

Nosocomial Ventilator-Associated Pneumonia in Cuban Intensive Care Units: Bacterial Species and Antibiotic Resistance

Manuel Medell, Marcia Hart MD MS, Amílcar Duquesne MD, Fidel Espinosa MD MS, Rodolfo Valdés PhD

ABSTRACT

INTRODUCTION Nosocomial pneumonia associated with use of mechanical ventilators is one of the greatest challenges confronted by intensivists worldwide. The literature associates several bacteria with this type of infection; most common in intensive care units are *Acinetobacter baumannii*, *Pseudomonas aeruginosa*, methicillin-resistant *Staphylococcus aureus* and some of the *Enterobacteriaceae* family.

OBJECTIVES To identify the causal agents of nosocomial ventilator-associated pneumonia in patients receiving mechanical ventilation in the intensive care units of Havana's Hermanos Ameijeiras Clinical-Surgical Teaching Hospital in 2011, and to characterize their antibiotic resistance.

METHODS A cross-sectional descriptive study was conducted using hospital administrative data of quantitative cultures from positive tracheal aspirates for January through December, 2011. Records were analyzed from 77 intensive care unit patients who developed nosocomial ventilator-associated pneumonia. Variables examined were age and sex, and pathogens identified from culture of tracheal aspirate and related antibiotic susceptibility.

RESULTS Species most frequently isolated were: *Acinetobacter baumannii* in 53 patients (68.8%), *Pseudomonas aeruginosa* in 34 patients

(44.2%), other species of *Pseudomonas* in 15 patients (19.5%), and *Serratia marcescens*, *Klebsiella pneumoniae*, and *Escherichia coli* in 12 patients each (15.6%). Some patients presented more than one pathogen in concurrent or successive infections. Antimicrobial susceptibility testing found high percentages of resistance to antibiotics in all these pathogens. Least resistance was found to colistin.

CONCLUSIONS The prevalence of antibiotic resistance in bacteria causing nosocomial ventilator-associated pneumonia is of concern. Colistin is the drug of choice among the antibiotics reviewed, but sensitivity to other antibiotics should be assessed to search for more appropriate broad-spectrum antibiotics for treating nosocomial ventilator-associated pneumonia. Our results also suggest the need to strengthen infection control efforts, particularly in intensive care units, and to reassess compliance with quality control procedures. Multidisciplinary research involving microbiologists, epidemiologists, internists and intensivists is needed to fully understand the etiological and resistance patterns observed.

KEYWORDS *Acinetobacter baumannii*, nosocomial infections, mechanical ventilation, ventilator-associated pneumonia, bacterial resistance, microbial sensitivity tests, bacterial sensitivity tests, Cuba

INTRODUCTION

Nosocomial infections include infections that happen in hospital and were not present at time of admission, and infections acquired in hospital that become apparent within seven days following hospital discharge.[1] Ventilator-associated pneumonia (VAP) is the second most frequent hospital-acquired infection and one of the most aggressive; it is often associated with higher rates of morbidity and mortality, as well as with increased hospital stays and costs.[2] VAP constitutes 80% of nosocomial pneumonia, occurring in approximately 10% to 20% of patients requiring mechanical ventilation for more than 48 hours,[3] with case fatality between 24% and 76%.[4] While hospitals are not the only settings for mechanical ventilation, in this paper the adjective nosocomial is implicit wherever VAP is mentioned.

Most VAP occurs in intensive care units (ICU), where it affects up to 50% of patients;[5] VAP risk in ICU is two to five times higher than in other hospital services.[6,7] The main risk factor is invasive mechanical ventilation,[5] with incidence varying between 10 and 20 episodes per 1000 days of mechanical ventilation (DMV), with risk accumulated at a rate of 1% to 3% per day.[5]

Recent publications indicate VAP rates between 1 and 4 cases per 1000 DMV in developed countries;[6] the International Nosocomial Infection Control Consortium reported 5 cases of VAP per 1000 DMV in the United States.[7] In different regions, reported rates per 1000 DMV were 7.9 in Colombia[8] and 18.2 in Poland.[9] In 2009, rates per 1000 DMV in ICUs in central Cuba were recorded up to 19.5.[10] In Havana's Hermanos Ameijeiras Clinical-Surgical Teaching Hospital (HHA), the cumulative rate for 2000 to 2004 was 4.2.[11]

VAP causal pathogens vary globally, geographically, by hospital and even by service.[5] Nosocomial pneumonia is usually bacte-

rial, but viral or fungal VAP occasionally occurs. The most frequent VAP-associated pathogens, particularly after long hospital stays, are species from the *Enterobacteriaceae* family, *Pseudomonas aeruginosa*, methicillin-resistant *Staphylococcus aureus* (MRSA) and *Acinetobacter baumannii*. [12] These species have also been found in recent HHA ICU studies of VAP microbial etiology, predominantly nonfermenting bacilli such as *Pseudomonas aeruginosa* y *Acinetobacter baumannii*, which have shown intrinsic resistance to many antibiotics.[13]

In recent years there has been an increase in the spectrum of antibiotic resistance in causal agents of VAP in ICUs, along with higher incidence rates.[14,15] The increasing resistance to antibiotics shown by hospital-associated bacteria (particularly the gram-negative, nonfermenting bacilli) reduces treatment options and is frequently associated with clinical deterioration and even death.[16]

In the United States, 50% to 60% of the more than 2 million hospital-associated infections annually are caused by multidrug-resistant bacteria, resulting in some 77,000 deaths per year.[17]

Considering the prevalence and consequences of nosocomial VAP and its increasing resistance to commonly used antibiotics, as well as gaps in our knowledge concerning the particular causal agents present in our institution, we analyzed HHA ICU patient records for 2011 to extract data regarding isolation, identification and antibiotic resistance of bacteria removed by tracheal aspiration from ICU patients with nosocomial VAP.

METHODS

This is a cross-sectional, retrospective descriptive study using data from laboratory records.

Setting and population HHA, a tertiary care hospital in Havana, Cuba, has 625 beds, 15 medical services, 12 surgical units, and 3 ICUs. In 2011, 174 patients in HHA ICUs received mechanical ventilation; of these, 77 developed VAP with no other possible source than HHA. Quantitative cultures of positive tracheal aspirates from these patients were analyzed in the HHA microbiology laboratory.

Variables Age and sex of the patients, isolated microorganism species, and antibiotic susceptibility.

VAP diagnosis This had been determined by the HHA department of epidemiology using American Thoracic Society criteria.[18]

Culture and sensitivity Quantitative cultures of the samples were done in the HHA microbiology laboratory, using the Vitek2Compact automatic reader (Biomérieux, France).[19] The HHA protocol for culture of tracheal aspirates[20] is as follows: Samples are homogenized with Sputasol (OXOID, UK) after centrifugation 10 min at 1500 rpm in a Kokusan H-103N centrifuge (Japan). This is followed by 1/10 serial dilutions (0.1 in 1 mL) in physiological saline (NaCl 0.9%) up to 10⁻⁶ and 0.1 mL of each dilution is plated in blood agar (Biolife, Italy), McConkey's agar (Biolife, Italy) and chocolate agar. The plates are then incubated in aerobiosis at 37 °C for 18 to 24 hours. They are considered positive when there are >10⁴ colony-forming units per mL (CFU/mL).

The HHA protocol for culture and sensitivity testing[20] is as follows: Pure cultures of the samples are analyzed using Vitek2Compact (BioMérieux, France) automatic reader[19] and data automatically transmitted from Vitek2 to the GalenLab hospital management system (Softel, Cuba).[21,22] Antibiotics tested and concentrations used were ampicillin/sulbactam (10 µg/10 µg), aztreonam (30 µg), meropenem (30 µg), amikacin (10 µg), gentamicin (10 µg), ciprofloxacin (5 µg), colistin (10 µg) and ceftriaxone (30 µg). Cutoff minimal inhibitory concentration values are: ampicillin/sulbactam, ≥32 µg/mL; aztreonam, ≥16 µg/mL for *Enterobacteriaceae* and ≥32 µg/mL for *Acinetobacter baumannii* and *Pseudomonas aeruginosa*; meropenem, ≥16 µg/mL; amikacin, ≥64 µg/mL; gentamicin, ≥16 µg/mL; ceftriaxone, >64 µg/mL; ciprofloxacin, ≥4 µg/mL; colistin, ≥8 µg/mL for *Enterobacteriaceae* and *Pseudomonas aeruginosa*, and ≥4 µg/mL for *Acinetobacter baumannii*.

Data collection and analysis All laboratory data were extracted from clinical records stored in the hospital management system. Simple counts and percentages were analyzed.

Ethical considerations The study was approved by the HHA ethics committee. Personal identifiers were kept confidential in data analysis.

RESULTS

VAP patients were predominantly male (43/77, 55.8%) and older. The largest group was aged >65 years (33/77, 42.9%), followed by those aged 50 to 64 (19/77, 24.7%), 35 to 49 (13/77, 16.9%), 25 to 34 (10/77, 13%) and 20 to 24 years (2/77, 2.6%).

Quantitative cultures of tracheal aspirates isolated one to three different pathogens per patient. *A. baumannii*, *P. aeruginosa*, other *Pseudomonas spp.*, and *S. marcescens* were identified in 53 (68.9%), 34 (44.2%), 15 (19.5%), and 15 (19.5%) patients, respectively. *K. pneumoniae* (15.6%) and *E. coli* (15.6%) were also frequently isolated (Table 1).

The most resistant species isolated was *A. baumannii*, for which sensitivity studies revealed high resistance to seven of the eight

antibiotics tested, with the exception of colistin, to which 52 of 53 isolates were sensitive (98.1%) (Table 2). The next most resistant bacteria were *S. marcescens* (resistant to five of eight antibiotics), *Pseudomonas spp.* (four of eight), *K. pneumoniae* (four of eight), *E. coli* (four of eight) and *P. aeruginosa* (three of eight). Gentamicin was the antibiotic to which greatest resistance was observed and colistin the least (Table 2).

DISCUSSION

Most infections acquired by patients mechanically ventilated at the HHA ICUs in 2011 were caused by nonfermenting bacilli, particularly *Acinetobacter baumannii*. This contrasts with other authors who report *Enterobacteriaceae*, *Pseudomonas aeruginosa*, and methicillin-resistant *Staphylococcus aureus* as the main agents isolated.[8,16] Nevertheless, *A. baumannii* VAP has also been reported frequently in hospital ICUs in California, USA,[23] Taiwan[24] and French Polynesia.[25]

A. baumannii is a gram-negative bacterium encountered mainly in hospital environments. It persists for long periods of time in both dry and humid settings, and can also resist desiccation, which could increase transmission of epidemic strains usually found in ICUs.[26] Transmission of *A. baumannii* is associated frequently with mechanical ventilation equipment, aspirators, humidifiers, and other devices previously in contact with patients colonized by these bacteria.[27] When appropriate control measures are not taken, the hands of ICU personnel can be an important vector for patient-to-patient transmission.[28] Thus, inadequate equipment sterilization, insufficient handwashing or a general breakdown of hospital infec-

Table 1: Pathogens isolated from tracheal aspirates of VAP patients in HHA ICUs, 2011

Group	Species	Positive-isolate patients* (n)	%
Gram negative			
<i>Acinetobacter spp.</i>	<i>A. baumannii</i>	53	68.8
	<i>A. lwoffii</i>	3	3.9
<i>Pseudomonas spp.</i>	<i>P. aeruginosa</i>	34	44.2
	Other	15	19.5
<i>Stenotrophomonas malthophilii</i>	Subspecies <i>malthophilii</i>	7	9.1
<i>Escherichia spp.</i>	<i>E. coli</i>	12	15.6
	<i>K. pneumoniae</i>	12	15.6
<i>Klebsiella spp.</i>	<i>K. ozaenae</i>	4	5.2
	<i>S. marcescens</i>	15	19.5
<i>Serratia spp.</i>	<i>S. liquefaciens</i>	1	1.3
	<i>E. cloacae</i>	2	2.6
<i>Enterobacter spp.</i>	<i>E. aerogenes</i>	5	6.5
	<i>E. agglomerans</i>	1	1.3
	<i>E. amnigenus</i>	1	1.3
<i>Citrobacter spp.</i>	<i>C. freundii</i>	2	2.6
	<i>C. amalonaticus</i>	1	1.3
<i>Proteus spp.</i>	<i>P. mirabilis</i>	2	2.6
Gram positive			
<i>Staphylococcus spp.</i>	MRSA	11	14.3
	Coagulase-negative <i>S. aureus</i>	5	6.5

*23 patients (29.9%) had more than one pathogen per VAP episode (up to 3), and some patients had >1 episode.

HHA: Hermanos Ameijeiras Clinical-Surgical Teaching Hospital, Havana

MRSA: methicillin-resistant *Staphylococcus aureus*

VAP: nosocomial ventilator-associated pneumonia

Table 2: Antibiotic resistance of most frequently isolated pathogens in VAP patients in HHA ICUs, 2011

Species	AMS (%)		CEF (%)		ATM (%)		GEN (%)		AMK (%)		MRP (%)		CIP (%)		COL (%)	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
<i>A. baumannii</i>	53/53	100.0	53/53	100.0	53/53	100.0	53/53	100.0	37/53	69.8	48/53	90.6	53/53	100.0	1/53	1.9
<i>P. aeruginosa</i>	32/34	94.1	28/34	82.3	14/34	41.2	20/34	58.8	15/34	44.1	12/34	35.3	16/34	47.1	0/34	0.0
<i>Pseudomonas spp</i>	15/15	100.0	11/15	73.3	7/15	46.7	11/15	73.3	9/15	60.0	3/15	20.0	5/15	33.3	0/15	0.0
<i>S. marcescens</i>	9/15	60.0	5/15	33.3	8/15	53.3	6/15	40.0	10/15	66.7	3/15	20.0	9/15	60.0	15/15*	100.0
<i>K. pneumoniae</i>	9/12	75.0	12/12	100.0	7/12	58.3	12/12	100.0	3/12	25.0	0/12	0.0	5/12	41.7	3/12	25.0
<i>E. coli</i>	5/12	41.7	12/12	100.0	5/12	41.7	12/12	100.0	12/12	100.0	0/12	0.0	10/12	83.3	0/12	0.0

**S. marcescens* possesses intrinsic resistance to colistin

AMS: ampicillin/sulbactam CEF: ceftriaxone ATM: aztreonam GEN: gentamicin AMK: amikacin MRP: meropenem CIP: ciprofloxacin COL: colistin
 HHA: Hermanos Ameijeiras Clinical-Surgical Teaching Hospital, Havana VAP: ventilator-associated pneumonia

tion control protocols can lead to high rates of ICU infection by *A. baumannii*. Our results suggest the need for thorough investigation of quality control systems in HHA to assess compliance with infection control norms and to identify why *A. baumannii* is the predominant bacterium found in these ICU patients.

P. aeruginosa was the second most frequently isolated agent in the hospital's ICU VAP patients. Globally, it is perhaps the most common species affecting mechanically-ventilated ICU patients.[29–32] It has a special tropism for the tracheal epithelium[33] and is able to colonize the lower respiratory tract of intubated patients through both endogenous and exogenous routes.[34]

Microorganisms of the *Enterobacteriaceae* family, chiefly *E. coli* and *K. pneumoniae*, are also reported frequently in association with VAP. [35,36] A study in a hospital in eastern Cuba found percentages of enterobacterial infection in VAP patients similar to those in this study. [37] However, in our research, the prevailing *Enterobacteriaceae* species in VAP patients was *S. marcescens*, in contrast with other studies reviewed.[23,31–33,37,38] The literature reports *S. marcescens* infections in VAP patients as limited to ICU outbreaks associated with failure to properly sterilize medical equipment, contamination of ventilation equipment, and substandard asepsis.[38]

Another important issue emerging from our study, as well as in the international literature, is the presence of multidrug resistance habitually found with nosocomial bacteria. In critically ill patients, antibiotic resistance negatively affects clinical course and increases ICU costs.[39]

Antibiotic resistance in nosocomial bacteria may be the most important factor to consider in treating VAP. Another recent study by our group at HHA showed that *A. baumannii* species isolated from VAP patients were more resistant than those found in patients with ventilator-associated tracheobronchitis or in asymptomatic colonized patients. The same was observed for *P. aeruginosa*. [13] The high resistance to almost all antibiotics by the most frequent bacterial species isolated means that in our hospital we cannot treat VAP empirically without first conducting culture and sensitivity tests.

Low levels observed of bacterial resistance to colistin are consistent with other reports.[40] Colistin has been found to be more effective with simultaneous intravenous administration and nebulization. [41,42] Nevertheless, it should be noted that some microorganisms

(such as *S. marcescens*, *Proteus spp.*, *Providencia spp.*, and *Morganella morganii*) exhibit intrinsic resistance to colistin;[41] all *S. marcescens* isolates in our study were resistant to colistin.

A. baumannii was not only the species most frequently isolated in our study but was also the most antibiotic resistant. Carbapenems (meropenem and/or imipenem) are considered the treatments of choice when sensitivity assays show low levels of resistance.[43] but all isolates reported here showed very high levels of resistance to these drugs, even higher than previously reported some years ago in hospitals in Madrid and Hong Kong.[43,44] Our findings are similar to Hart's 2010 report of a substantial increase in resistance to colistin, tigecycline, aminoglycosides and carbapenems in HHA[45] compared to eight years earlier.[46] *A. baumannii*'s growing antibiotic resistance has become an important problem for our hospital. Thus, reinforcing infection quality control procedures—particularly in ICUs—is critical, as is further research to identify contamination sources.

An important limitation of this study was inability to assess resistance to more antibiotics, including tigecycline and rifampicin, considered effective for *A. baumannii*. Nor were we able to assess use of multidrug therapy for VAP.

The main importance of our results is that they reveal the principal species causing nosocomial VAP in HHA ICUs; the most recent previous study in 2002[46] was able to identify microbial genera but not species. Identifying pathogen antibiotic resistance in our facilities will support drug resistance monitoring in future research, and thus may contribute to improved treatment planning.

CONCLUSIONS

Prevalence of antibiotic resistance in bacteria causing VAP is of great concern. Colistin is the drug of choice among the antibiotics reviewed, but sensitivity to other drugs should be assessed to search for more appropriate broad-spectrum antibiotics to treat VAP patients. Our results suggest the need for strengthened infection control efforts in the ICUs, and for reassessing compliance with quality control procedures. Multidisciplinary research involving microbiologists, epidemiologists, internists and intensivists is needed to fully understand the etiological agents and resistance patterns observed.

ACKNOWLEDGMENTS

The authors thank the HHA department of hygiene and epidemiology for providing data. 

REFERENCES

1. Hechavarría JC, Suárez R, Armaignac G, del Pozo C. Infección nosocomial en la Unidad de Cuidados Intensivos. MEDISAN. 2001;5(4):12–7. Spanish.
2. Yu VL, Singh N. Excessive antimicrobial usage causes measurable harm to patients with suspected ventilator-associated pneumonia. Intensive Care Med. 2004 May;30(5):735–8.
3. Peleg AY, Hooper DC. Hospital-acquired infections due to gram-negative bacteria. N Engl J Med. 2010 May 13;362(19):1804–13.
4. Chastre J, Fagon JY. Ventilator-associated pneumonia. Am J Respir Crit Care Med. 2002 Apr 1;165(7):867–903.
5. Díaz E, Lorente L, Valles J, Rello J. Neumonía asociada a la ventilación mecánica. Med

- Intensiva. 2010 Jun-Jul;34(5):318–24. Spanish.
6. Tao L, Hu B, Rosenthal VD, Zhang Y, Gao X, He L. Impact of a multidimensional approach on ventilator-associated pneumonia rates in a hospital of Shanghai: Findings of the International Nosocomial Infection Control Consortium. *J Crit Care*. 2012 Oct;27(5):440–6.
 7. Comunidad Científica Internacional de Control de Infecciones Nosocomiales [Internet]. Buenos Aires: Comunidad Científica Internacional de Control de Infecciones Nosocomiales; c2008 [cited 2012 Nov 1]. Available from: <http://www.inicc.org/espanol/contacto.php>. Spanish.
 8. Ortiz G, Fonseca N, Molina F, Garay M, Lara A, Dueñas C. Epidemiología de la neumonía asociada a ventilador en 39 unidades de cuidados intensivos de Colombia (2007-2009). Informe año 2010. *Acta Colombiana Cuidado Intens*. 2011;11(1):12–9. Spanish.
 9. Kübler A, Duszynska W, Rosenthal VD, Fleischer M, Kaiser T, Szewczyk E, et al. Device-associated infection rates and extra length of stay in an intensive care unit of a university hospital in Wrocław, Poland: International Nosocomial Infection Control Consortium's (INICC) findings. *J Crit Care*. 2012 Feb;27(1):105.e5–10.
 10. Ramírez M, Fernández B, Cruz A, Jardines E, Bermúdez Y. Comportamiento de las infecciones nosocomiales en Unidad de Cuidados Intensivos en un quinquenio (2005–2009). *MediSur*. 2011;9(5):40–6. Spanish.
 11. Frómata I, Izquierdo F, López M. Infecciones nosocomiales en un hospital del tercer nivel. Experiencia de 5 años. *Rev Cubana Med*. 2008 Jul–Sep;47(3). Spanish.
 12. Fica CA, Cifuentes DM, Hervé EB. Actualización del Consenso "Neumonía asociada a ventilación mecánica". Primera parte. Aspectos diagnósticos. *Rev Chilena Infect*. 2011 Apr;28(2):130–51. Spanish.
 13. Medell M, Hart M, Marrero O, Espinosa F, Montes de Oca Z, Valdés R. Clinical and microbiological characterization of pneumonia in mechanically ventilated patients. *Braz J Infect Dis*. 2012;16(5):442–7.
 14. Baker JJ, Lambert RL, Poulos KM, Feldman JL. Managing the cost of care: a predictive study to identify critical care patients at risk for nosocomial pneumonia. *J Health Care Finance*. 2000 Spring;26(3):73–82.
 15. Espinosa F, Hart M, Halley MC, Zamora R. Control multidisciplinario de la infección nosocomial en un hospital de nivel terciario. *Rev Cubana Med*. 2011;50(1):100–10. Spanish.
 16. Larrondo HM. Infección por bacilos Gram-negativos no fermentadores. Problemática en las unidades de cuidados intensivos. *Rev Habanera Cienc Méd*. 2011;9(5):78–82. Spanish.
 17. Tafur JD, Torres JA, Villegas MV. Mechanisms of antibiotic resistance in Gram negative bacteria. *Infect*. 2008 Jul–Sep;12(3):120–4.
 18. Hesses MT, Kaye D. Nosocomial pneumonia. *Crit Care Clin*. 1998 Apr;4(2):245–57.
 19. BIOMERIEUX [Internet]. Marcy l'Etoile (FR): bioMérieux S.A.; c1996–2012. VITEK® 2 Compact; 2012 [cited 2012 Oct 12]; [about 2 screens]. Available from: http://www.biomerieux-diagnostics.com/servlet/srt/bio/clinical-diagnostics/dynPage?open=CNL_CLN_PRD&doc=CNL_PRD_CPL_G_PRD_CLN_64&pubparams.sform=1&lang=en
 20. Procedimientos de Microbiología. Hospital Hermanos Ameijeiras [Internet]. Havana: Hermanos Ameijeiras Hospital; c2012 [cited 2011 Dec]. Available from: <http://www.hha.sld.cu>. Spanish.
 21. Galen Lab. Softel. Empresa de Software Cubana. Ministerio de Informática y Comunicaciones [Internet]. Havana: Ministry of Education (CU); c2012 [cited 2012 Oct 12]; [about 2 screens]. Available from: <http://www.eured.cu/index.php/Softel>. Spanish.
 22. Solución informática integral para la atención primaria de salud [Internet]. Havana: Softel; [date unknown] [cited 2012 Oct 12]. 28 p. Available from: <http://www.di.sld.cu/Oferas/presentaciones/Presntaci%C3%B3n%20sistemas%20para%20APS.pdf>. Spanish.
 23. Valentine SC, Contreras D, Tan S, Real LJ, Chu S, Xu HH. Phenotypic and molecular characterization of *Acinetobacter baumannii* clinical isolates from nosocomial outbreaks in Los Angeles County, California. *J Clin Microbiol*. 2008 Aug;46(8):2499–507.
 24. Liu SY, Lin JY, Chu C, Su LH, Lin TY, Chiu CH. Integron-associated imipenem resistance in *Acinetobacter baumannii* isolated from a regional hospital in Taiwan. *Int J Antimicrob Agents*. 2006 Jan;27(1):81–4.
 25. Naas T, Levy M, Hirschauer C, Marchandin H, Nordmann P. Outbreak of carbapenem-resistant *Acinetobacter baumannii* producing the carbapenemase OXA-23 in a tertiary care hospital of Papeete, French Polynesia. *J Clin Microbiol*. 2005 Sep;43(9):4826–9.
 26. Borer A, Gilad J, Smolyakov R, Eskira S, Peled N, Porat N, et al. Cell phones and *Acinetobacter* transmission. *Emerg Infect Dis*. 2005 Jul;11(7):1160–1.
 27. Giamarellou H, Antoniadou A, Kanellakopoulou K. *Acinetobacter baumannii*: a universal threat to public health? *Int J Antimicrob Agents*. 2008 Aug;32(2):106–19.
 28. Karageorgopoulos DE, Falagas ME. Current control and treatment of multidrug-resistant *Acinetobacter baumannii* infections. *Lancet Infect Dis*. 2008 Dec;8(12):751–62.
 29. Cortiñas Sáenz M, Lizán García M, Jiménez-Vizuete JM, Moreno Cuesta J, Cuesta García J, Peyro R. Incidencia de las neumonías nosocomiales precoces y tardías asociadas a ventilación mecánica en una unidad de reanimación críticos polivalente. *Rev Esp Anestesiol Reanim*. 2007 Mar;54(3):147–54. Spanish.
 30. Kollef MH, Morrow LE, Niederman MS, Leeper KV, Anzueto A, Benz-Scott L, et al. Clinical characteristics and treatment patterns among patients with ventilator-associated pneumonia. *Chest*. 2006 May;129(5):1210–8.
 31. Agbaht K, Díaz E, Muñoz E, Lisboa T, Gomez F, Depuydt PO, et al. Bacteremia in patients with ventilator-associated pneumonia is associated with increased mortality: a study comparing bacteremic vs nonbacteremic ventilator-associated pneumonia. *Crit Care Med*. 2007 Sep;35(9):2064–70.
 32. Kollef MH, Afessa B, Anzueto A, Veremakis C, Kerr KM, Margolis BD, et al. NASCENT Investigation Group. Silver-coated endotracheal tubes and incidence of ventilator-associated pneumonia: the NASCENT randomized trial. *JAMA*. 2008 Aug 20;300(7):805–13.
 33. Niederman MS, Mantovani R, Schock P, Pappas J, Fein AM. Patterns and routes of tracheobronchial colonization in mechanically ventilated patients: the role of nutritional status in colonization of the lower airway by *Pseudomonas* species. *Chest*. 1989 Jan;95(1):155–61.
 34. Vallésa J, Mariscal D. Neumonía por *Pseudomonas aeruginosa*. *Enferm Infecc Microbiol Clin*. 2005;23(Suppl 3):30–6. Spanish.
 35. Ostos OL, Cifuentes Y, Hernández R, Muñoz L. Neumonía Nosocomial. *NOVA*. 2006 Jun–Dec;4(6):94–9. Spanish.
 36. Quintanilla JA, Orellana R, Alfaro C. Perfil microbiológico de infecciones nosocomiales en la Unidad de Terapia Intensiva del Hospital Clínico Viedma. *Gac Méd Bol*. 2011;34(1):50–5. Spanish.
 37. Labaut N, Riera R, Pérez I, Castañeda Y. Neumonía asociada a la ventilación mecánica en una unidad de cuidados intensivos. *MEDISAN*. 2011;15(12):17–59. Spanish.
 38. Manning ML, Archibald LK, Bell LM, Banerjee SN, Jarvis WR. *Serratia marcescens* transmission in a pediatric intensive care unit: a multifactorial occurrence. *Am J Infect Control*. 2001 Apr;29(2):115–9.
 39. López-Pueyo MJ, Barcenilla-Gaite F, Amaya-Villar R, Garnacho-Montero J. Multiresistencia antibiótica en unidades de críticos. *Med Intensiva*. 2011 Jan–Feb;35(1):100–10. Spanish.
 40. Speller DC. The clinical impact of antibiotic resistance. *J Antimicrob Chemother*. 1988 Nov;22(5):583–6.
 41. Kofteridis DP, Alexopoulou C, Valachis A, Maraki S, Dimopoulou D, Georgopoulos D, et al. Aerosolized plus intravenous colistin versus intravenous colistin alone for the treatment of ventilator-associated pneumonia: A matched case-control study. *Clin Infect Dis*. 2010 Dec 1;51(11):1238–44.
 42. Pérez-Pedrero MJ, Sánchez-Casado M, Rodríguez-Villar S. [Nebulized colistin treatment of multi-resistant *Acinetobacter baumannii* pulmonary infection in critical ill patients]. *Med Intensiva*. 2011 May;35(4):226–31. Spanish.
 43. Poirel L, Nordmann P. Carbapenem resistance in *Acinetobacter baumannii*: mechanisms and epidemiology. *Clin Microbiol Infect*. 2006 Sep;12(9):826–36.
 44. Alarcón T, López-Brea M, García Peñuela E, Aznar E. Patrón de sensibilidad de aislamientos clínicos de *Acinetobacter baumannii* en Madrid vs. Hong Kong. *Rev Esp Quimioter*. 2006;19(1):45–50. Spanish.
 45. Hart M, Espinosa F, Halley MC, Martínez ML, Montes de Oca Z. Resistencia a antibióticos en cepas de *Acinetobacter baumannii* aisladas de enero a marzo del 2010 en el Hospital Clínico Quirúrgico "Hermanos Ameijeiras". *Rev Cubana Med*. 2010;49(3):218–27. Spanish.
 46. González JG, Lescay M, Machado A, Pardo A, Ortiz M. Neumonía Nosocomial. Resultado de un año de trabajo en la UCI del Hospital Hermanos Ameijeiras. *Rev Cub Med Int Emerg*. 2002;1:32–41. Spanish.

THE AUTHORS

Manuel Medell Gago (corresponding author: dcuetoc@infomed.sld.cu), microbiologist and health technologist, department of microbiology, Hermanos Ameijeiras Clinical-Surgical Teaching Hospital (HHA), Havana, Cuba.

Marcia Hart Casares, medical microbiologist, microbiology department, HHA, Havana, Cuba.

Amílcar Duquesne Alderete, microbiology resident, Pedro Kourí Tropical Medicine Institute, Havana, Cuba.

Fidel Espinosa Rivero, medical microbiologist, microbiology department, HHA, Havana, Cuba.

Rodolfo Valdés Véliz, biologist with a doctorate in biochemistry, Genetic Engineering and Biotechnology Center, Havana, Cuba.

Submitted: February 7, 2012

Approved for publication: April 18, 2013

Disclosures: None