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Short report

Survey of screening methods, rates and policies for the detection of carbapenemase-producing Enterobacteriaceae in English hospitals

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SUMMARY

Multi-drug-resistant Gram-negative bacteria are of major clinical concern. The increasing prevalence of carbapenemase-producing Enterobacteriaceae (CPE), resistant to all beta-lactams including carbapenems and able to colonize the large intestine, represents a key threat. Rapid, accurate detection of intestinal CPE colonization is critical to minimize transmission, and hence reduce costly, difficult-to-treat CPE infections. There is currently no 'gold standard' CPE detection method. A survey of diagnostic laboratories in England found considerable heterogeneity in diagnostic CPE testing methods and procedures.

Introduction

Antibiotic resistance in bacteria is of increasing concern. In particular, the prevalence of carbapenemase-producing Enterobacteriaceae (CPE) has increased in recent years, and CPE have become an important threat to public health [1,2]. Rapid, accurate detection of these organisms in patients is paramount to ensure that appropriate patient management, infection prevention and infection control procedures are put in place to minimize spread [3]. This is complicated, however, by a number of factors, not least which patients to screen for CPE carriage. It is unrealistic and too expensive to test all patients in most hospitals, and so detection is usually targeted at particular 'at risk' patient subgroups [3,4].

There is no 'gold standard' method for detection of CPE in stool samples or rectal swabs; UK Standards for Microbiology Investigations guidelines recommend only that methods used should 'have demonstrated performance at least equivalent to plating on to a commercially-prepared agar specifically recommended for this purpose' [5]. Molecular methods allow rapid screening for selected carbapenemase genes, and real-time polymerase chain reaction assays offer laboratories the ability to reduce turnaround times. It has been reported that these tests may have lower limits of detection than conventional agar-based methodologies [6,7].

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Finally, cost is an important factor in CPE detection, and assay cost is often a major concern to hospitals when devising their CPE detection policy, especially given the potentially large volume of testing. However, CPE can contribute to a large burden on healthcare facilities in many different ways. Infections are often difficult and expensive to treat, and can lead to a prolonged hospital stay, with the associated increase in costs. Also, colonized patients require isolation. As such, minimization of CPE transmission is key.

Generation of evidence to support adoption of a preferred CPE detection method would thus be greatly beneficial to healthcare systems in the UK. However, for the reasons described above, no single method is likely to meet these requirements. Testing algorithms, combining screening and confirmatory/validation tests, can offer improved sensitivity and specificity compared with single assays [8]. As such, a survey was undertaken to determine current testing practices across laboratories in England.

Methods

Two surveys were sent to all ($N = 153$) acute National Health Service (NHS) hospital trusts in England and their associated laboratories. One survey ('laboratory survey', eight questions) gathered information on the testing protocols used to detect CPEs in the laboratory, while the other ('trust survey', 10 questions) gathered data on CPE testing rates and policies. Each site was assigned a unique study number so that results could not be linked back to an individual trust. Data were input directly, by site, into the web-based database Bristol Online Survey Tool (https://www.onlinesurveys.ac.uk/) before being downloaded for basic statistical analysis in Excel (Microsoft Corp., Redmond, WA, USA).

Data were analysed to identify commonly used detection methods and compare methods and policies across different NHS trusts. Rates of testing and CPE positivity were calculated per 10,000 patient bed-days (pbds) to allow comparison between hospitals of differing size. Data were gathered for the period 1st January 2016 to 31st December 2016.

Results

Laboratory and trust surveys were completed by 50/153 (32.7%) and 36/153 (23.5%) participants, respectively; 34 trusts/laboratories completed both surveys. A wide variety of screening protocols were reported (Figure 1).

Laboratory results

Phenotypic tests made up 25/45 (55.6%) local confirmatory tests, but there was considerable heterogeneity and no one phenotypic test was clearly preferred. Twelve laboratories used a molecular test, with the Gene Xpert Carba-R (Cepheid, Sunnyvale, CA, USA) found to be the most popular molecular assay [11/12 (91.7%)].

When testing clinical isolates for CPE, 10 (20%) laboratories used alternative tests to those employed for screening. All laboratories using alternative laboratory methods used chromogenic agar as the first stage in their screening protocol; however, for clinical isolates (that had already been isolated from a sample), this step was omitted and the laboratories proceeded directly to phenotypic and molecular tests.

Trust results

The most common reason for screening patients for CPE was a history of hospitalization abroad in the last 12 months [34/36 (94.4%)]. The second most common reason was patients hospitalized in the last 12 months in a UK hospital with a recent CPE outbreak [28/36 (77.8%)]. Admission to a particular unit (most commonly an intensive care unit) in a hospital was cited as a reason by 6/36 (16.7%). Other reasons given for testing included transfer from a UK hospital out of the region, contacts or previous positive results from a previous outbreak, and dialysis patients that had travelled abroad or had treatment away from their base hospital.

All trusts that responded had a written CPE screening policy detailing where, when and how often patients should be screened. Most trusts [30/36 (83.3%)] reported screening up to three times during an admission if each screen was negative. Patients with a known previous positive screen were rescreened in 31/36 trusts. In addition, 24/31 (77.4%) hospitals reported rescreening patients with a previous CPE-positive result if the patient was readmitted to hospital.

Although there were 36 respondents to the trust questionnaire, six gave the total number of beds instead of patient bed-day data; rate data could therefore only be calculated for 30 trusts. To preserve anonymity, data from trusts were combined into English regions (Figure 2). Nationally, 60 samples were screened per 10,000 pbds, with 0.33/10,000 of these testing positive for CPE, which equates to a positivity rate of 0.85%.

The response rates by region were as follows: 9/22 (40.9%) from north-east England, Yorkshire and Humber; 4/28 (14.3%) from north-west England; 6/25 (24%) from the Midlands; 6/17 (35.3%) from south-west England; and 11/61 from south-east England (including London). There was a marked difference in the number of screening samples tested per 10,000 pbds (Figure 2). The highest level of testing was seen in north-west England, with 121 samples screened/10,000 pbds, followed by south-east England (98/10,000 pbds) and north-east England (39/10,000 pbds). The highest number of positive screens/10,000 pbds was also seen in the region that had the highest testing rate: north-west England. In contrast, however, the second highest positive screen/10,000 pbds rate was seen in north-east England, although south-east England had a higher screening rate.

Discussion

There was no consensus between trusts on which patients should be screened or how often to test them. However, trusts were mostly in agreement that patients that had been hospitalized aboard in the last 12 months should be screened for CPE carriage. Trusts were reasonably consistent in their reasons for rescreening, with those patients with a previous CPE-positive result readmitted to hospital meeting the local criteria for rescreening. In addition, patients with a negative screen were screened up to a maximum of three times per admission.

All laboratories reported that they screened faecal and/or rectal samples, as recommended by UK Standards for Microbiology Investigations guidelines [5]. Culture using chromogenic

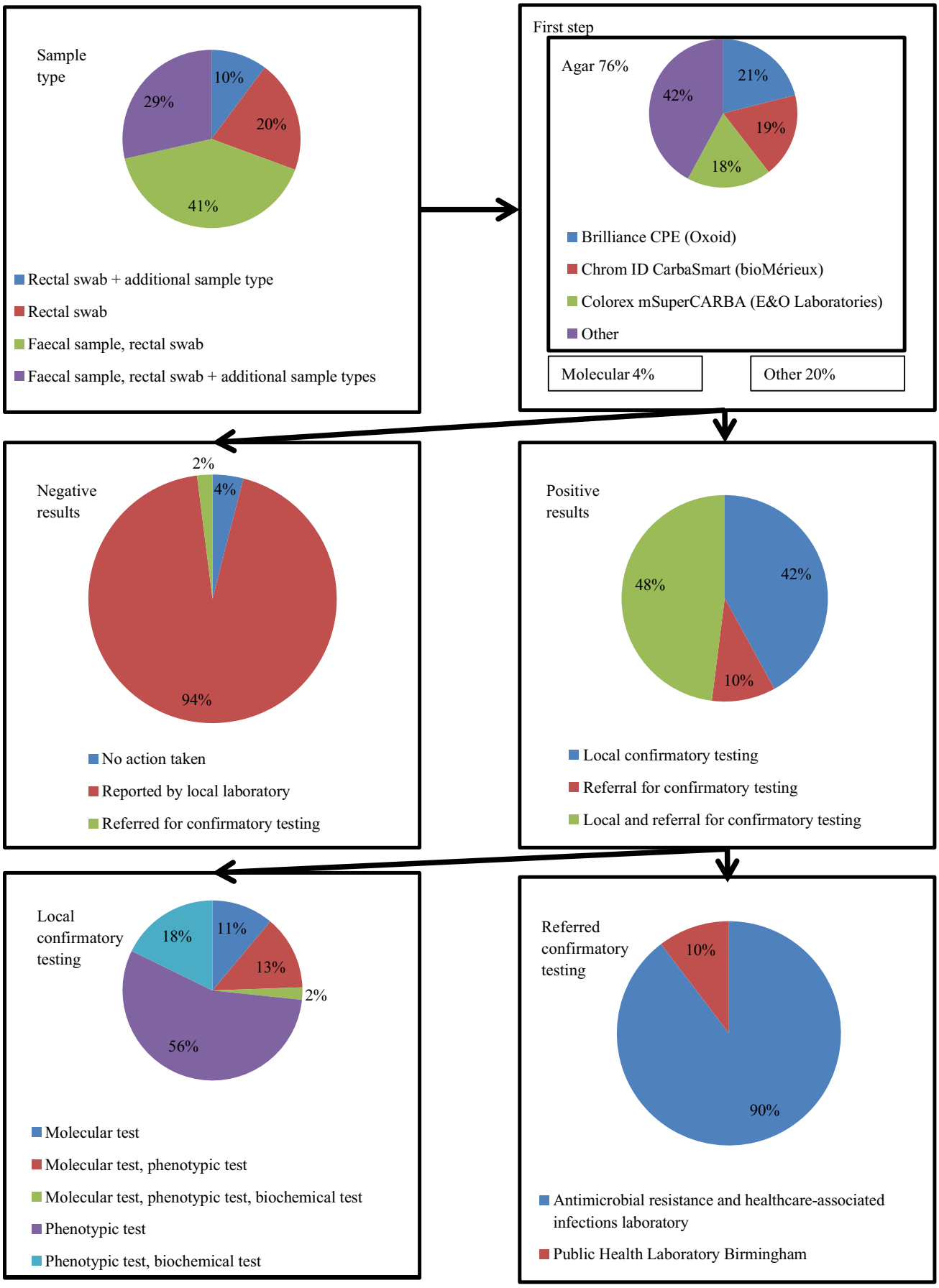

Figure 1. Flowchart detailing the wide variety of screening protocols across the UK.

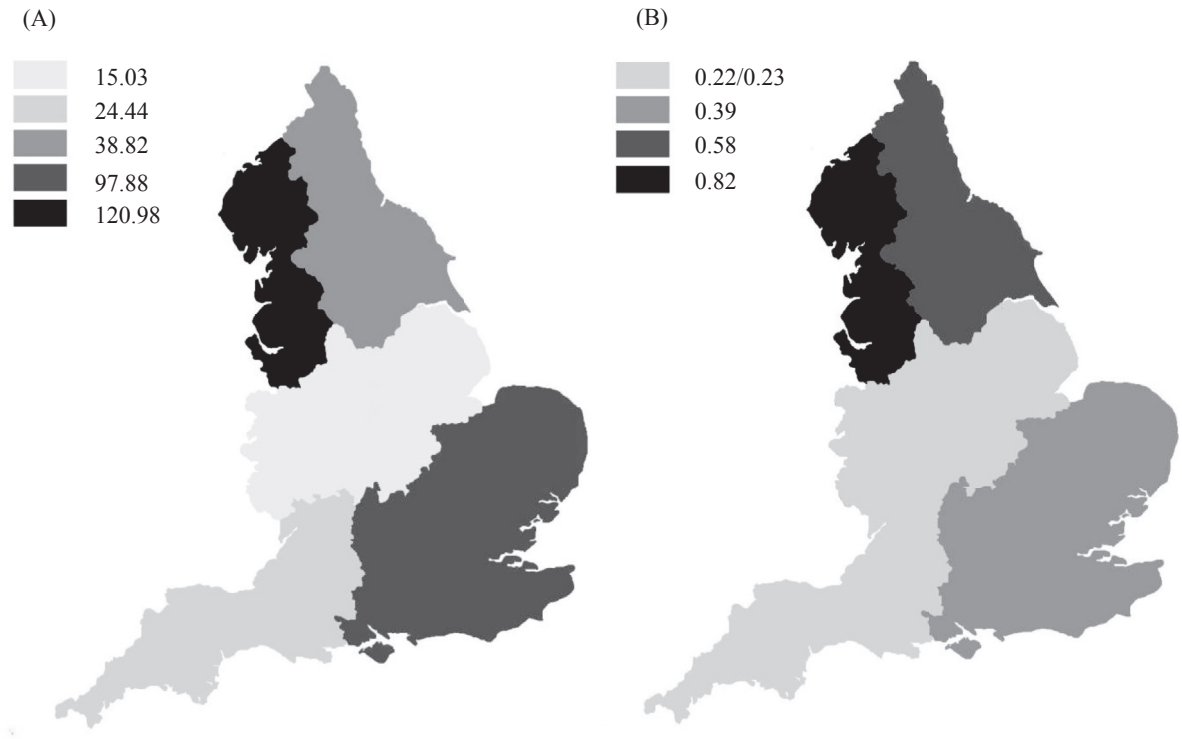

Figure 2. Maps showing (A) number of screen samples tested/10,000 patient bed-days (pdbs) and (B) number of screen sample positive results/10,000 pbds by region.

agar (76%) was by far the most popular first step in trusts' screening policies, although the media types varied. Laboratories were confident that a negative result by this method was a genuine negative and so reported as such. Confirmatory testing was performed for all samples with a positive result by the first-step test, but this confirmatory testing is where most of the heterogeneity in the testing methods was introduced. Although over 50% of laboratories used phenotypic methods, there was no consensus on which phenotypic method to use, possibly due to the variable sensitivity and specificity, and difficulty in result interpretation [5].

A considerable number of trusts referred samples/isolates, particularly positive samples, to external laboratories. The ideal algorithm would enable each laboratory to be confident with their in-house testing method and reduce the requirement, not to mention cost and time delays introduced, in referring samples for confirmatory testing. Local testing also increases the impact that results can have on patient management to prevent onward transmission. Timely reporting of CPE screening enables patients that have been isolated or cohort nursed to be returned to the wards if they are CPE negative, as they are not a transmission risk. Conversely, patients with a sample that was positive on screening and who needed to be isolated could have this process expedited due to reduced turnaround times. Collecting data regarding isolation policies was beyond the remit of this work, but accurate CPE detection would obviously impact on this area.

There were some limitations to this study. There was a disappointing response rate to the survey, with only 34/153 (22%) trusts/laboratories completing both questionnaires. Nevertheless, the data clearly demonstrate the considerable heterogeneity of testing within trusts. The majority of respondents were from south-east England, but there was representation across the country. The surveys should perhaps have included a definition of patient bed-days to ensure that the required data were received. It is unclear whether respondents were confused about what the survey was asking for, or if they could not access the data easily.

Unbeknown to the authors at the time, a similar survey was sent to the same hospitals, gathering data on the awareness, uptake and implementation of the Public Health England toolkit for CPE detection, management and control [9]. The authors of that study found that CPE prevention and control was influenced by a complex set of factors, which led to variable implementation of the toolkit across England.

The present study confirms the authors' suspicion that there is marked heterogeneity in CPE screening/testing across England. This highlights the requirement for the development of a diagnostic testing algorithm to ensure uniformity of optimized testing across the UK. In addition, the rate of testing varied widely, which suggests that there is considerable scope for missing cases in some centres.

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Conflict of interest statement
None declared.

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