Acinetobacter spp. as Nosocomial Pathogens: Microbiological, Clinical, and Epidemiological Features

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INTRODUCTION

The control of hospital-acquired infection caused by multiply resistant gram-negative bacilli has proved to be a particular problem over the last 20 years in developed countries. An increasing incidence during the 1970s of resistant members of the family Enterobacteriaceae involved in nosocomial infections was followed by the therapeutic introduction of newer broad-spectrum antibiotics in hospitals and a subsequent increase in the importance of strictly aerobic gram-negative bacilli, including Pseudomonas aeruginosa, Stenotrophomonas (Xanthomonas) maltophilia, and Acinetobacter spp.

Of these “newer” pathogens, it is now recognized that Acinetobacter spp. play a significant role in the colonization and infection of patients admitted to hospitals. They have been implicated in a variety of nosocomial infections, including bacteremia, urinary tract infection, and secondary meningitis, but their predominant role is as agents of nosocomial pneumonia, particularly ventilator-associated pneumonia in patients confined to hospital intensive care units (ICUs). Such infections are often extremely difficult for the clinician to treat because of the widespread resistance of these bacteria to the major groups of antibiotics. Various mechanisms of antibiotic resistance have been recognized in these bacteria, and combination therapy is usually required for effective treatment of Acinetobacter nosocomial infections. These therapeutic difficulties are coupled with the fact that these bacteria have a significant capacity for long-term survival in the hospital environment, with corresponding enhanced opportunities for transmission between patients, either via human reservoirs or via inanimate materials.

Despite the increasing significance and frequency of multiply resistant Acinetobacter infections, many clinicians still lack an appreciation of the potential importance of these organisms in hospitals, in part because of the confused taxonomic status which, until recently, was associated with these organisms. However, new molecular identification and typing methods for members of this genus have now been developed, and these should form a rational scientific foundation for proper epidemiological studies of genotypically related strains involved in outbreaks of hospital infection. Although some rare cases of community-acquired infections caused by Acinetobacter spp. have been reported, the primary pathogenic role of these bacteria is undoubtedly as nosocomial pathogens in hospitals. The purpose of this review is to summarize the current state of knowledge regarding Acinetobacter spp. in relation to this role, including their taxonomy, identification, microbiology, epidemiology, infections, and resistance to antibiotics and the potential therapeutic approaches. Interested readers are also referred to the recent thesis published by Gerner-Smidt (63).

TAXONOMY

Historical Features

Bacteria now classified as members of the genus Acinetobacter have suffered a long history of taxonomic change. The original concept of the genus Acinetobacter (27, 28, 151) included a heterogeneous collection of nonmotile, gram-negative, oxidase-positive, and oxidase-negative saprophytes that could be distinguished from other bacteria by their lack of pigment (89). Extensive nutritional studies (14) showed clearly that the oxidase-negative strains differed from the oxidase-positive strains, and in 1971, the Subcommittee on the Taxonomy of Moraxella and Allied Bacteria recommended that the genus Acinetobacter comprise only oxidase-negative strains (119). This division has been supported by the use of transfor-

mation tests (104), which have now been used for over two decades as the basis for inclusion of individual isolates within the genus.

Gram-negative, nonfermentative bacteria currently recognized as belonging to the genus Acinetobacter have been classified previously under at least 15 different “generic” names, the best known of which are Bacterium antratium (171), Herellea vaginicola and Mima polymorpha (42); Achromobacter, Alcaligenes, Micrococcus calcoaceticus, and “BSW” (105); and Moraxella glucidolytica and Moraxella lwoffii (27, 151). It is only relatively recently that rational taxonomic proposals for these organisms have emerged, and delineation of species within the genus is still the subject of research (see below).

Current Taxonomic Status

The genus Acinetobacter is now defined as including gram-negative (but sometimes difficult to destain) coccobaci, with a DNA G+C content of 39 to 47 mol%, that are strictly aerobic, nonmotile, catalase positive, and oxidase negative. Good growth occurs on complex media between 20 and 30°C without growth factor requirements, while nitrates are reduced only rarely. Crucially, extracted DNA is able to transform mutant strain BD413 trpE27 to the wild-type phenotype (104). Most Acinetobacter strains can grow in a simple mineral medium containing ammonium or nitrate salts and a single carbon and energy source such as acetate, lactate, or pyruvate.

Bergey’s Manual of Systematic Bacteriology classified the genus Acinetobacter in the family Neisseriaceae (106), with one species, Acinetobacter calcoaceticus. This “species” has often been subdivided in the literature into two subspecies, subsp. antratus (formerly Herellea vaginicola) and subsp. lwoffii (formerly Mima polymorpha) (81, 105), but this arrangement has never been formally approved by taxonomists. More recent taxonomic developments have resulted in the proposal that members of the genus should be classified in the new family Moraxellaceae, which includes Moraxella, Acinetobacter, Psychrobacter, and related organisms (164) and which constitutes a discrete phylogenetic branch in superfamily II of the Proteobacteria on the basis of 16S rRNA studies and rRNA-DNA hybridization assays (163, 216). Further details of the laboratory identification of members of the genus Acinetobacter are given in a later section.

Delineation of Species

Traditionally, a microbial species has been considered to be a group of strains that show a high degree of similarity in terms of their phenotypic properties. However, it is now generally accepted that nucleic acid hybridization and sequencing studies provide the best available and most rational methods for designating species and determining relationships between different organisms. A formal molecular definition of a species has been proposed (224); it states that a species should include strains with approximately 70% or greater DNA-DNA relatedness and 5°C or less divergence values (ΔTm). Genomic species that can be differentiated by phenotypic properties can then be given a formal species name.

Although it was known from early DNA hybridization experiments performed by a nitrocellulose filter method that the genus Acinetobacter was heterogeneous (92), only two species, A. calcoaceticus and A. lwoffii, were included in the Approved Lists of Bacterial Names (184) and only one species was described in Bergey’s Manual of Systematic Bacteriology (106). On the basis of the DNA relatedness criteria outlined above, 19 DNA-DNA homology groups (genomic species) have now been recognized within the genus (23, 25, 138, 196), although
outbreaks of infection (47), while *A. johnsonii* has been associated with catheter-related bacteremia (177). A study in Sweden found that *Acinetobacter* genomic species 3 was predominant among clinical isolates (196).

It is worth re-emphasizing the close relationship between genomic species 1 (*A. calcoaceticus*), 2 (*A.baumannii*), 3, and 13TU. This *A. calcoaceticus-A. baumannii* complex (66, 108) contains isolates that are mostly glucose acidifying, and the complex therefore corresponds quite well to the *A. calcoaceticus* subspp. *anitatus* designation that is, regrettably, still used in some new reports. Early studies demonstrated that these organisms, identified originally as *Mima* and *Herellea vaginicola*, are members of the human skin flora (192). The majority of glucose-negative, nonhemolytic strains found in clinical specimens seem to be identified mainly as *A. lwofii, A. johnsonii*, or *Acinetobacter* genomic species 12, and it seems that these species are also natural inhabitants of human skin. Most hemolytic isolates are identified as *A. haemolyticus* or *Acinetobacter* genomic species 6. Other groups seem to be implicated only occasionally in human infections.

In conclusion, although *A. baumannii* appears to be the *Acinetobacter* genomic species of greatest clinical importance, repeated isolation of another genomic species (particularly one belonging to the *A. calcoaceticus-A. baumannii* complex) from a patient should be a cause for suspicion of infection, especially if clinical symptoms are also present.

**LABORATORY IDENTIFICATION**

**Isolation from Clinical Specimens**

*Acinetobacters* can be grown readily on common laboratory media such as nutrient agar and tryptic soy agar, although defined media consisting of a mineral base containing ammonium or nitrate salts and one or more carbon sources have been used for specific purposes (14, 23, 24, 66, 105, 108). However, for direct isolation from clinical specimens, it is more useful to use a selective medium that suppresses the growth of other microorganisms. A selective and differential medium containing bile salts, sugars, and bromocresol purple (122) is available commercially as Herellea agar (Difco). This has been modified by the addition of various antibiotics (85), and the addition of antibiotics to more common media has also been used in the investigation of several outbreaks of *Acinetobacter* spp. isolated from clinical sources*

<table>
<thead>
<tr>
<th>Genomic species</th>
<th>Tracheal aspirate</th>
<th>Blood culture and central venous line</th>
<th>Wound swab</th>
<th>Other sites</th>
<th>Total no.</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>A. baumannii</em></td>
<td>208</td>
<td>113</td>
<td>70</td>
<td>35</td>
<td>426</td>
</tr>
<tr>
<td>Sp. 3</td>
<td>6</td>
<td>24</td>
<td>10</td>
<td>15</td>
<td>55</td>
</tr>
<tr>
<td><em>A. johnsonii</em></td>
<td>0</td>
<td>19</td>
<td>2</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td><em>A. lwofii</em></td>
<td>2</td>
<td>12</td>
<td>2</td>
<td>5</td>
<td>21</td>
</tr>
<tr>
<td><em>A. junii</em></td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td><em>A. haemolyticus</em></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Sp. 10</td>
<td>0</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>Sp. 11</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Sp. 12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sp. 6</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Unidentified</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>218</td>
<td>191</td>
<td>90</td>
<td>85</td>
<td>584</td>
</tr>
</tbody>
</table>

* Data from reference 172.

**TABLE 2. Distribution of *Acinetobacter* spp. isolated from clinical sources**

<table>
<thead>
<tr>
<th>Species name</th>
<th>Genomic species number according to:</th>
<th>Type strain</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>A. calcoaceticus</em></td>
<td>1 1 1N</td>
<td>ATCC 23055</td>
</tr>
<tr>
<td><em>A. baumannii</em></td>
<td>2 2 1N</td>
<td>CIP 70.34</td>
</tr>
<tr>
<td>UN</td>
<td>3 3 NT</td>
<td>ATCC 19004</td>
</tr>
<tr>
<td>UN</td>
<td>4UG 13TU NT</td>
<td>ATCC 17903</td>
</tr>
<tr>
<td><em>A. haemolyticus</em></td>
<td>4 4 4N</td>
<td>ATCC 17906</td>
</tr>
<tr>
<td><em>A. junii</em></td>
<td>5 5 NT</td>
<td>ATCC 17908</td>
</tr>
<tr>
<td>UN</td>
<td>6 6 4N</td>
<td>ATCC 17979</td>
</tr>
<tr>
<td><em>A. johnsonii</em></td>
<td>7 7 3N</td>
<td>ATCC 17909</td>
</tr>
<tr>
<td><em>A. lwofii</em></td>
<td>8 8TU 2N</td>
<td>ATCC 15309</td>
</tr>
<tr>
<td>UN</td>
<td>9 9TU NT</td>
<td>ATCC 9957</td>
</tr>
<tr>
<td>UN</td>
<td>10 10 UG</td>
<td>ATCC 17924</td>
</tr>
<tr>
<td>UN</td>
<td>11 11 UG</td>
<td>ATCC 11171</td>
</tr>
<tr>
<td><em>A. radioresistens</em></td>
<td>(12)12 5N</td>
<td>IAM 13186</td>
</tr>
<tr>
<td>UN</td>
<td>13 14TU NT</td>
<td>ATCC 17905</td>
</tr>
<tr>
<td>UN</td>
<td>14 NT NT</td>
<td>Bouvet 382</td>
</tr>
<tr>
<td>UN</td>
<td>15 NT NT</td>
<td>Bouvet 240</td>
</tr>
<tr>
<td>UN</td>
<td>16 UG NT</td>
<td>ATCC 17988</td>
</tr>
<tr>
<td>UN</td>
<td>17 NT NT</td>
<td>Bouvet 942</td>
</tr>
<tr>
<td>UN</td>
<td>NT 15TU NT</td>
<td>Tjernberg 151a</td>
</tr>
</tbody>
</table>

* UN, unnamed genomic species.  
* NT, not tested; UG, ungrouped.  
* Unpublished result.

there are some minor discrepancies in the numbering schemes proposed for genomic species by different laboratories (Table 1) and a definitive numbering scheme has yet to be finally agreed. Seven of the genomic species have been given formal species names, with the species *A. radioresistens* (137) being shown to be equivalent to genomic species 12 (196). Groups 1, 2, 3, and 13TU (196) have been shown to have an extremely close relationship and are referred to by some research groups as the *A. calcoaceticus-A. baumannii* complex (66). There is still a need for a rapid and reliable method of assigning new isolates to individual genomic species.

**Species of Clinical Importance**

Numerous studies have now supported the original observation (24) that *A. baumannii* is the main genomic species associated with outbreaks of nosocomial infection. In a typical study of 584 *Acinetobacter* strains isolated from 420 patients at 12 different hospitals over a 12-month period (172), 426 (72.9%) strains were identified as *A. baumannii*, with 208 *A. baumannii* isolates being recovered from respiratory tract specimens, 113 being recovered from blood cultures and central venous lines, 70 being recovered from wound swabs, and 35 being recovered from other miscellaneous specimens (Table 2). This large study also identified 158 isolates that belonged to species other than *A. baumannii*, of which the most common were *Acinetobacter* genomic species 3 (55 isolates), *A. johnsonii* (29 isolates), and *A. lwofii* (21 isolates).

Further investigations are required to define the clinical significance of *Acinetobacter* spp. other than *A. baumannii*. Such isolates in clinical specimens are often considered to be contaminants derived from the environment. Diagnosis of infection with “unusual” *Acinetobacter* genospecies therefore often depends on clinical indications and repeated isolation of the same strain from a single patient. *Acinetobacter* genomic species 3 and 13TU (196) have been implicated in nosocomial infections(47), while *A. johnsonii* has been associated with catheter-related bacteremia (177). A study in Sweden found that *Acinetobacter* genomic species 3 was predominant among clinical isolates (196).

It is worth re-emphasizing the close relationship between genomic species 1 (*A. calcoaceticus*), 2 (*A. baumannii*), 3, and 13TU. This *A. calcoaceticus-A. baumannii* complex (66, 108) contains isolates that are mostly glucose acidifying, and the complex therefore corresponds quite well to the *A. calcoaceticus* subspp. *anitatus* designation that is, regrettably, still used in some new reports. Early studies demonstrated that these organisms, identified originally as *Mima* and *Herellea vaginicola*, are members of the human skin flora (192). The majority of glucose-negative, nonhemolytic strains found in clinical specimens seem to be identified mainly as *A. lwofii, A. johnsonii*, or *Acinetobacter* genomic species 12, and it seems that these species are also natural inhabitants of human skin. Most hemolytic isolates are identified as *A. haemolyticus* or *Acinetobacter* genomic species 6. Other groups seem to be implicated only occasionally in human infections.

In conclusion, although *A. baumannii* appears to be the *Acinetobacter* genomic species of greatest clinical importance, repeated isolation of another genomic species (particularly one belonging to the *A. calcoaceticus-A. baumannii* complex) from a patient should be a cause for suspicion of infection, especially if clinical symptoms are also present.
bacter infection (7, 29). A novel antibiotic-containing selective medium that combines selectivity with differential characteristics has recently been described (90), and this medium, Leeds Acinetobacter Medium, is useful for the recovery of most Acinetobacter spp. from both clinical and environmental sources. For environmental screening, especially in areas where acinetobacters may be present in only small numbers, liquid enrichment cultivation may also be useful (13). Specimens contaminated with a variety of microorganisms can be used to inoculate a liquid mineral medium containing a single carbon and energy source and ammonium or nitrate salt as the nitrogen source, with a final pH of 5.5 to 6.0. Vigorous shaking during incubation is needed so that any acinetobacters present can outgrow any pseudomonads. After incubation for 24 to 48 h, a loopful of the culture broth is inoculated on to a selective medium and any presumptive Acinetobacter colonies are identified further. This method has been used to recover acinetobacters from fecal specimens (79) and from various clinical and environmental specimens (49).

Clinical isolates, which belong mostly to genomic species 2 (A. baumannii), 3, or 13TU (Table 1), grow at 37°C or higher, but some other genomic species will grow only at lower temperatures. A general cultivation temperature of 30°C has been recommended (88), but a lower temperature or combination of temperatures may be advisable, depending on the type and origin of the specimen.

Morphological, Cultural, and Metabolic Characteristics

Acinetobacters are short, plump, gram-negative (but sometimes difficult to destain) rods, typically 1.0 to 1.5 by 1.5 to 2.5 μm in the logarithmic phase of growth but often becoming more coccoid in the stationary phase (Fig. 1). Pairing or clustering of cells often occurs. Gram stain variability, as well as variations in cell size and arrangement, can often be observed within a single pure culture (14). Acinetobacter spp. normally form smooth, sometimes mucoid, pale yellow to greyish-white colonies on solid media, although some environmental strains that produce a diffusible brown pigment have been described (143). The colonies are comparable in size to those of enterobacteria. All members of the genus are strict aerobes, oxidase negative, catalase positive, and nonfermentative. It is the negative oxidase test that serves as a rapid presumptive test to distinguish Acinetobacter spp. from otherwise similar nonfermentative bacteria. Most strains are unable to reduce nitrate to nitrite in the conventional nitrate reduction assay. Some clinical isolates, particularly those belonging to genomic species 4 (A. haemolyticus), may show hemolysis on sheep blood agar plates. Although rare Acinetobacter strains showing growth factor requirements have been isolated (14, 223), most strains can grow in a simple mineral medium containing a single carbon and energy source. A wide variety of organic compounds can be used as carbon sources, although relatively few strains can use glucose (14), but no single metabolic test enables unambiguous differentiation of this genus from other similar bacteria. Such unambiguous identification relies currently on the ability of extracted DNA to restore the wild-type phenotype to mutant Acinetobacter strain BD413 trpE27 in a transformation assay (104).

Species Identification

The division of Acinetobacter isolates into genomic species is based on DNA-DNA relatedness. Several different DNA hybridization methods have been used, including a nitrocellulose filter method (92), the S1 endonuclease method (23), the hydroxyapatite method (196), and a quantitative bacterial dot filter method (195). The last method is probably the simplest, but all of these methods are laborious and unsuitable for use in routine microbiology laboratories.

A scheme of 28 phenotypic tests that claimed to discriminate between 11 of the initial 12 genomic species described was originally proposed (23), although only 74 of the 255 strains included in the identification matrix were also allocated to genomic species by DNA-DNA hybridization. Subsequently, a simplified scheme of 16 tests which, except for tests for glucose acidification and detection of hemolysis on sheep blood agar, comprised growth temperature and carbon source utilization.
tests was described (24). However, when tested against 198 strains identified by DNA-DNA hybridization (66), only 78% of the strains were identified correctly, with differentiation between the closely related glucose-accumulating genomic species 1, 2, 3, and 13TU (the A. calcoaceticus-A. baumannii complex) being particularly difficult. A more detailed and successful phenotypic identification scheme has been described (108), but it seems that single or even a few tests cannot be used for unambiguous phenotypic identification of the different genomic species.

As far as commercial identification systems are concerned, the widely used API 20NE system, based largely on carbon source assimilation tests, contained only A. baumannii, A. haemolyticus, and A. Iwoffi in the 1993 database release, together with A. junii and A. johnsonii as a combination, whereas the type species A. calcoaceticus and the other genomic species were not included at all. This system sometimes has problems with sensitivity and reproducibility (113), and the differences between the genomic species are so slight that a reliable identification seems unrealistic. Indeed, two studies comparing the API 20NE system with species identification by DNA-DNA hybridization have demonstrated a poor correlation (87, 226).

Identification of the clinically relevant genomic species 2 (A. baumannii), 3, and 13TU by API 20NE is particularly difficult. Another commercial system, Biolog, differentiates bacteria on the basis of their oxidation of 95 different carbon sources. Promising results with this system have been obtained for 129 Acinetobacter strains identified by DNA-DNA hybridization (21), but further refinement of the database is clearly required.

Phenotypic identification methods for individual Acinetobacter species are not totally reliable (225), and this can be a source of confusion in clinical microbiology laboratories. To avoid future problems in interpretation of the scientific literature, it is important that persons working with Acinetobacter spp. state the precise species identification method used and indicate clearly that identifications are presumptive when this is appropriate.

To avoid the problems with phenotypic species identification, new molecular identification methods are currently being evaluated against DNA-DNA hybridization. Ribotyping studies of strains belonging to the A. calcoaceticus-A. baumannii complex have shown that this method can generate patterns that are specific for particular genomic species (62). Similarly, restriction analysis of 16S rRNA genes amplified by PCR has indicated that a combination of patterns generated by five restriction enzymes can be used to discriminate most genomic species, including genomic species 1, 2, 3, and 13TU (215), while PCR amplification of 16S-23S spacer regions resolved 15 of 17 genomic species (139).

**NOSOCOMIAL INFECTIONS CAUSED BY ACINETOBACTER SPP.**

**Overview**

Although A. baumannii is now recognized to be the Acinetobacter genomic species of greatest clinical importance, it is difficult to extrapolate the older literature to say with certainty what a culture reported in 1980 as A. anitratus would now be called. Even today, many reports of infection caused by “A. baumannii” do not include the necessary tests for specific rather than presumptive identification. Given this qualification, Acinetobacter spp. have been isolated from various types of opportunistic infections, including septicaemia, pneumonia, endocarditis, meningitis, skin and wound infection, and urinary tract infection (19, 56, 96, 135). The distribution by site of Acinetobacter infection does not differ from that of other nosocomial gram-negative bacteria, with the main sites of infection in several surveys (69, 96, 101, 102) being the lower respiratory tract and the urinary tract. Acinetobacter species have emerged as particularly important organisms in ICUs (18, 60, 80, 136, 182, 183, 214), and this is probably related, at least in part, to the increasingly invasive diagnostic and therapeutic procedures used in hospital ICUs over the last two decades.

The true frequency of nosocomial infection caused by Acinetobacter spp. is not easy to assess, partly because the isolation of these organisms from clinical specimens may not necessarily reflect infection but, rather, may result from colonization (190). Acinetobacter species accounted for 1.4% of all nosocomial infections during a 10-year period (1971 to 1981) in a university hospital in the United States (117), with the principal sites and types of infection including the respiratory tract, bacteremia, peritonitis, urinary tract infection, surgical wounds, meningitis, and skin or eye infection. A more recent study in a university hospital found that hospitalization in an ICU and previous administration of antibiotics were associated with Acinetobacter colonization at various body sites in 3.2 to 10.8 per 1,000 patients, with Acinetobacter infection accounting for 0.3% of endemic nosocomial infections in critically ill patients and for 1% of nosocomial bacteremia hospital-wide (190). These figures are in agreement with previous observations (33). One study has reported a seasonal incidence of Acinetobacter infection (157), with an increase in infection rates in late summer and early winter—a difference that could be related to temperature and humidity changes but one that has not yet been confirmed by other studies.

**Respiratory Infection**

Numerous outbreaks of nosocomial pulmonary infection caused by Acinetobacter spp. in ICUs have now been described (18, 30–32, 40, 80, 189, 214), and the role played by Acinetobacter spp. in ventilator-associated pneumonia appears to be increasing. Regardless of the bacteriological method used to define the cause of pneumonia precisely, several studies have reported that about 3 to 5% of nosocomial pneumonias are caused by Acinetobacter spp. (33, 38). In patients with pneumonia enrolled in the National Nosocomial Infection Study (170), this organism accounted for 4% of the total number of pulmonary infections from 1990 to 1992.

Using specific diagnostic techniques, several recent investigators have demonstrated the increasing role played by Acinetobacter spp. (probably A. baumannii) in nosocomial pneumonia for the subset of ICU patients requiring mechanical ventilation. In studies in which only mechanically ventilated patients were included and bacteriological studies were restricted to uncontaminated specimens obtained by bronchoscopic techniques (54, 197), 15 and 24%, respectively, of all episodes of pneumonia included at least one Acinetobacter sp. Although other studies have reported lower infection frequencies of 3 to 5% (33, 38), these data suggest clearly that nosocomial pneumonia caused by Acinetobacter spp. is now emerging as a prominent complication of mechanical ventilation. Interestingly, this increased incidence has occurred despite many major advances in the management of ventilator-dependent patients and the routine use of effective procedures to disinfect respiratory equipment.

A number of factors have been suspected or identified as increasing the risk of pneumonia or colonization of the lower respiratory tract by Acinetobacter spp.; in the ICU, these include advanced age, chronic lung disease, immunosuppression, surgery, use of antimicrobial agents, presence of invasive de-
sives such as endotracheal and gastric tubes, and type of respiratory equipment (18, 30, 31, 120, 146, 190).

To try to better define the link between the use of ventilators and pneumonia caused by A. baumannii, 159 consecutive patients who received mechanical ventilation for >72 h in a medical-surgical ICU over a 13-month period were studied (211). Fiberoptic bronchoscopy with protected-specimen brush and bronchoalveolar lavage was performed on each patient suspected of having pneumonia because of the presence of a new pulmonary infiltrate, fever, and purulent tracheal secretions, but the diagnosis of pulmonary infection was retained only if protected-specimen brush and/or bronchoalveolar lavage specimens grew \( \geq 10^2 \) and \( \geq 10^4 \) CFU of at least one microorganism per ml, respectively. By the criteria used in this study, nosocomial pneumonia associated directly with A. baumannii occurred in 19 (12%) of the 159 study patients, while the organism was present in 27% of ventilator-associated pneumonia cases diagnosed during this period.

Crude mortality rates of 30 to 75% have been reported for nosocomial pneumonia caused by Acinetobacter spp., with the highest rates reported in ventilator-dependent patients (18, 54, 197). It is therefore clear that the prognosis associated with this type of infection is considerably worse than that associated with other gram-negative or gram-positive bacteria, with the exception of P. aeruginosa. In a study of patients in which the diagnosis was retained only if protected-specimen brush specimens grew \( >10^3 \) CFU of at least one organism per ml (54), mortality associated with Pseudomonas or Acinetobacter pneumonia was >75%, compared with only 55% for pneumonia caused by other organisms \( P < 0.05 \).

Although these statistics indicate that nosocomial pneumonia caused by Acinetobacter spp. is a severe disease in ventilator-dependent patients, it is difficult to establish whether such critically ill patients would have survived if nosocomial pneumonia had not occurred. In a cohort study in which patients who had developed pneumonia caused by Acinetobacter spp. and other organisms were matched carefully with control subjects for the severity of underlying illness and other important variables, such as age, indication for ventilatory support, and duration of exposure to risk (55), the attributable mortality in cases of infection caused by nonfermentative organisms exceeded 40%, with a corresponding relative risk of death of 2.5.

Bacteremia

Although differentiation between blood specimen contamination by skin inhabitants and true bacteremia is sometimes rather difficult, the most common Acinetobacter species causing significant bacteremia is now identified as A. baumannii in most series of adult patients in whom proper species identification is made (172). Acinetobacter species may be found either as a single pathogen or as part of polymicrobial bacteremia. Immunosuppressed patients make up the largest group of adult patients. In these patients, the source of bacteremia is often a respiratory tract infection, with the highest rate of nosocomial bacteremia occurring during the second week of hospitalization. Malignant disease, trauma, and burns seem to be among the most common predisposing factors.

A second important group of patients may consist of neonates. One report from Japan described 19 neonates with Acinetobacter septicemia in the neonatal ICU over a period of 30 months. All cases were of late-onset type septicaemia in infants hospitalized for long periods, with a mortality rate of 11% (166). The predisposing risk factors for septicemia were low birth weight, previous antibiotic therapy, mechanical ventilation, and the presence of neonatal convulsions. A second report (135) described an outbreak of septicemia in a neonatal ICU which was confined to seven babies receiving parenteral nutrition. All babies had severe clinical symptoms and signs of septic shock, and five required ventilatory support, but they all recovered uneventfully after appropriate antibiotic therapy. In a more recent study from Israel (156), nine cases of Acinetobacter sepsis in a neonatal ICU were observed over a period of 31 months. The clinical course was fulminating in four babies who subsequently died. Thus, Acinetobacter spp. should be added to the list of organisms capable of causing severe nosocomial infection in neonatal ICUs.

As far as risk factors for adults are concerned, surgical wound infections caused by Acinetobacter spp. have been described, and such wound infections may lead to bacteremia. There are also a number of reports in the literature describing Acinetobacter bacteremia in burn patients (75, 78). Several studies have shown that there is a correlation between vascular catheterization and Acinetobacter infection (158, 177). Changing the catheter insertion site every 48 h and appropriate adherence to aseptic protocols may reduce the risk. An association between Acinetobacter bacteremia and the use of transducers for pressure monitoring has been reported (15), and prompt attention to sterilization techniques when handling equipment such as transducers may also reduce the infection rate. In general, the underlying disease seems to determine the prognosis of the patient. The prognosis of patients with malignant disease and burns is rather poor, but trauma patients have a better prognosis. Previous antibiotic treatment is associated with the selection of resistant strains (194).

Meningitis

Secondary meningitis is the predominant form of Acinetobacter meningitis, although sporadic cases of primary meningitis have been reported, particularly following neurosurgical procedures or head trauma (20). Until 1967, there were about 60 reported incidents of Acinetobacter meningitis, most of which were community acquired. However, since 1979, the vast majority of cases have been nosocomial infections, with almost all caused probably (but not definitely) by A. baumannii. Mortality rates from different series range from 20 to 27%. Most patients have been adult men and had undergone lumbar punctures, myelography, ventriculography, or other neurosurgical procedures, although one patient had posttraumatic otorrhea without intervention (183). A case of Acinetobacter meningitis associated with a ventriculoperitoneal shunt with concomitant tunnel infection in which A. baumannii was isolated from cerebrospinal fluid has been described (174). Risk factors include the presence of a continuous connection between the ventricles and the external environment, a ventriculostomy, or a cerebrospinal fluid fistula. In addition, the presence of an indwelling ventricular catheter for more than 5 days is an important risk factor. Another important predisposing factor is the heavy use of antimicrobial agents in the neurosurgical ICU. One outbreak subsided spontaneously only when the selective pressure of antibiotics was reduced (183).

A particularly interesting outbreak of Acinetobacter meningitis was described in a group of children with leukemia (110) following the administration of intrathecal methotrexate. Of the 20 children who received intrathecal methotrexate, 8 returned within 2 to 19 h of treatment with signs and symptoms of acute meningeal irritation. Acinetobacter organisms were isolated from the cerebrospinal fluid of five of these patients, as well as from the methotrexate solution. Three of the children died as a result of meningitis, and five recovered. The
outbreak was caused by the use of inappropriately sterilized needles.

Urinary Tract Infection

Nosocomial urinary tract infection is caused only infrequently by Acinetobacter spp. It occurs most commonly in elderly debilitated patients, in patients confined to ICUs, and in patients with permanent indwelling urinary catheters. Most patients (80%) tend to be men (148), perhaps reflecting the higher prevalence of indwelling urinary catheters in this population as a result of prostatic enlargement. It should, however, be noted that not every isolation of Acinetobacter spp. from the urinary tract of patients with an indwelling urinary catheter can be correlated with actual infection (84).

Other Miscellaneous Infections

A few very rare cases of native-valve infective endocarditis caused by Acinetobacter spp. have been reported (76). Dental procedures and open heart surgery have been identified as possible incidence events. Acinetobacter infective endocarditis does not differ clinically from infective endocarditis caused by other microorganisms, but there are wide variations in the presentation and clinical course of the disease.

Acinetobacter spp. can also cause peritonitis in patients undergoing continuous ambulatory peritoneal dialysis. It is difficult to be certain that all such episodes are nosocomial, but technique failure and diabetes mellitus are the main underlying risk factors. The mean duration of risk factors before the onset of peritonitis ranged from 2 to 13 months. The most common manifestations were abdominal pain or cloudy dialysate, but only a minority of patients had fever. Most patients respond to antibiotic therapy without the need to interrupt continuous ambulatory peritoneal dialysis (57, 121, 213).

Acinetobacter cholangitis and septic complications following percutaneous transhepatic cholangiogram and percutaneous biliary drainage have been reported, primarily among elderly patients with obstructive jaundice caused by malignant disease or choledochoolithiasis. In one study, 13.5% of patients undergoing transhepatic cholangiography or biliary drainage developed infection, with the most common isolates being Enterobacter cloacae and Acinetobacter spp. (165). Other, more rare case reports include typhilitis after autologous bone marrow transplantation (133) and osteomyelitis and extremity infections following injury (44, 125). Eye infections following keratoplasty (228) and the fitting of contact lenses (11) have also caused opthalmic infections with Acinetobacter spp.

PATHOGENESIS OF ACINETOBACTER INFECTIONS

Predisposing Factors

Various risk factors predisposing to severe infection with Acinetobacter spp. have been identified; some of these also apply to organisms causing other nosocomial infections. Susceptible patients include those who have recently undergone major surgery, those with severe underlying disease (e.g., malignancy, burns or immunosuppression), and particularly the elderly, although outbreaks of Acinetobacter infection have also been described in neonates (135, 189).

Most detailed studies of risk factors have involved studies of respiratory tract infections, and a number of factors have been suspected or identified as increasing the risk of pneumonia or colonization of the lower respiratory tract by Acinetobacter spp. (probably A. baumannii in most cases) in the ICU; these include advanced age, chronic lung disease, immunosuppression, surgery, use of antimicrobial agents, presence of invasive devices such as endotracheal and gastric tubes, and type of respiratory equipment (18, 30, 31, 120, 146, 190). Although many of these variables are likely to be interrelated, only a few studies of potential risk factors have used appropriate statistical modelling to define independent risk determinants (206).

A case-control analysis in which ICU patients with respiratory colonization or infection with Acinetobacter spp. were compared with matched ICU controls who had other gram-negative bacilli in their sputum (146) was used to investigate an outbreak of infection with aminoglycoside-resistant Acinetobacter spp. involving 98 patients at a university hospital in North Carolina. The duration of the ICU stay before colonization or infection with Acinetobacter spp. was significantly longer for infected patients than for controls (14.7 versus 5.9 days; \( P = 0.002 \)). Although exposure to invasive devices and procedures did not differ significantly between the two groups, infected patients received respiratory therapy for significantly longer than did controls (14.7 versus 6.6 days; \( P = 0.006 \)). Aminoglycoside usage in the two groups was comparable, but infected patients received an aminoglycoside for a longer duration before colonization or infection than did controls (9.0 versus 6.1 days; \( P = 0.08 \)) and had also received more cephalosporins than did controls (1.9 versus 1.2; \( P = 0.018 \)).

A similar study of 40 patients infected or colonized with A. baumannii (120), in which these patients were compared by logistic regression analysis with 348 noninfected and noncolonized patients who were present in the ICU at the same time, also demonstrated that the severity of the underlying disease, as evaluated by the APACHE II score (112), and the presence of a previous infection that required antimicrobial treatment were independent factors for acquiring A. baumannii infection.

In conclusion, extended ICU care as a result of severe underlying disease, prolonged respiratory therapy with mechanical ventilation, and previous antimicrobial therapy are all key factors in predisposing to Acinetobacter infection. Since the only factor amenable to control in the ICU setting is antimicrobial therapy, avoidance of unnecessary antibiotics should be a high priority in management of such patients. The use of antibiotics probably alters the normal flora and results in the selection of resistant microorganisms such as Acinetobacter spp.

Virulence of Acinetobacter spp.

Although Acinetobacter spp. are considered to be relatively low-grade pathogens (105, 147, 185), certain characteristics of these organisms may enhance the virulence of strains involved in infections; these characteristics include (i) the presence of a polysaccharide capsule formed of L-rhamnose, D-glucose, D-glucuronic acid, and D-mannose (109), which probably renders the surface of strains more hydrophilic, although hydrophobicity may be higher in Acinetobacter strains isolated from catheters or tracheal devices (109, 159); (ii) the property of adhesion to human epithelial cells in the presence of fimbriae and/or capsular polysaccharide (152, 159, 160); (iii) the production of enzymes which may damage tissue lipids (153); and (iv) the potentially toxic role of the lipopolysaccharide component of the cell wall and the presence of lipid A (10). In common with other gram-negative bacteria, Acinetobacter spp. produce a lipopolysaccharide responsible for lethal toxicity in mice, pyrogenicity in rabbits, and a positive reaction in the Limulus amoebocyte lysate test. The production of endotoxin in vivo is probably responsible for the disease symptoms observed during Acinetobacter septicaemia.
A. baumannii appears to have only limited virulence in mice (50% lethal dose, 10⁶ to 10⁸ CFU per mouse) when inoculated intraperitoneally, even in neutropenic mice. However, experimental studies in a murine model of Acinetobacter pneumonia have shown that this pneumonia closely resembles that in humans (103). Experimentally, mixed infections combining other bacteria with Acinetobacter spp. are more virulent than infections with Acinetobacter spp. alone (140). Slime produced by the Acinetobacter strain studied was considered to be the main factor responsible for the enhancement of virulence in mixed infections, but few acinetobacters are slime producing; indeed, of 100 isolates tested (140), only 14 had slime producing ability. The same study demonstrated that slime was associated with cytotoxicity against neutrophils and inhibition of the migration of neutrophils into peritoneal exudate of mice. No correlation was observed between the amount of slime produced and the degree of virulence.

The ability of a bacterium to obtain the necessary iron for growth in the human body is also an important virulence determinant, and some Acinetobacter strains have been shown to produce siderophores, such as aerobactin, and iron-repressible outer membrane receptor proteins (2, 51, 186).

**EPIDEMIOLOGY**

**Human Carriage**

Acinetobacters can form part of the bacterial flora of the skin, particularly in moist regions such as the axillae, groin, and toe webs, and it has been suggested that at least 25% of normal individuals carry Acinetobacter spp. on their skin (188, 192). Acinetobacter spp. have also been found occasionally in the oral cavity and respiratory tract of healthy adults (69, 161), but the carriage rate of Acinetobacter spp. in nonhospitalized patients, apart from on the skin, is normally low.

In contrast, the carriage rate may be much higher in hospitalized patients, especially during outbreaks of infection. Throat swabs have been found to be positive for Acinetobacter spp. in 7 to 18% of patients, while tracheostomy swabs were positive in 45% of hospitalized patients (162). High colonization rates of the skin, throat, respiratory system, or digestive tract, of various degrees of importance, have been documented in several outbreaks. In particular, outbreaks involving mechanically ventilated ICU patients are associated with a high colonization rate of the respiratory tract (7, 30, 60, 146), which may indicate contamination of respiratory therapy equipment as the possible source of an outbreak. In addition, patients often have skin colonization during outbreaks. Such colonization of patients plays an important role in subsequent contamination of the hands of hospital staff during trivial contacts, thereby contributing to the spread and persistence of outbreaks (67). Colonization of the digestive tract of patients with Acinetobacter spp. is unusual (79), but several studies have documented oropharyngeal colonization of patients with respiratory tract colonization, and digestive tract colonization has been reported to be a major reservoir of resistant strains (166, 227).

Several conclusions regarding colonization in hospitalized patients can be drawn from the published studies: (i) a high rate of colonization can be found in debilitated hospitalized patients, especially during outbreak situations; (ii) a predominant site of colonization is the skin, but other sites, such as the respiratory or digestive tract, may also be involved and may predominate on certain occasions; and (iii) the observed discrepancies between carriage rates for outpatients and hospitalized patients suggests that infecting or colonizing organisms in hospital-acquired infections may derive more often from cross-transmission or hospital environmental sources rather than from endogenous sources in patients.

The large proportion of colonized patients in a given hospital setting means that the differentiation between colonization and infection may not be straightforward.Nosocomial Acinetobacter infections may involve any site, but they predominate in the respiratory tract, urinary tract, and wounds. Many isolates from the skin and the respiratory tract should still be considered to be colonizing rather than infecting organisms. A steady increase (from 25 to 45%) in the proportion of Acinetobacter isolates from superficial wounds has been recorded over the past decade (94), and the skin, respiratory tract, and superficial wounds should therefore be considered to be potential important reservoirs of infecting organisms during outbreak situations.

**Persistence in the Hospital Environment**

Numerous studies have documented the presence of Acinetobacter spp. in the hospital environment, but rates of positive cultures may vary widely, depending on the epidemiological setting. Acinetobacter spp. have been found in 27% of hospital sink traps and 20% of hospital floor swab cultures (162). Air contamination in the absence of a colonized patient is comparatively rare, but several studies have documented extensive contamination by Acinetobacter spp. of the environment, including respirators and air samples, in the vicinity of infected or colonized patients (40). During an outbreak of infection originating from an ICU, 12 (11.5%) of 104 air samples from wards harboring colonized patients were positive for Acinetobacter spp., as well as 7 (8%) of 89 sink trap swabs and 13 (17%) of 75 samples from bedside cupboards in the same areas (39). Extensive contamination of the environment, including air samples, was found in an outbreak of infection with multiresistant Acinetobacter spp. (7); again, contamination was found essentially in the vicinity of infected or colonized patients, with 16 of 82 settle plate cultures from the environment of three colonized patients found to be positive. Bed linen from colonized patients was positive consistently, but linen from noncolonized patients was also positive on several occasions, as well as overblankets from empty beds in the vicinity of one ventilated colonized patient and bed curtains around colonized patients. Persistent environmental contamination was documented for up to 13 days after the discharge of a patient. A further notable example of the role of the immediate bed environment in the dissemination of Acinetobacter spp. was seen in a large outbreak involving 63 of 103 patients admitted to a burns unit over a 21-month period (182). The outbreak was traced to contamination of mattresses through breaches in plastic covers that allowed water penetration and persistence of the organism in the wet foam of the mattresses. More recently, feather pillows were found to be contaminated with considerable numbers of acinetobacters in an outbreak of infection in The Netherlands (226). It is therefore apparent that contaminated bedding materials may play an important role in the nosocomial dissemination of these organisms.

The above data indicate that certain Acinetobacter spp. can persist in the environment for several days, even in dry conditions on particles and dust, thereby probably contributing to the development and persistence of outbreaks. It has been reported that Acinetobacter cells can survive on dry surfaces for durations even longer than that found for Staphylococcus aureus (67, 132). Environmental contamination during an outbreak in a pediatric ICU was demonstrated on various equipment and surfaces in the unit (telephone handles, door pushplates, patient charts, tabletops, etc.), all of which were
probably contaminated by the hands of staff (67). Similarly, an epidemic strain of multiresistant Acinetobacter spp. has been shown to survive for up to 6 days after inoculation on to dry filter paper, a duration similar to that found with S. aureus, which persisted for 7 days, but significantly greater than the survival times for Escherichia coli and Pseudomonas spp., both of which persisted for 24 h or less (7). Prolonged survival of Acinetobacter spp. on hospital floors and air-dried washcloths has also been described (30). Survival is probably also helped by the ability of Acinetobacter spp. to grow at a range of different temperatures and pH values (13, 14, 88, 201).

In summary, Acinetobacter spp. have unique characteristics among nosocomial gram-negative bacteria that favor their persistence in the hospital environment. These organisms spread easily in the environment of infected or colonized patients and can persist in that environment for many days, a factor that may explain their propensity for causing extended outbreaks. However, it should be noted that acinetobacters are ubiquitous organisms that can also be isolated readily from nonclinical sources such as soil, drinking and surface waters, sewage, and a variety of different foodstuffs (201). There appears to be a significant population difference between the genomic species found in clinical specimens and those found in other environments (59), and it is therefore vital that acinetobacters be identified to the genomic species level and then typed before epidemiological conclusions can be drawn.

The dissemination and persistence of Acinetobacter spp. in the hospital environment probably accounts for the specific role that has been reported for contaminated materials as a reservoir of infection, especially during outbreaks. In some persistent outbreaks, contaminated materials have been shown to act as a source of the outbreak. Materials used for respiratory therapy or support have been implicated in many such cases (32, 80, 187). Thus, an outbreak of 24 cases of infection with Acinetobacter spp., occurring mostly in debilitated patients with intravascular catheters, was traced to contaminated room air humidifiers (187). Contaminated air samples were found up to 10 m from the humidifiers, and probable skin colonization of patients in the vicinity of the devices resulted in intravascular catheter infection. A similar outbreak occurred in patients undergoing peritoneal dialysis (1), and contamination of dialysis fluid bottles, via a contaminated water bath used to warm the dialysis fluid, was demonstrated. This outbreak was controlled after revision of the decontamination procedures for the heating buckets and for starting infusion of dialysis fluids. Other outbreaks have involved inadequate sterilization of autoclavable reusable needles used for administration of intrathecal methotrexate in patients with leukemia (110), defective heating of a washing machine used for decontamination of reusable ventilator tubings (32), and inadequate decontamination of respiratory monitoring devices and resuscitation bags (80, 189, 214). Ethylene oxide sterilization of such contaminated equipment has been shown to be effective. Radiation resistance of Acinetobacter clinical isolates has been demonstrated (36), and these results indicate that special attention should be paid to medical devices that are normally sterilized by irradiation, particularly devices used in ICUs.

However, although respiratory equipment may be responsible for persistent outbreaks as a result of inadequate decontamination between use in consecutive patients, such equipment may act in some instances only as an intermediate reservoir of organisms and not as the primary source of infection. Thus, in one outbreak, a respiratory therapist with hand lesions from dermatitis was found to be a chronic carrier of Acinetobacter spp. and was contaminating the equipment during assembly and testing (30). Medical equipment may therefore become contaminated both by the patients themselves and by staff during handling, and the latter possibility should always be considered when outbreaks of infection occur, especially in respiratory ICUs.

**TYING SYSTEMS**

Typing methods are important tools for establishing the sources and mode(s) of transmission for epidemic strains. Early attempts to develop typing systems for Acinetobacter spp. have been reviewed previously (22). No single typing system has so far gained acceptance for typing Acinetobacter spp., and this area is still the subject of research. The following sections describe the different typing systems that are currently being applied to Acinetobacter spp. Some of these are based on the latest taxonomic developments, while others aim simply to discriminate individual strains without determining their precise genomic species. The inherent advantages and disadvantages of the different approaches to bacterial typing have been considered elsewhere (203).

**Biotyping**

Biochemical profiles comprising binary characteristics (with results being scored as positive or negative) can be used for comparative typing of strains. A biotyping system consisting of five tests (24, 26), devised originally for dividing isolates of A. baumannii into 19 biotypes, has also been used to type the related genomic species 3 and 13TU in various hospital outbreaks of infection (26, 64, 65). The API 20NE system has been used to distinguish 31 different biotypes among 122 different Acinetobacter strains (202), but this system sometimes has problems with sensitivity and reproducibility (113). However, cluster analysis of carbon source growth assays has been used to identify a major grouping of isolates that was related to the epidemiological origin of the strains (48). Other commercial systems with large numbers of substrates may therefore be of use, but such systems have yet to be assessed with epidemiologically defined strains of Acinetobacter spp. from different outbreaks.

**Antibiograms**

Numerous studies have used antibiotic susceptibility patterns (antibiograms) to detect emerging resistance patterns and to group similar isolates (5, 7, 17, 100, 190, 219), often on the basis of MICs, breakpoints, or zone diffusion sizes. Such results are often expressed as resistant, susceptible, or intermediate. A more informative approach uses the actual diameters of inhibition zones in disc diffusion tests for cluster analysis, and such groupings have been shown to correlate well with other typing and epidemiological data (45). However, it must be emphasized that antibiogram typing results should be interpreted with caution, since unrelated strains may exhibit the same antibiogram (100) and changes in susceptibility may occur during episodes of infection.

**Serotyping**

There have been numerous attempts to type Acinetobacter strains by serological reactions, but only limited success was obtained in early work (3, 41, 81), and most such schemes have been rendered obsolete by the taxonomic developments in the genus. More recent work involving checkerboard tube agglutinations and reciprocal cross-absorptions with polyclonal rabbit immune sera against heated cells has allowed the delineation of 34 serovars in A. baumannii and 26 serovars in genomic...
species 3 (207–209). However, antigenic differences between
*A. baumannii* and genomic species 3 serovars were not entirely
satisfactory, and the relationship with strains belonging to
genomic species 13TU is unclear. Further work with large
numbers of epidemiologically defined strains identified unam-
biguously by DNA-DNA hybridization is required to test the
utility of this method.

**Phage Typing**

Two complementary sets of bacteriophages (comprising 25
phages, allowing the identification of 125 phage types, and 14
phages, allowing the identification of 25 phage types) have
been used in a number of different epidemiological studies of
*Acinetobacter* isolates from France and other European coun-
tries (26, 29, 68, 99, 167, 218). Predominant phage types (num-
bers 17 and 124) have been identified in some outbreaks (167,
218). However, this system has been used only at the Phage
Typing Center of the Institut Pasteur in Paris, and it seems that
a substantial proportion of strains from other geographical
locations may be nontypeable. Although some doubt has been
cast upon the reproducibility of the results (26), phage typing
may be useful, albeit time-consuming, when used in conjunc-
tion with other typing methods.

**Bacteriocin Typing**

Two reports of bacteriocin typing of *Acinetobacter* isolates
have been published. In the first study (9), 176 strains were
typed by means of 10 indicator strains that were susceptible to
bacteriocins. Overall typeability was 65%, but 56% of strains
belonged to only two groups. The second study (189) used 19
bacteriocin-containing lysates to type 100 strains. Only 46% of
strains were typeable, but 16 isolates, including 11 from an
outbreak, belonged to the same type. Bacteriocin typing of
isolates identified by DNA-DNA hybridization has not been
reported, and the usefulness of this method for typing clinically
important genomic species remains to be investigated.

**Protein Profiles**

Both cell envelope and whole-cell protein patterns have
been used in a series of epidemiological and taxonomic studies
of *Acinetobacter* spp. Analysis of cell envelope protein patterns
by sodium dodecyl sulfate-polyacrylamide gel electrophoresis
has shown heterogeneity in unrelated strains, while multiple
isolates from patients or outbreaks were indistinguishable (46,
49). This method has been used successfully to trace specific
strains during endemic episodes and outbreaks in hospitals (39,
47, 226). Electrophoretic analysis of whole-cell protein frac-
tions has the advantage that sample preparation is simpler than
preparation of cell envelopes. Similarities between *Aci-
tobacter* isolates from outbreaks and dissimilarities in unrelated
control strains have been reported in several studies (4, 5, 128),
but as with other phenotypically based methods, apparent dif-
fferences between isolates from a common origin should be
interpreted with caution.

**Multilocus Enzyme Electrophoretic Typing**

Multilocus enzyme electrophoresis investigates the relative
electrophoretic mobilities of a large number of cellular en-
zymes (178). Investigation of 27 esterases and 2 dehydroge-
nases in 81 *Acinetobacter* isolates identified between 2 and 17
variants for each enzyme (150). A separate study of 13 enzymes
in 65 *Acinetobacter* clinical isolates identified 14 different types,
which of 1 type was found in 41 multiresistant isolates with
common whole-cell protein profiles (193). These results sug-

gest that multilocus enzyme electrophoresis has the potential
to be developed into a useful technique for strain identifica-
tion.

**Plasmid Profiles**

Numerous studies have now used plasmid typing as a rapid
and simple method for identifying *Acinetobacter* strains (5, 61,
65, 67, 91, 113, 175). The plasmids found in *Acinetobacter*
strains vary considerably in both size and number. Thus, be-
tween one and four plasmids varying in size from 2.1 to >100
kb were found in 13 strains belonging to the *A. calcoaceticus-A.
baumannii* complex, but no plasmids at all were found in 10
other strains examined (65). Nevertheless, analysis of plasmid
profiles has been useful in delineating several outbreaks of
*Acinetobacter* infection (15, 80, 113, 219). Strains with similar
plasmid profiles have been differentiated further either by re-
striction endonuclease digestion of plasmid DNA to generate
plasmid fingerprints (113, 219) or by hybridization of plasmids
with a labelled probe from one of the strains (65). Overall,
itis can be concluded that plasmid typing may be extremely useful
in epidemiological studies, provided that the results are inter-
preted in conjunction with other typing methods and the origin
of the strains is known.

**Analysis by Pulsed-Field Gel Electrophoresis**

Analysis by pulsed-field gel electrophoresis of restriction
fragment length polymorphisms generated from intact chro-
mosomal DNA has been used to compare fingerprints ob-
tained from *Acinetobacter* strains following restriction with
*Apal* (77, 176, 191), *SmaI* (6), *ApaI* and *SmaI* (74), and *NheI*
and *SmaI* (190). These studies have indicated considerable
DNA polymorphism in the clinically important genomic speci-
"es 2 (*A. baumannii*), even within biotypes, and good correla-
tion between strains from within defined outbreaks or multiple
isolates from single patients. Equipment for pulsed-field gel
electrophoresis is costly, while the preparation of intact chro-
mosomal DNA and subsequent digestion and electrophoresis
require several days. Nevertheless, pulsed-field gel electro-
phoresis seems to provide highly discriminatory results and
extremely useful epidemiological information.

**Ribotyping**

This method has been described in detail for *Acinetobacter*
spp. (62). Briefly, purified chromosomal DNA is digested with
restriction enzymes, electrophoresed, blotted, and then hybridi-
ized with a labelled cDNA probe derived from *E. coli* rRNA.
Patterns generated by restriction with *EcoRI*, *ClaI*, or *SalI*
have been used to investigate 70 strains that had been identi-
fied as either *A. calcoaceticus*, *A. baumannii*, or genomic spe-
cies 2 or 13TU by DNA-DNA hybridization (62). Excellent
reproducibility was observed, and combined use of the three
enzymes generated 52 different types among the 70 unrelated
strains studied. Ribotype patterns within outbreaks have been
shown to be stable and to correlate with results obtained by
other typing methods (45). However, although the diversity of
ribotypes within the *A. calcoaceticus-A. baumannii* complex is
considerable, common patterns in apparently unrelated strains
have also been observed (45, 62). Again, this is a laborious
technique, but it can provide valuable epidemiological infor-
mation, particularly when used in combination with other typ-
ing methods.
PCR-Based Methods

Fingerprinting on the basis of PCR amplification of DNA sequences by either specific or random primers is being used increasingly for typing microorganisms. The core region of bacteriophage M13 has been used as a single primer to determine the relatedness of A. baumannii strains (77). The repetitive elements ERIC1 and ERIC2 (217) were also used successfully as single primers in one study for typing A. baumannii isolates from a tertiary-care hospital (190). In contrast, ERIC1 and ERIC2 primers were not useful for typing the isolates of A. baumannii from another outbreak (155), whereas the repetitive elements REP1-RI plus REP2-I generated PCR fingerprints that discriminated between epidemic and sporadic strains of A. baumannii and demonstrated four discrete clusters that were unique epidemiologically. Further studies are required to assess the longitudinal reproducibility of PCR-based typing methods. Comparisons between typing results obtained in different centers may be difficult, but these methods are extremely rapid and seem to be useful for tracing epidemic strains during outbreaks on a day-to-day basis.

CLINICAL ANTIBIOTIC RESISTANCE

Numerous reports in the medical and scientific literature have documented the high rates of antibiotic resistance found in Acinetobacter spp. (17, 29, 56, 101, 117, 190). A particular concern has been the frequent multiple antibiotic resistance exhibited by nosocomial acinetobacters and the resulting therapeutic problems involved in treating patients with nosocomial infections in ICUs. Until the early 1970s, nosocomial Acinetobacter infections could be treated successfully with gentamicin, minocycline, nalidixic acid, ampicillin, or carbencillin, either as single agents or in antibiotic combinations, but increasing rates of resistance began to be noticed between 1971 and 1974. Since 1975, successive surveys have shown increasing resistance in clinical isolates of Acinetobacter spp. (58, 71, 93, 141). High proportions of strains have become resistant to older antibiotics; indeed, many acinetobacters are now resistant to clinically achievable levels of most commonly used antibacterial drugs, including aminopenicillins, ureidopenicillins, narrow-spectrum (cephalothin) and expanded-spectrum (cefa-mandole) cephalosporins (93, 127), cephamycins such as cefoxitin (58), most aminoglycosides-aminocyclitol (43, 50, 72, 93), chloramphenicol, and tetracyclines. For some relatively new antibiotics, such as broad-spectrum cephalosporins (cefoxime, ceftazidime), imipenem, tobramycin, amikacin, and fluoroquinolones, partial susceptibility remains, but the MICs of these antibiotics for Acinetobacter spp. are increased substantially in the last decade. Imipenem remains the most active drug; indeed, until recently, imipenem retained activity against 100% of strains (8, 129, 177, 220), and in some reports the only active drugs were imipenem and the polymyxins. Unfortunately, the most recent extensive analyses of hospital outbreaks have documented the spread of imipenem-resistant strains (70, 191). This is a particularly worrying development which threatens the continued successful treatment of Acinetobacter infections. Most resistance to imipenem has been observed in strains identified as A. baumannii, while the MIC of carbapenems for non-A. baumannii strains has remained below 0.3 mg/liter, but the widespread emergence and/or spread of resistance to imipenem is likely to pose a serious threat in the near future.

Differences in antibiotic susceptibility have been observed between countries, probably as a result of environmental factors and different patterns of antimicrobial usage. Thus, most studies report 50 to 80% of isolates to be susceptible to gentamicin and tobramycin, while aminoglycosides no longer seem to be active at clinically achievable levels against A. baumannii isolates from Germany (173). Similarly, most Acinetobacter isolates in France, which were originally susceptible to fluoroquinolones, became susceptible (75 to 80%) to pefloxacin and other fluoroquinolones within 5 years of the introduction of these antibiotics.

Species other than A. baumannii isolated from the hospital environment, i.e., A. lwoffi, A. johnsonii, and A. junii, are involved less frequently in nosocomial infection and are generally more susceptible to antibiotics (60, 101, 210). Strains of A. lwoffi are more susceptible to β-lactams than is A. baumannii. A. haemolyticus, A. baumannii, and A. junii are normally susceptible to aminoglycosides and rifampin, but rifampin has mean MICs for A. baumannii of 2 to 4 mg/liter and has been used effectively in synergic combination with imipenem in ICUs in France (17).

BIOCHEMICAL AND GENETIC MECHANISMS OF ANTIBIOTIC RESISTANCE

Genetics of Resistance

Acinetobacter is a genus that appears to have a propensity to develop antibiotic resistance extremely rapidly, perhaps as a consequence of its long-term evolutionary exposure to antibiotic-producing organisms in a soil environment. This is in contrast to more “traditional” clinical bacteria, which seem to require more time to acquire highly effective resistance mechanisms in response to the introduction of modern radical therapeutic strategies; indeed, it may be their ability to respond rapidly to challenge with antibiotics, coupled with widespread use of antibiotics in the hospital environment, that is responsible for the recent success of Acinetobacter spp. as nosocomial pathogens. However, although all three of the major modes of chromosomal gene transfer have been demonstrated in Acinetobacter spp. (82, 107, 204), only conjugation has so far been shown to play a significant role in the transfer of antibiotic resistance genes between members of this genus (35, 205). Plasmids and transposons play an important role in the biology of most prokaryotic organisms, and Acinetobacter spp. appear to be no exception to this generalization (200). Several studies have reported that >80% of Acinetobacter isolates carry multiple indigenous plasmids of variable molecular size (61, 175), although other workers report problems in isolating plasmid DNA from Acinetobacter spp., often because of unappreciated difficulties in lysing the cell wall of these organisms. Although many clinical isolates of A. baumannii show widespread and increasing resistance to a whole range of antibiotics, there have been only a few studies (see below) in which plasmid-mediated transfer of resistance genes has been demonstrated. However, as postulated by Towner (200), failure to observe transfer of resistance may simply reflect the absence of a suitable test system for detecting such transfer. For historical reasons, workers attempting to transfer plasmids from clinical isolates of any gram-negative species have tended to use E. coli K-12 as a recipient strain. Complex and varied transfer frequencies of standard plasmids belonging to different incompatibility groups have been observed between Acinetobacter strain EBF 65/65 and E. coli K-12, and a number of these plasmids required an additional mobilizing plasmid for transfer to occur (35). Accordingly, it is not surprising that most reported cases of indigenous transmissible antibiotic resistance from Acinetobacter spp. have been associated with plasmids belonging to broad-host-range incompatibility groups (200). There remains a need to rigorously assess the potential for
mobilization of antibiotic resistance genes to and from the different genomic *Acinetobacter* species that have now been delineated. Transposons probably play an important role, in conjunction with integrons (37), in ensuring that particular novel genes can become established in a new gene pool, even if the plasmid vectors that transferred them are unstable, and there have been several reports of chromosomally located transposons carrying multiple antibiotic resistance genes in clinical isolates of *Acinetobacter* spp. (200). However, studies aimed at defining the general topological structure and organization of bacterial genetic material are currently somewhat unfashionable, and, as far as the genus *Acinetobacter* is concerned, there have been few significant advances since it was demonstrated that strain EBF 65/65 had a circular chromosomal linkage map (198). A total of 29 genetic loci have been mapped on the chromosome of strain EBF65/65 (222), but only one study has examined possible transposon insertion sites in the chromosome of this genus (199).

The following sections summarize the known biochemical and genetic mechanisms of resistance of *Acinetobacter* spp. to the major groups of antibiotics.

### β-Lactams

As with other gram-negative organisms, most resistance to β-lactams in *Acinetobacter* spp. is associated with the production of β-lactamases, including the widely distributed TEM-1 and TEM-2 enzymes (43, 72, 98, 149). An analysis of 76 ticarcillin-resistant (MIC, >256 mg/liter) *Acinetobacter* strains for their β-lactamate content found penicillinase activity in only 11% of the resistant strains (98), of which the majority produced an enzyme with a pl of 5.4 (TEM-1 like), although a few had an enzyme with a pl of 6.3, which is characteristic of the β-lactamase CARB-5. Some β-lactamate activity was also identified with a pl above 8.0. These were undefined enzymes that were presumed to be chromosomally encoded cephalosporinas because of their high pl. A separate study identified cephalosporinase activity in 9% of the clinical isolates of *A. baumannii* studied (220), and it therefore seems that cephalosporinas are the predominant β-lactamases in this species.

Four such enzymes, designated ACE-1 to ACE-4, have been studied in detail (86). All four enzymes were identified as cephalosporinas, although some possessed a little activity against penicillins and none had detectable hydrolyzing activity against aztreonam or the broad-spectrum cephalosporins, cephalazidine or cefotaxime. All four enzymes showed their maximum activity against cephaloridine and, except for ACE-4, showed good activity against cephadine. ACE-1 showed the broadest spectrum of activity with some hydrolysis of cefuroxime. The contribution of these chromosomal β-lactamases appears to be important in the expression of β-lactam resistance but may work in concert with a permeability reduction and altered penicillin-binding proteins that may already confer some inherent resistance (142, 168). The acquisition of plasmid-encoded penicillinases does not seem to have been of paramount importance in the long-term β-lactam resistance of this genus. There has so far been only one suggestion (95) of a possible plasmid-encoded extended-spectrum β-lactamase in *Acinetobacter* spp.

A particularly worrying development is the identification of a novel β-lactamase, designated ARI-1, in an imipenem-resistant strain of *A. baumannii* isolated from a blood culture at the Royal Infirmary, Edinburgh, in 1985 (144). This enzyme hydrolyzes both imipenem and azlocillin but not cefuroxime, ceftriaxone, or cefotaxime. Direct conjugative transfer of the ARI-1 gene from its original *A. baumannii* host to an *A. junii* recipient has been demonstrated (169), and the same plasmid can be visualized in the donor and recipient strains. These last observations suggest strongly that ARI-1 is a plasmid-encoded carbapenemase, a development that may have extremely serious long-term consequences.

The β-lactamases known to exist in *Acinetobacter* spp. are summarized in Table 3.

### Aminoglycosides

Aminoglycosides are used widely for the treatment of *Acinetobacter* infections, and increasing numbers of highly resistant strains have been reported since the late 1970s. All three types of aminoglycoside-modifying enzymes have been identified within clinical *Acinetobacter* strains (Table 4), but geographic variations in the incidence of particular genes has been observed; e.g., the gene for AAC(3)-Ia was found frequently in *Acinetobacter* strains from Belgium (36 of 45 strains) but was observed less frequently in strains from the United States (3 of 17 strains) and not at all in strains from Argentina (180, 181).

In addition, some strains have been observed to contain more than one aminoglycoside resistance gene, with as many as six different resistance genes being identified in some isolates. It

### TABLE 3. β-Lactamases described in *Acinetobacter* spp.

<table>
<thead>
<tr>
<th>Enzyme or strain</th>
<th>Location of gene</th>
<th>Predominant substrate</th>
<th>Molecular size (kDa)</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEM-1</td>
<td>Plasmid</td>
<td>Penicillin</td>
<td>29</td>
<td>149</td>
</tr>
<tr>
<td>TEM-2</td>
<td>Plasmid</td>
<td>Penicillin</td>
<td>29</td>
<td>43</td>
</tr>
<tr>
<td>CARB-5</td>
<td>Plasmid</td>
<td>Penicillin</td>
<td>29</td>
<td>12</td>
</tr>
<tr>
<td>ARI-1</td>
<td>Plasmid</td>
<td>Carbapenem</td>
<td>23</td>
<td>144</td>
</tr>
<tr>
<td>NCTC7844</td>
<td>Chromosome</td>
<td>Cephalosporin</td>
<td>30</td>
<td>127</td>
</tr>
<tr>
<td>ML9061</td>
<td>Chromosome</td>
<td>Cephalosporin</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>ACE-1</td>
<td>Chromosome</td>
<td>Cephalosporin</td>
<td>500</td>
<td>86</td>
</tr>
<tr>
<td>ACE-2</td>
<td>Chromosome</td>
<td>Cephalosporin</td>
<td>60.5</td>
<td>86</td>
</tr>
<tr>
<td>ACE-3</td>
<td>Chromosome</td>
<td>Cephalosporin</td>
<td>32.5</td>
<td>86</td>
</tr>
<tr>
<td>ACE-4</td>
<td>Chromosome</td>
<td>Cephalosporin</td>
<td>&gt;1,000</td>
<td>86</td>
</tr>
<tr>
<td>SHV-like</td>
<td>Unknown</td>
<td>Penicillin</td>
<td>UK</td>
<td>95</td>
</tr>
<tr>
<td>SHV-like</td>
<td>Unknown</td>
<td>Penicillin</td>
<td>UK</td>
<td>220</td>
</tr>
</tbody>
</table>

* UK, unknown.

### TABLE 4. Aminoglycoside-modifying enzymes identified in *Acinetobacter* spp.

<table>
<thead>
<tr>
<th>Enzyme Reference(s)</th>
<th>Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetylating</td>
<td></td>
</tr>
<tr>
<td>AAC(6)</td>
<td>114, 116, 130, 179</td>
</tr>
<tr>
<td>AAC(2)I</td>
<td>50</td>
</tr>
<tr>
<td>AAC(3)H</td>
<td>16, 220</td>
</tr>
<tr>
<td>AAC(3)II</td>
<td>131</td>
</tr>
<tr>
<td>AAC(3)V</td>
<td>53, 181</td>
</tr>
<tr>
<td>AAC(3)IV</td>
<td>181</td>
</tr>
</tbody>
</table>

| Adenylation         |               |
| ANT(3)I             | 179           |
| ANT(3)(9)           | 43, 72, 131, 220 |
| ANT(2)I             | 131           |
| AAD(2)              | 53, 181       |

| Phosphorylating     |               |
| APH(3)I             | 16, 43, 72, 181 |
| APH(3)H             | 130           |
| APH(3)III           | 97, 130       |
| APH(3)VI            | 114, 115, 124, 181, 220 |
| APH(3)J             | 52            |

* Enzymatic activity detectable only in vitro.
has been suggested that the novel gene aac(6')-Ig, identified only in \textit{A. haemolyticus}, where it is responsible for amikacin resistance, may be used to facilitate the identification of this species (116).

Few published studies have been devoted to investigating the genetic nature of aminoglycoside resistance in \textit{Acinetobacter} spp., but both plasmid and transposon locations for aminoglycoside resistance genes have been demonstrated (43, 53, 72, 73, 114, 131).

**Quinolones**

The emergence of \textit{Acinetobacter} spp. as important hospital pathogens has occurred at the same time as increased reliance on 4-quinolones for the treatment of serious infection. The development of 4-quinolone resistance is often quite difficult to demonstrate in the laboratory, and this finding has been extrapolated to suggest that resistance will be rare in the clinical situation. This is true for bacteria such as \textit{E. coli} but does not seem to be the case for nonfermentative gram-negative bacteria such as \textit{Acinetobacter} spp. Although the precise mechanism is virtually unknown, it is clear that \textit{Acinetobacter} spp. can develop 4-quinolone resistance readily. Bacterial resistance to 4-quinolones in other genera has often been attributed with multiple other resistance genes in transposon structures on large conjugative plasmids. Similarly, the chloramphenicol acetyltransferase I (CAT1) gene has been associated with both chromosomal and plasmid DNA in a clinical \textit{Acinetobacter} isolate, suggesting that the CAT1 gene might be transposed encoded and had improved its survival potential by locating in both replicons (53).

**THERAPY OF ACINETOBACTER INFECTIONS**

Very few of the major antibiotics are now reliably effective for the treatment of severe nosocomial \textit{Acinetobacter} infections, particularly in patients confined to ICUs. β-Lactam antibiotics should be used only after extensive in vitro susceptibility testing has been performed. Ticarcillin, often combined with sulbactam (111, 212), ceftazidime, or imipenem, may be useful. Aminoglycosides can sometimes be used successfully in combination with an effective β-lactam, and other combinations of a β-lactam with a fluoroquinolone or rifampin have also been proposed.

In a retrospective survey in France of prescribing habits in 89 ICUs (102), the first-line therapy for \textit{Acinetobacter} infections included amikacin, imipenem, ceftazidime, and/or a quinolone (pefloxacin or ciprofloxacin). In 56% of cases, imipenem was prescribed either as a single agent or in combination with amikacin (18%), while ceftazidime plus amikacin was prescribed in 17% of cases and amikacin was used as a single agent in 26% of cases. For second-line therapy after in vitro susceptibility testing, a combination of imipenem plus an aminoglycoside was used in 59% of cases, ceftazidime plus an aminoglycoside was used in 30% of cases, and ceftazidime combined with a quinolone was used in 11% of cases. A previous study (129) had shown that imipenem was used as monotherapy in 20% of 33 nosocomial infections, imipenem in combination with amikacin was used in 40%, and pefloxacin plus amikacin or tobramycin (depending on the antibiogram) was used in 20% of cases; treatment failure and death (caused by \textit{Acinetobacter} infection and/or underlying disease) occurred in 17% of patients who received antibiotics. Many similar studies can be found in the medical literature (8, 29, 118, 214). In general, the recommended drugs in most recent studies have been either extended-spectrum penicillins, broad-spectrum cephalosporins, or imipenem, combined with an aminoglycoside.

**CONCLUSIONS**

\textit{Acinetobacter} spp. now account for a substantial proportion of endemic nosocomial infections. The relative importance of endemic and epidemic infections is difficult to delineate, but since about 50% of isolates are recovered from ICU patients and many such isolates correspond to epidemic strains, it can be estimated that about half of all infections are of epidemic origin. Recent trends indicate increasing antimicrobial resistance of \textit{Acinetobacter} isolates (29, 94), posing a serious threat to hospitalized patients. Such outbreaks are often associated with multiple epidemic strains by sensitive typing techniques; however, multiresistant strains differing by only one or two antibiotic susceptibility markers are often shown to be closely related (70, 176, 191). For practical purposes, multiresistant strains of a similar antibiotype should be considered epidemic a priori unless proven otherwise.

The variety of potential sources of contamination or infection with \textit{Acinetobacter} spp. in the hospital environment makes...
control of outbreaks caused by these organisms one of the most difficult challenges in infection control. Outbreaks may result from intrinsic contamination of medical equipment and devices (e.g., respiratory equipment, intravenous catheters, or needles) used in patients for monitoring or therapy and/or from contamination of the environment, either by the airborne route or by contact with patients (e.g., mattresses, pillows, air humidifiers). Persistence of *Acinetobacter* spp. in the environment provides ample opportunities for contamination of patients and staff and may explain continuing long-term outbreaks. The emphasis of initial control measures should, however, be on strict isolation of infected or colonized patients to limit dissemination of outbreak strains in the environment. Isolation and cohorting of patients and staff has been shown to be effective in some outbreaks (56, 70, 145, 176), but this method alone has often been found to be insufficient to control outbreaks. It is useful to review hand-washing policy and practices, because cross-transmission via the hands of staff has been demonstrated in several outbreaks (67, 70). Concomitant to isolation precautions, an investigation of the dissemination of *Acinetobacter* strains in the environment should be undertaken, and if substantial contamination is found in the vicinity of infected or colonized patients, housekeeping practices should be reviewed and, if necessary, reinforced (39). In some instances, extensive measures, including closing the unit for complete disinfection, has been necessary (182, 191). In one outbreak, even this measure was not sufficient, because of persistence of the epidemic organism on contaminated equipment in the unit (182). Case-control studies are appropriate to find a common environmental source to which patients have been exposed. When exposure to a particular item of equipment is implicated, it is necessary to determine whether extrinsic contamination has occurred during use in infected or colonized patients or whether intrinsic contamination (e.g., via ineffective sterilization or contamination by staff carriers during handling) is the cause (80).

There is some evidence that increased use of antibiotics favors the emergence and spread of *Acinetobacter* spp. (29, 94). An outbreak of imipenem-resistant *Acinetobacter* infections following increased use of imipenem in response to an outbreak involving cephlosporin-resistant *Klebsiella pneumoniae* has been described previously (70). Multiresistant *Acinetobacter* spp. are likely to be selected in the hospital environment in response to increasing antibiotic pressure. Control of antibiotic usage is therefore also an important part of preventive measures against the emergence of epidemic *Acinetobacter* infection.

*Acinetobacter* spp. are increasingly important nosocomial pathogens and are capable of rapid adaptation to the hospital environment. There is no doubt that these organisms will pose continuing problems in the future, which is disturbing because of the extent of their ever-increasing antibiotic resistance profiles. A combination of control measures is often required to contain these organisms. Continued awareness of the need to maintain good housekeeping and control of the environment, including equipment decontamination, strict attention to hand-washing and isolation procedures, and control of antibiotic usage, especially in high-risk areas, appears to be the combination of measures most likely to control the previously unabated spread of *Acinetobacter* spp. in hospitals.

**ACKNOWLEDGMENTS**

We are indebted to numerous colleagues for contributing to our understanding of the biology and role of *Acinetobacter* spp. as nosocomial pathogens over many years.

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Acinetobacter spp. as nosocomial pathogens


