Rapid Screening of Methicillin-Resistant Staphylococcus aureus carrying the mecC gene in a Portuguese Hospital

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ABSTRACT

Background: The discovery of mecC gene in MRSA isolates and its report in neighboring Spain and France, advises for monitoring its presence in Portuguese hospitals since changes in local epidemiology can occur quickly. The implementation of rapid procedures based on the automated system VITEK2 allow for simple screening of mecC MRSA isolates with the profile of susceptibility to oxacillin and resistance to cefoxitin signaling positive results for detailed analysis.

Methods: This works aims to perform a retrospective study for the presence of suspect mecC MRSA in a Portuguese hospital using to the two methodologies included in microbiology laboratories routine.

Result: Our results do not suggest the presence of mecC MRSA, but highlight the possibility of introducing a simple method in clinical laboratories with high percentage of S. aureus isolates.

Conclusion: The implementation of this simple procedure in the laboratory routine is a rapid and economic way to monitoring the presence of mecC MRSA.

Keywords: MRSA, mecC MRSA, Prevalence, Screening

Introduction

S. aureus is a predominant human pathogen that can cause a diverse range of diseases. Its impact in human health is enhanced by the development of antibiotic resistances, mainly through Methicillin Resistant S. aureus (MRSA) [1].

MRSA is resistant to almost all β-lactam antibiotics, and it is known that its resistance is caused by the production of a penicillin-binding protein (PBP), named PBP2a, that reduces the binding affinities to β-lactam antibiotics. PBP2a is encoded by the gene mecA located in MRSA chromosome [2].

The identification of MRSA in diagnostic microbiology laboratories can be achieved by a variety of methods, including antimicrobial susceptibility testing, detection of PBP2a by latex agglutination tests and molecular detection of the mecA gene [3].

In 2011, a new mecA gene homolog, mecALGA251, was found in isolates from both humans and animals. The International Working Group on the Classification of Staphylococcal Cassette Chromosome (SCC) Elements renamed it to mecC [4]. The mecC gene shares 69% nucleotide homology with mecA and was found in a novel SCC element designated as SCCmec type XI [4].

MRSA isolates harboring the mecC gene have been reported in several European countries mainly from humans who had contact with livestock, and/or wild and domestic animals, emphasizing that contact with animals poses a zoonotic risk and that mecC MRSA can be transmitted between species and consequently could be regarded as a LA-MRSA[1].

The discovery of mecC MRSA is of concern for microbiology laboratories since these isolates originate negative results, both by latex agglutination test and by the PCR assay for mecA [1, 3]. Routine diagnostic tests do not enable the identification of mecC gene, which still requires confirmation using PCR assays that are currently available only at reference laboratories.

The cultural and geographical proximity of France and Spain allied with close to 50% for over 10 years of MRSA prevalence in Portuguese hospitals, one of the highest in Europe [5], highlights the urgency to implement routine laboratory testing methods to rapidly detect and treat these emerging strains.
mecC MRSA isolates are susceptible to oxacillin but resistant to cefoxitin, when tested using Staph AST cards on Vitek2 automated antimicrobial susceptibility testing system (BioMérieux, France)\(^3\) a profile that differs from other MRSA strains. This simple procedure enables the laboratory to suspect of mecC MRSA presence. By performing it routinely, laboratory teams and physician can monitor changes in the hospital mecC MRSA distribution and prevalence over time\(^3\).

**Materials and Methods**

**Aims and Study Design:** This works aims to perform a retrospective study for the presence of suspect mecC MRSA in a Portuguese hospital using two methodologies (PBP2a and Vitek2) included in microbiology laboratories routine.

**Study Population and Data Collection:** Based on database from the microbiology laboratory of Centro Hospitalar Baixo Vouga, Aveiro, Portugal, a retrospective analysis of 835 \textit{S. aureus} isolates, between 2014 and 2016 was performed. Only one isolate per patient was included. Isolates were collected from various clinical sources, including respiratory tract (\(n = 192\)), blood (\(n = 190\)), wounds (\(n = 324\)), urine (\(n = 83\)) and others (\(n = 46\)). Patient demographic characteristics and clinical data were obtained from the medical records.

**Laboratory Methods:** Data of oxacillin and cefoxitin obtained with automated system (Vitek2-Biomerieux) was analyzed. To test the inclusion of this procedure in the day-to-day activities of the clinical laboratory a sample of 84 MRSA strains collected from Medicine department during 2014 were retested for the PBP2a test (Alere). A positive control of mecC MRSA – negative to PBP2a, susceptible to oxacillin and resistant to cefoxitin – was included in this analysis to procedure validation\(^1\).

**Result**

Between 2014 and 2016 a total of 835 \textit{S. aureus} isolates were identified by the microbiology laboratory with 409 classified as MSRA (Table 1). A sample of 84 MRSA from 2014 was retested for PBP2a. All 409 MRSA were resistant to both oxacillin and cefoxitin (Table 2) and all 89 retested isolates were positive to PBP2a test. The positive control for mecC MRSA\(^1\) originated a negative result on the PBP2a test and was susceptible to oxacillin and resistant to cefoxitin when tested with AST619 Staphy cards on automated system Vitrek2.

<table>
<thead>
<tr>
<th>Year of analysis</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolates (n)</td>
<td>291</td>
<td>249</td>
<td>295</td>
</tr>
<tr>
<td>Age (Mean ± SD)</td>
<td>64.9 ± 23.5</td>
<td>65.2 ± 22.2</td>
<td>71.7 ± 23.7</td>
</tr>
<tr>
<td>Male sex, n</td>
<td>178</td>
<td>146</td>
<td>172</td>
</tr>
<tr>
<td>Clinical Source</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory tract</td>
<td>81</td>
<td>44</td>
<td>67</td>
</tr>
<tr>
<td>Blood</td>
<td>62</td>
<td>62</td>
<td>66</td>
</tr>
<tr>
<td>Wounds</td>
<td>108</td>
<td>107</td>
<td>109</td>
</tr>
<tr>
<td>Urine</td>
<td>27</td>
<td>26</td>
<td>30</td>
</tr>
<tr>
<td>Other sources</td>
<td>13</td>
<td>10</td>
<td>23</td>
</tr>
</tbody>
</table>

**Table 1: Characterization of \textit{S. aureus} isolates** between 2014 and 2016, in Centro Hospitalar Baixo Vouga, Aveiro, Portugal.

<table>
<thead>
<tr>
<th></th>
<th>Control</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>\textit{S. aureus} isolates</td>
<td>291 (100%)</td>
<td>176 (60.5%)</td>
<td>249 (100%)</td>
<td>121 (48.6%)</td>
</tr>
<tr>
<td>MRSA isolates</td>
<td></td>
<td>291</td>
<td>249</td>
<td>295</td>
</tr>
<tr>
<td>Oxacillin/Cefoxitin Profile</td>
<td>-</td>
<td>176</td>
<td>121</td>
<td>112</td>
</tr>
<tr>
<td>R/R</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>S/S</td>
<td>Positive</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>S/R</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>PBP2a test*</td>
<td>Negative</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

**Table 2: Susceptibility profile on automated method (Vitrek2, 619 AST card)**
Discussion
Based in the 2015 ECDC report, Portugal is the third European country with the highest prevalence of MRSA (46.8%), nevertheless is one of the countries that shows a significant decreasing trend [6]. In the last decades, MRSA infections were limited to hospitals, but the exponential emergence of community-associated MRSA infections shaped the epidemiology of S. aureus leading to the replaced of hospital-associated MRSA (HA-MRSA) clones by community-associated MRSA [7]. Between 2009-2010 Tavares A, et al.[9] studied a total of 1,487 S. aureus isolates collected from 16 Portuguese healthcare institutions located in different geographic regions of Portugal, reporting that MRSA clones present in the community were clones typically found in hospitals. This signals Portugal as a region where the transfer of strain between setting can be recognized, valorizing potential risks for public health of a third epidemiological form of MRSA, livestock-associated MRSA (LA-MRSA) [1].

In humans, mec MRSA was isolated in hospital patients from Slovenia [9], Germany [10], Republic of Ireland [11], Denmark [12], Spain [13] [14] and France [15], Garcia-Garrote et al.[14] reported the first mec MRSA fatal human case in Spain, a patient with sepsis who died in the emergency department. In the same study mec MRSA was reported in 6 other human cases, predominantly in skin and soft tissue infections. In France, Laurent, et al.[15] described the presence of mec MRSA in joint infections in humans and clustered animal cases, 2 cows with clinical mastitis, demonstrates the ability of such strains to cause clustered cases.

Studies in UK [12], France [15], Sweden [16] and Finland [17] confirmed mec MRSA wide geographic range and shown frequent presence in dairy cattle. A study in Germany found it in companion animals [18]. These findings suggest that dairy cattle, companion animals and wild animal, might work as reservoirs of infection and could share mec with other animals, when they coexist in the same habitat.

Our results do not suggest the presence of mec MRSA, but highlight the possibility of introducing a simple method in clinical laboratories with high percentage of S. aureus isolates, allowing a routine and rapid screen of the presence of mec MRSA, contributing for monitor changes in mec MRSA prevalence over time. This type of method can rapidly and easily be introduced in the majority of clinical laboratories and performed in all MRSA isolates. Although the overall prevalence of mec MRSA is still very low (0,009%), higher in animals (0,1%) that in humans (0,004%), it is important to evaluated clinically mec MRSA presence, to clarify its epidemiology [19]. In fact, the clinical of mec MRSA is not fully determined and study alternatives that can contribute to understand its impact is fundamental. Screening the presence of mec MRSA with routine diagnostic tests is a useful and important procedure, specially in regions with high prevalence of MRSA, like Portugal. Currently, mec MRSA do not constitute a risk for public health but changes in local epidemiology can occur quickly, especially when the strain is already present in neighboring countries, such as Spain.

Conclusion
This work showed that, a minimal effort and investment in health professionals training is sufficient to keep a clinical laboratory team in alert to the emerge of mec MRSA. Implementing this strategy will allow, in the event of positive results for mec MRSA, to a rapid shift to more advance molecular methods, as PCR, avoiding future false negatives for MRSA, which ultimately leads to better treatment and management of the affected population, with better clinical outcomes expectation.

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Reference
5. (ECDC) ECfDPaC. European Centre for Disease Prevention and Control 2014.

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