichia coli* was shown to be the most prevalent isolate in two investigations from India and Sudan, while *Klebsiella spp.* is increasingly becoming recognised as the most dangerous urinary pathogen.^{25,26}

This finding is consistent with research on UTIs conducted in France, which found that when compared to common bacteria (*E. coli* and *K. pneumoniae*), the rates of infection due to pathogens *Pseudomonas aeruginosa*, *Enterobacter spp.*, and *Proteus mirabilis* were the lowest.^{27,28}

Conclusion

It can be fairly concluded that UTIs occur mainly in females as compared to males, especially between the ages of 31 and 50 years, and are caused mainly by *E. coli* and *K. pneumoniae*.

Conflict of Interest: None

References

1. Najar MS, Saldanha CL, Banday KA. Approach to urinary tract infections. Indian J Nephro. 2009 Oct;19(4):129-39. [PubMed] [Google Scholar]
2. Chen CY, Chen YH, Lu PL, Lin WR, Chen TC, Lin CY. Proteus mirabilis urinary tract infection and bacteremia: risk factors, clinical presentation, and outcomes. J Microbiol Immunol Infect. 2012;45(3):228-36. [PubMed] [Google Scholar]
3. Naber KG, Bishop MC, Bjerklund-Johansen TE, Botto H, Çek M, Grabe M, Lobel B, Palou J, Tenke P. Guidelines on the management of urinary and male genital tract infections. European Association of Urology; 2006.
4. Laupland KB, Bagshaw SM, Gregson DB, Kirkpatrick AW, Ross T, Church DL. Intensive care unit – acquired urinary tract infections in a regional critical care system. Crit Care. 2005;9(2):R60-5. [PubMed] [Google Scholar]
5. Nachimuthu R, Chettipalayam SS, Velram A, Kurumandur RP, Velu RK. Urinary tract infection and antimicrobial susceptibility patterns of extended spectrum of beta lactamase producing clinical isolates. Adv Biol Res. 2008;2(5-6):78-82.
6. Zorc JJ, Levine DA, Platt SL, Dayan PS, Macias CG, Krief W, Schor J, Bank D, Shaw KN, Kuppermann N; Multicenter RSV-SBI Study Group of the Pediatric Emergency Medicine Collaborative Research Committee of the American Academy of Pediatrics. Clinical and demographic factors associated with urinary tract infection in young febrile infants. Pediatrics. 2005 Sep;116(3):644-8. [PubMed] [Google Scholar]
7. Hibore ME. Prevalence and antibiotic susceptibility patterns of selected bacterial uropathogens among patients with urinary tract infection cases in Wonji Hospital, Ethiopia [dissertation]. Sciences Department of Biology, School of Graduate Studies, Harmaya University; 2012.
8. Dermurari D, Kamal CM, Singh SN, Kumar A. Ofloxacin and nitrofurantoin sensitivity pattern in patient of urinary tract infection (UTI) at a tertiary care teaching hospital. Int Arch Biomed Clin Res. 2015;1(1):17. [Google Scholar]
9. Kariuki S, Revathi G, Corkill J, Kiiru J, Mwituria J, Mirza N, Hart CA. Escherichia coli from community-acquired urinary tract infections resistant to fluoroquinolones

- and extended-spectrum beta-lactams. *J Infect Dev Ctries.* 2007;1(3):257-62. [PubMed] [Google Scholar]
10. Lalitha MK [Internet]. Manual on antimicrobial susceptibility testing; 2004 [cited 2011 Jan 12]. Available from: <http://www.scribd.com/doc/47234185/Antimicrobial> [Google Scholar]
 11. Cheesbrough M. Biochemical tests to identify bacteria. In: District laboratory practice in tropical countries. New York: Cambridge University Press; 2009. p. 45-58.
 12. Abed Al-Mefregi BK. Effect of iron oxide nanoparticles on protease enzyme activity in *Escherichia coli* isolated from urinary tract infection [dissertation]. Al-Mustansiriyah University, College of Science; 2016.
 13. Ibrahim SA, Mohamed DA, Suleman SK. Microbial causes of urinary tract infection and its sensitivity to antibiotics at Heevi Pediatric Teaching Hospital/Duhok City. *Med J Babylon.* 2020;17(1):109. [Google Scholar]
 14. Khan R, Saif Q, Fatima K, Meher R, Shahzad HF, Anwar KS. Clinical and bacteriological profile of UTI patients attending a north Indian tertiary care center. *J Integr Nephrol Androl.* 2015;2(1):29-34. [Google Scholar]
 15. Almkhtar SH. Urinary tract infection among women aged (18-40) years old in Kirkuk city, Iraq. *Open Nurs J.* 2018;12(1):248-54. [Google Scholar]
 16. Al-Gasha'a FA, Al-Baker SM, Obiad JM, Alrobiai FA. Prevalence of urinary tract infections and associated risk factors among patients attending medical city hospital in Baghdad City, Iraq. *Am J Infect Dis.* 2020;16(2):77-84.
 17. Hussein NH, Rasool KH, Taha BM, Hussein JD. Prevalence and antimicrobial susceptibility patterns of bacteria isolated from Urinary Tract Infections (UTIs) in children at children hospital in Baghdad. *Al-Kindy Coll Med J.* 2017;13(1):102-7. [Google Scholar]
 18. Odoki M, Aliero AA, Tibyangye J, Maniga JN, Wampande E, Kato CD, Agwu E, Bazira J. Prevalence of bacterial urinary tract infections and associated factors among patients attending hospitals in Bushenyi district, Uganda. *Int J Microbiol.* 2019;2019:4246780. [PubMed] [Google Scholar]
 19. Jacobsen SM, Stickler DJ, Mobley HL, Shirliff ME. Complicated catheter-associated urinary tract infections due to *Escherichia coli* and *Proteus mirabilis*. *Clin Microbiol Rev.* 2008;21:26-59. [PubMed] [Google Scholar]
 20. Mahato S, Mahato A, Yadav J. Prevalence and identification of uropathogens in Eastern Nepal and understanding their antibiogram due to multidrug resistance and ESBL. *Asia Pac J Microbiol Res.* 2018;2:9-17. [Google Scholar]
 21. Mansoor IY, AL-Otraqchi KI, Saeed CH. Prevalence of urinary tract infections and antibiotics susceptibility pattern among infants and young children in Erbil city. *Zanco J Med Sci.* 2015;19:915-22. [Google Scholar]
 22. Ramalingam K, Surasani VM, Bollu M. Prevalence of asymptomatic bacteriuria in antenatal women coming to NRIMC & GH. *Bangladesh J Obstet Gynaecol.* 2015;30(1):30-6.
 23. Muharram SH, Ghazali SN, Yaakub HR, Abiola O. A preliminary assessment of asymptomatic bacteriuria of pregnancy in brunei darussalam. *Malays J Med Sci.* 2014;21(2):34-9. [PubMed] [Google Scholar]
 24. Garnizov TM. Asymptomatic bacteriuria in pregnancy from the perspective of public health and maternal health care: review and case report. *Biotechnol Biotechnol Equip* 2016;30(3):443-7. [Google Scholar]
 25. Saeed S, Tariq P. Symptomatic and asymptomatic urinary tract infections during pregnancy. *Int J Microbiol Res.* 2011;2(2):101-4.
 26. Hamdan HZ, Ziad AH, Ali SK, Adam I. Epidemiology of urinary tract infections and antibiotics sensitivity among pregnant women at Khartoum North Hospital. *Ann Clin Microbiol Antimicrob.* 2011;10(1):2. [PubMed] [Google Scholar]
 27. Beyene G, Tsegaye W. Bacterial uropathogens in urinary tract infection and antibiotic susceptibility pattern in Jimma University specialized Hospital, Southwest Ethiopia. *Ethiop J Health Sci.* 2011;21:141-6. [PubMed] [Google Scholar]
 28. Alsamarai AG, Latif IA, AbdulAziz MM. Urinary tract infection in Iraq: evaluation of early detection methods and etiology. *World J Pharm Pharm Sci.* 2016;5:181-94.