In vitro activity of azithromycin in faecal isolates of Aeromonas hydrophila

Actividad in vitro de azitromicina en aislados fecales de Aeromonas hydrophila

Dear Editor:

Aeromonas is a genus of gram-negative bacilli that are similar in morphology to the Enterobacteriaceae. Numerous species have been described, the most frequent of which are A. caviae, A. veronii and, above all, A. hydrophila. These bacteria are transmitted through contaminated fresh and salt waters. In humans, they are most commonly involved in wound infections, systemic disease (usually in patients with underlying conditions) and especially acute gastroenteritis (AGE). In Spain, Aeromonas is considered the third most frequent enteropathogenic bacterium identified in patients with AGE, following Campylobacter and Salmonella, accounting for 6–7% of cases; in the Valencian metropolitan area, the incidence of AGE due to Aeromonas is of 20 cases per 1,000,000 inhabitants. Recently, the European Society for Paediatric Gastroenterology Hepatology and Nutrition (ESPGHAN) and the European Society for Paediatric Infectious Diseases (ESPID) have recommended oral azithromycin for the treatment of moderate to severe gastroenteritis based on the bacterial enteropathogens that are most commonly involved. However, due to the lack of data on Aeromonas species, we do not have any evidence of the actual usefulness of this antimicrobial. The aim of our study was to assess the in vitro activity of azithromycin against clinical isolates of Aeromonas.

We conducted a prospective descriptive study of clinical isolates of A. hydrophila from patients with AGE during 2015. We isolated the bacterial strains by culturing stool samples in selective CIN agar (Becton-Dickinson). Bacterial identification and antibiotic susceptibility testing were performed by means of standardised and widely used techniques, specifically with NC70 panels of the commercially available MicroScan WalkAway system (Siemens). Furthermore, we used Etest strips (bioMérieux) to determine the minimum inhibitory concentration (MIC) in a McFarland 0.5 bacterial suspension; and interpreted the results applying the epidemiological cut-off values established by the European Committee on Antimicrobial Susceptibility Testing (EUCAST) for Shigella and Salmonella (sensitivity: MIC < 16 mg/L). We analysed the cases by on time, age and sex as well as the microbiological characteristics of the isolated strains.

During the period under study, A. hydrophila was isolated from a total of 50 clinical samples. The median age of the patients was 8 years (range, 0–89 years). Fifty-four percent were children (78% aged less than 4 years) and 32% elderly. Fifty-two percent were male. All isolates came from patients in primary care, and no patients reported having been hospitalised. The isolates did not exhibit a significant seasonal pattern, although 58% of detections occurred in summer or spring. The percentage of isolates that showed in vitro sensitivity to antibiotics commonly used to treat AGE were: 0% for ampicillin, 10% for amoxicillin/clavulanic acid, 92% for cefotaxime, 100% for cefotaxime, 100% for ciprofloxacin, 100% for gentamicin and 96% for cotrimoxazol. All isolates were considered sensitive to azithromycin; the determined MICs ranged between 0.5 and 8.0 mg/L, and the MIC50 (concentration required to inhibit 50% of bacterial strains) and the MIC90 (for inhibition of 90% of strains) were 3.0–6.0 mg/L, respectively.

Antibiotic treatment is not always indicated for AGE caused by Aeromonas, so the use and choice of antimicrobials should be based on the symptoms and age of the patient, the site of infection (intestinal or extraintestinal), the immune status of the patient and the local prevalence of different pathogens and patterns of drug resistance. The antibiotic sensitivity of Aeromonas has been studied mainly in environmental bacterial strains, but few studies have analysed clinical isolates and the use of azithromycin. In our experience, A. hydrophila showed a high sensitivity to azithromycin in vitro, although it would be advisable to have international committees on microbiology to establish clinical breakpoints to determine the sensitivity or resistance to azithromycin, as has been done for Salmonella and Shigella. Given its easy dosage (one dose a day), low toxicity and evidence of the high sensitivity of Campylobacter and also Salmonella to it, azithromycin has been established as the empirical treatment of choice in cases of bacterial AGE that require antibiotic therapy.
**Light and noise: Environmental factors in intensive care units**

**Factores ambientales de luz y ruido en las unidades de cuidados intensivos**

_Dear Editor:_

Intensive care units (ICUs) are settings characterised by very sophisticated equipment that require specialised facilities and in many instances produce environments with poor natural light and background noise.1–2 In these high-tech units, the activities involved in advanced life support and subsequent care may predispose to discomfort. Katherine Kolcaba defined comfort as the state experienced through having the human needs for relief, ease, and transcendence addressed in four contexts: physical, psychospiritual, sociocultural, and environmental.3

Aware of the importance of these factors in the care of critically ill patients, we reviewed the standards on light and noise in ICUs and studied the characteristics of these two variables in the PICU of a tertiary care hospital.

We measured environmental light with a CEM DT-1308 light metre in luxes (lx). Measurements were made in the morning and at night and taking into account the three types of lighting that predominate in the unit under study: natural light, white/cold light and warm/yellow light. We defined light colour based on colour temperature expressed as Kelvin (K). Based on this parameter, cool light corresponds to white tones exceeding 5000 K (fluorescent lights), while warm light corresponds to yellow tones of less than 3300 K (halogen lights).4

We measured environmental noise with a PCE-999 type 2 audiometer in decibels (dB). We recorded the noise level every 2 h for 6 days.

The references used for comparison were the European Union Lighting Standard for Interior Lighting (EN 12464.1) and, for environmental noise, guidelines of the American Academy of Pediatrics (AAP) and the Council on Environmental Health, as well as the standards proposed by the World Health Organization (WHO). We ought to note that in order to avoid the Hawthorne effect (the alteration of behaviour in subjects aware of being observed) we performed these measurements without the knowledge of the health care staff in the unit.

We collected a total of 28 light measurements and 72 environmental noise measurements. The recommended light levels are 100 to 1000 lx during the day and 20 lx at night. The median natural light was 51.7 (0–207.2) luxes. As for direct cool lighting, the daytime median was 195.6 (88.1–347.2) luxes compared to 159.6 (57.0–206.7) at night. In comparison, our analysis of indirect warm light resulted in a median of 67.5 (11.4–193.7) luxes during the day versus a median of 27.4 (13.2–72.4) at night. All daytime light measurements complied with the standards, although nighttime luminosity far exceeded the recommended luxes.

When we analysed the environmental noise in the ICU, we found a mean 57.64 ± 3.67 dB during the day versus 55.48 ± 3.17 at night. Both levels exceed the daytime threshold of 45 dB and the nighttime threshold of 35 dB recommended by the reviewed standards.

Therefore, we can conclude that in order to improve environmental factors in our unit, we must continue to promote the use of natural light or, in its absence, warm lighting.

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Jorge Jover-García, Virginia Pérez-Doñate, Javier Colomina-Rodríguez*

Servicio de Microbiología, Hospital Universitario de la Ribera, Alzira, Valencia, Spain

*Corresponding author.
E-mail address: jcolomina@hospital-ribera.com
(J. Colomina-Rodríguez).

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