



Nosocomial Infections: A brief Review

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Abstract

Many patients around the world suffer harm due to infections caused by viruses, bacteria, fungi, protozoa or helminthes that are no longer susceptible to the common medicines used to treat them. Reports are most often generated on the basis of laboratory results on microbes obtained from human patients. Nosocomial is one such common infection through-out the world. It is an infection whose growth and development is favored by hospital environment. This review elaborates the details of this infections in brief. The review presents its various types, bio-medical classification, pathogen responsible, effective antibiotics against this infection, antibiotic resistance in patients and general guidelines. This concise information could be useful for further research, bio-medical applications, disease management, pharmacy practice, drug administration and exploring the efficacious drug to treat the patient.

Keywords: Nosocomial, Antibiotics, Microbes

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1. Introduction

Bacteria that cause disease react to the antibiotics used as treatment by becoming resistant to them, sooner or later. This natural process of adaptation, antimicrobial resistance, means that the effective lifespan of antibiotics is limited. Unnecessary use and inappropriate use of antibiotics favours the emergence and spread of resistant bacteria. A crisis has been building up over decades, so that today many common and life-threatening infections are becoming difficult or even impossible to treat, sometimes turning a common infection into a life-threatening one. It is time to take much stronger action worldwide to avert a situation that entails an ever increasing health and economic burden¹. Many patients around the world suffer harm due to AMR because infections – caused by viruses, bacteria, fungi, protozoa or helminthes – are no longer susceptible to the common medicines used to treat them. Reports on AMR are most often generated on the basis of laboratory results on microbes obtained from human patients. These reports are used to inform decisions on the treatment of individual patients, and also as evidence for policies at local, national, and international levels. Data from around the world confirm that AMR, including multidrug resistance, is increasing among many pathogens responsible for infections in health-care facilities and in the community².

1.1. Nosocomial infection

Nosocomial infections can be defined as those occurring within 48 hours of hospital admission, 3 days of discharge or 30 days of an operation. They affect 1 in 10

patients admitted to hospital.

Gram-positive bacteria are the commonest cause of nosocomial infections with *Staphylococcus aureus* being the predominant pathogen. There has been an increase in the rate of antibiotic resistant bacteria associated with nosocomial infections in ICU. Bacteria develop resistance when they acquire new genetic material. Poor antibiotic prescribing selects for resistant bacteria. The genetic material that encodes resistance is transferred to other strains. Methicillin-resistant *S. aureus* (MRSA) causes up to 60% of nosocomial infection in ICU. Hospital-acquired infection or HAI, infections include fungal and bacterial infections and are aggravated by the reduced resistance of individual patients^{3,4}.

Hospital-acquired bacterial species, such as *K. pneumoniae*, but also in the typical community-acquired species, *Escherichia coli*. This gene has been identified in strains that possess other resistance mechanisms contributing to their multidrug resistance patterns. It has been recently extensively reported from the United Kingdom, India, Pakistan and albeit to a lesser extent, from a number of other countries worldwide⁵. The Centers for Disease Control and Prevention (USA), 13,300 patients died of antibiotic-resistant bacterial infection in the US during 1992. An incredible 150% increase in the occurrence of drug-resistant *Pneumococcal* was noted between 1987 and 1994. The frequency of methicillin-resistant *Staphylococcus* rose from 2% in 1975 to 32% in 1992⁶.

1.2 Present status of nosocomial infections in various countries

To take up the detailed studied of nosocomial infections it is important to take up the a brief look at the status of the infection in India and other countries. In India, a number of cases are increasing day by day and the status in other countries is given in [table I](#).

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2. Common nosocomial infections

a. Hospital-acquired pneumonia (HAP)

HAP is defined as pneumonia that occurs 48 hours or more after admission, which was not incubating at the time of admission [7,8]. HAP may be managed in a hospital ward or in the intensive care unit (ICU) when the illness is more severe. Rates of HAP due to MDR pathogens have increased dramatically in hospitalized patients, especially in intensive care and transplant patients⁹.

b. Ventilator associated pneumonia (VAP)

VAP refers to pneumonia that arises more than 48–72 hours after end tracheal incubation^{7,10}. Although not included in this definition, some patients may require intubation after developing severe.

c. Methicillin resistant *Staphylococcus aureus* (MRSA)

Infections due to gram-positive cocci, such as *Staphylococcus aureus*, particularly Methicillin resistant *S. aureus* (MRSA), have been rapidly emerging in the United States^{11,12}. Pneumonia due to *S. aureus* is more common in patients with diabetes mellitus, head trauma, and those hospitalized in ICUs. MRSA produces a penicillin-binding protein with reduced affinity for β -lactam antibiotics that is encoded by the *mec A* gene, which is carried by one of a family of four mobile genetic elements¹³⁻¹⁵.

d. Fungal pathogens

Nosocomial pneumonia due to fungi, such as *Candida* species and *Aspergillus fumigatus*, may occur in organ transplant or immunocompromised, neutropenic patients, but is uncommon in immunocompetent patients. Nosocomial *Aspergillus* species infections suggest possible airborne transmission by spores, and may be associated with an environmental source such as contaminated air ducts or hospital construction. By comparison, isolation of *Candida albicans* and other *Candida* species from endotracheal aspirates is common, but usually represents colonization of the airways, rather than pneumonia in immunocompetent patients, and rarely requires treatment with antifungal therapy¹⁶⁻²⁰.

e. *Pseudomonas aeruginosa*

P. aeruginosa, the most common MDR gram-negative

bacterial pathogen causing HAP/VAP, has intrinsic resistance to many antimicrobial agents. This resistance is mediated by multiple efflux pumps, which may be expressed all the time or may be transformed by mutation. Resistance to piperacillin, ceftazidime, cefepime, other oxy imino- β -lactams, imipenem and meropenem, aminoglycosides or fluoroquinolones is increasing in the United States^{11, 21-24}.

f. *Acinetobacter species*

Acinetobacter species have nonetheless become problem pathogens because of increasing resistance to commonly used antimicrobial agents. More than 85% of isolates are susceptible to carbapenems, but resistance is increasing due either to IMP-type metalloenzymes or carbapenemases of the OXA type. An alternative for therapy is sulbactam, usually employed as an enzyme inhibitor, but with direct antibacterial activity against *Acinetobacter* species^{5,25}.

g. *Stenotrophomonas maltophilia*

S. maltophilia, which shares with *B. cepacia* a tendency to colonize the respiratory tract rather than cause invasive disease, is uniformly resistant to carbapenems, because of a ubiquitous metallo- β -lactamase. *S. maltophilia* and *B. cepacia* are most likely to be susceptible to trimethoprim-sulfamethoxazole, ticarcillin-clavulanate, or a fluoroquinolone. *B. cepacia* is also usually susceptible to ceftazidime and carbapenems¹⁴.

h. Urinary tract infection

Enterococcus faecalis is a normal commensal in the human and animal gastrointestinal tract but it has become increasingly recognised as one of the leading cause of nosocomial infections. Urinary tract infections (UTI) are the most frequent, although more serious infections, such as bacteremia, endocarditis and neonatal infections also occur. One of the main reasons why enterococci can survive in the hospital environment is their resistance to a variety of antimicrobials. In fact, in addition to their intrinsic resistance to low levels of aminoglycosides, cephalosporins, lincosamydes and many β -lactams, enterococci are also able to acquire resistance to many antibiotics, either by mutation of existing chromosomal genes or by transfer of resistance determinants. The past two decades have therefore witnessed the rapid emergence of multidrug resistant enterococci²⁶⁻²⁸.

i. Legionnaires' disease

Table 1. Present status of nosocomial infections in other countries

United States: The Centers for Disease Control and Prevention (CDC)	1.7 million hospital-associated infections, urinary tract infection (36%), followed by surgical site infection (20%), bloodstream infection (BSI), and pneumonia (both 11%)
France: at national level, prevalence among patients in health care facilities was	Estimates 6.7% in 1990 to 7.4%6.7% in 1996, 5.9% in 2001 and 5.0% in 2006. The rates for nosocomial infections were 7.6% in 1996, 6.4% in 2001 and 5.4% in 2006.
Italy: A survey in Lombardy gave a rate of 4.9% of patients in 2000.	Since 2000, estimates show that about 6.7% infection rates, i.e. between 450,000 and 700,000 patients, which caused between 4,500 and 7,000 deaths.
United Kingdom:	Estimates of 10% infection rate, with 8.2% estimated in 2006.
Switzerland:	Range between 2 and 14%. A national survey gave a rate of 7.2% in 2004.
Finland:	Estimated at 8.5% of patients in 2005

Legionella pneumophila as a cause of HAP is variable, but is increased in immune compromised. Patients, such as organ transplant recipients or patients with HIV disease, as well as those with diabetes mellitus, underlying lung disease, or end-stage renal disease. HAP due to *Legionella* species is more common in hospitals where the organism is present in the hospital water supply or where there is ongoing construction. Because detection is based on the widespread use of *Legionella* urinary antigen, rather than culture for *Legionella*, disease due to serogroups other than serogroups 1 may be under diagnosed. Detailed strategies for prevention of *Legionella* infections and eradication procedures for *Legionella* species in cooling towers and the hospital water supply are outlined in the CDC/HICPAC Guidelines for Preventing Health-care-associated

Pneumonia^{8,16,29-31}.

5. Antibiotic resistance

Trends in antibiotic resistance and their consequences for health, welfare and the economy are rapidly changing. Antibiotic resistance threatens the success of medical interventions at all levels of health care and creates a set of specific challenges for clinical, therapeutic and public health interventions with local, national, and global dimensions. Bacteria that belong to the normal flora in humans become indiscriminately exposed to antibiotic compounds every time antibiotics are used. Therefore, the most significant resistance has been emerging among these microorganisms. Since most of them are truly opportunistic pathogens, the most vulnerable segment of societies i.e. the

Table 2. Common Antibiotics and their mode of action.

Mode of action	Class of antibiotic	Examples	Clinical uses
Cell wall inhibitors	Penicillin	Penicillin V and G	Gram-positive
	Semi-synthetic penicillin	Ampicillin, Amoxicillin	Gram-positive and -negative bacteria, except penicillinase producing bacteria, e.g. <i>S. aureus</i>
	Cephalosporins	Cefotaxime, cefradine, ceftazidime	Gram-negative organisms with later generation better with Gram-positive
	Monobactams	Aztreonam	Gram-negative organisms
	Carbapenems	Meropenem	Broad-spectrum
	β lactamase inhibitors	Clavulanate	
	Glycopeptides	Vancomycin	Gram-positive organisms (e.g. MRSA and enterococci)
Cell membrane inhibitors	Antifungal		
	Polyenes	Nystatin	Aspergillus, Candida
	Imidazoles	Ketonazole	
	Triazoles	Fluconazole	
Protein synthesis inhibitors	Aminoglycoside	Gentamicin	
	Macrolides	Erythromycin	Gram-positive organisms
	Oxaolidinines	Linezolid	<i>H. influenza</i>
	Ketolides	Telithomycin	
	Streptogramins	Synercid	
Nucleic acids inhibitors	Fluoroquinolonones	Ciprofloxacin	Broad Gram-negative Spectrum
	Nitro imidazoles	Metronidazole	<i>C. difficile</i>
	Sulphonamides	Sulphonamides	

allow Genetic changes reflect phenotypic alleles, and enable the bacteria to deal with the antibiotic. These mechanisms can be summarized as follows^{36,37}:

• *Antibiotic inactivating enzymes* e.g. β -lactamases, aminoglycoside modifying enzymes, chloramphenicol acetyl transferase etc.

• *Impaired uptake of antibiotics* which can be natural due to cell envelope characteristics. In the case of acquired resistance changes in porins may interfere with antibiotic transport.

the bacteria to grow in the presence of the antibiotic. This mechanism is seen in glycopeptide, aminoglycoside, macrolide, sulpha/trimethoprim resistance amongst others.

In essence all strategies aim at optimizing the antibiotic stress in the environment, decrease unintended interaction between antibiotics and pathogens, restrict the spread of resistant organisms and treat infections with the minimum amount of antibiotic necessary to effect cure. Towards this end a number of countries have evolved national programmes that tackle the complex issue. The common methods being focused on are^{37,38}:

- Surveillance of antibiotic use and resistance rates.
- Optimizing antibiotic use with treatment guidelines.
- Education of professionals and the public.
- Prevention with infection control measures and immunization.

7. Control of antimicrobial resistance

Table 3. List of infection causing agents and their resistance against antibiotics.

S. no.	Causative agent	Cause	Resistant against antibiotics
1.	<i>E coli</i>	urinary tract infections and bacteremia in humans	Aminopenicillins, such as amoxicillin or ampicillin, and narrow spectrum cephalosporins.
2.	<i>S Aureus</i> (MRSA)	infection among hospitalized patients	Vancomycin, Methicillin
3.	<i>P aeruginosa</i>	opportunistic infections among immune compromised individuals	Multidrug resistance
4.	<i>Vibrio cholerae</i>	Watery diarrhea.	furazolidone, cotrimoxazole, nalidixic acid, tetracycline
5	<i>Klebsiellae</i>	pneumonia, bacteremia, thrombophlebitis, urinary tract infection (UTI), cholecystitis, diarrhea, upper respiratory tract infection, wound infection, osteomyelitis, and meningitis	β -lactam, multidrug resistant
6.	<i>Acinetobacter</i> sp.	nosocomial pneumonia, ventilator associated pneumonia	Penicillin, chloramphenicol, amino glycosides, fluoroquinolones
7.	<i>Stenotrophomonas maltophilia</i>	pneumonia, urinary tract infection, or blood stream infection; in immunocompromised	Multidrug resistant
8.	<i>Serratia</i> sp.	Nosocomial infections of the bloodstream, lower respiratory tract, urinary tract, surgical wounds, and skin and soft tissues in adult patients	Multidrug resistant
9.	<i>S. typhi</i>	typhoid, or enteric fever	Fluroquinolones, chloramphenicol,
10.	<i>S. paratyphi</i>	Paratyphoid fevers	Fluroquinolones, chloramphenicol,
11.	<i>Neisseria gonorrhoea</i>	sexually transmitted diseases	Penicillin, fluoroquinolone
12.	<i>Neisseria meningitides</i>	sporadic and epidemic meningitis	Penicillin
13.	<i>Streptococci</i> sp.	meningitis, bacterial pneumonia, endocarditis, erysipelas and necrotizing fasciitis	tetracycline's and Macrolides
14.	<i>Enterococcus fecalis</i>	Urinary tract infections (UTI), bacteremia, endocarditis and neonatal infections	Ampicillin, trimethoprim, sulphonamides, ciprofloxacin.

young, elderly and immune-compromised are likely to face infections and the consequences of failing antibiotic effectiveness. The WHO Global Strategy for Containment of Antibiotic Resistance^{2,32-34}.

6. Causes of antibiotic resistance

Development of an alternate metabolic pathway would would

- Industry involvement, financial resource mobilization and drug development.
- Regulatory issues with central prescribing restrictions and advertising restrictions.
- Audit with evaluation of interventions, audit of compliance and physician feed back.

7. Guidelines

The 2001 WHO global strategy¹ for the containment of AMR addresses *what to do and how to do it* and provides a framework of interventions to slow the emergence and reduce the spread of antimicrobial resistant microorganisms wherever anti-infective medicines are used, through:

- reducing the disease burden and spread of infection;
- improving access to appropriate antimicrobials;
- improving the use of antimicrobials;
- strengthening health systems and their surveillance capabilities;
- enforcing regulation and legislation;
- encouraging the development of appropriate new drugs and vaccines.

WHO is engaged in guiding the response to AMR through:

- policy guidance, support for surveillance, technical assistance, knowledge generation and partnerships, including through disease prevention and control programmes;
- essential medicines quality, supply and rational use;
- infection prevention and control;
- patient safety; Laboratory quality assurance.

Conclusion

Hospital acquired infection in medical terms is known as nosocomial infection. It is an infection whose growth and development is favored by hospital environment. It easily spreads to the regular visitors in the hospital and the hospital staff. It includes fungal and bacterial infections that are aggravated by the low immunity. The most effective technique for controlling nosocomial infection is to strategically implement quality assurance, quality control, good laboratory practices measures to the health care sectors and evidence-based management. For those with ventilator associated or hospital acquired pneumonia, controlling and monitoring hospital indoor air quality needs to be on agenda in management, whereas for nosocomial rotavirus infection, a hygiene protocol has to be enforced along with the well defined management for ambulance transport.

References

1. WHO, The evolving threat of antimicrobial resistance, Options for action. ISBN 978 92 4 150318 1 (2012).
2. ECDC, 2010a. Annual Report of the European Antimicrobial Resistance Surveillance Network (EARS-Net). Antimicrobial resistance surveillance in Europe 2009, retrieved 20 February 2011 from http://www.ecdc.europa.eu/en/publications/Publications/1011_SUR_annual_EARS_Net_2009.pdf.
3. Louis V, Bihari M.B., Suter P. The prevalence of nosocomial Infection in intensive care units in Europe. European Prevalence of infection in Intensive care (EPIC) study. *J Am Med Ass* **274** (1995) 639–44.
4. Inweregbu K., Dave J, & Pittard A, Nosocomial infections. Continuing Education in Anaesthesia, *Critical Care & Pain*. **5** (2005)14-17.
5. Nordmann P., Poirel L. Emerging carbapenemases in gram-negative aerobes. *Clinical Microbiology and Infection*. **8** (2002) 321–331.
6. Sengupta S, & Chattopadhyay M K, Antibiotic Resistance of Bacteria: A Global Challenge. *Resonance* (2012) 171-191. (VOL MISSING)
7. Niederman MS, Guidelines for the management of respiratory infection why do we need them, how should they be developed, and can they be useful? *Current Opinion in Pulmonary Medicine*. **2** (1996) 161–165.
8. Tablan O C, Anderson L J, Besser R, Bridges C, & Hajjeh R, Healthcare Infection Control Practices Advisory Committee, Centers for Disease Control and Prevention. Guidelines for preventing health-care–associated pneumonia, 2003: recommendations of the CDC and the Healthcare Infection Control Practices Advisory Committee. *MMWR Recommend Rep*, **53** (RR -3) (2004) 1–36.
9. Richards M J, Edwards J R, Culver D H, & Gaynes R P, Nosocomial infection in medical ICUs in the United States: National Nosocomial Infections Surveillance System. *Crit Care Med*, **27** (1999) 887–892.
10. Craven D E, Kunches L M, Kilinsky V, Lichtenberg D A, Make B J, & McCabe W R, Risk factors for pneumonia and fatality in patients receiving continuous mechanical ventilation. *American Review of Respiratory Disease*. **133** (1986) 792–796.
11. Richards M J, Edwards J R, Culver D H, & Gaynes R P, Nosocomial infection in medical ICUs in the United States: National Nosocomial Infections Surveillance System. *Crit Care Med*, **27** (1999) 887–892.
12. Fridkin S K, Increasing prevalence of antimicrobial resistance in intensive care units. *Crit Care Med*, **29** (2001) N64–N68.
13. Rello J, Torres A, Ricart M, Valles J, Gonzalez J, Artigas A, & Rodriguez- Roisin R. Ventilator-associated pneumonia by *Staphylococcus aureus*: comparison of methicillin-resistant and methicillin-sensitive episodes. *Am J Respirat Crit Care Med*, **150** (1994) 1545–1549.
14. De-Lencastre H, De-Jonge B L, & Matthews P R, & Tomasz A. Molecular aspects of methicillin resistance in *Staphylococcus aureus*. *J Antimicrob Chemotherapy* **33** (1994) 7–24.
15. Ma X X, Ito T, Tiensasitorn C, Jamklang M, Chongtrakool P, Boyle-Vavra S, & Daum SR, Novel type of staphylococcal cassette chromosome mechanism identified in community-acquired Methicillin-resistant *Staphylococcus aureus* resistant strains. *Antimicrob Agents Chemotherapy*, **46** (2002) 1147–1152.
16. El-Ebiary M, Sarmiento X, Torres A, Nogue S, Mesalles E, Bodi M, & Almirall J, Prognostic factors of severe *Legionella pneumonia* requiring admission to ICU. *Am J Respirat Crit Care Med*, **156** (1997)1467–1472.
17. Krasinski K, Holzman RS, Hanna B, Greco MA, Graff M, & Bhogal M, Nosocomial fungal infection during hospital renovation. *Am J Infect Control*, **6** (1985) 278–282.
18. Lentino J R, Rosenkranz M A, Michaels J A, Kurup V P, Rose H D, & Rytel M W, Nosocomial aspergillosis: a retrospective review of airborne disease secondary to road construction and contaminated air conditioners. *Am J Epidemiol*, **116** (1982) 430–437.

19. Loo VG, Bertrand C, Dixon C, Vitye D, DeSalis B, McLean AP, Brox A, & Robson HG, Control of construction-associated nosocomial aspergillosis in an antiquated hematology unit. *Infection Control Hospital Epidemiol*, **17** (1996) 360–364.
20. Gage A A, Dean D C, Schimert G, & Minsley N, Aspergillus infection after cardiac surgery. *Archives of Surgery*. **101** (1970) 384–387.
21. Van Eldere J, Multicentre surveillance of Pseudomonas aeruginosa susceptibility patterns in nosocomial infections. *J Antimicrob Chemotherapy*, **51** (2003) 347–352.
22. Landman D, Quale JM, Mayorga D, Adedeji A, Vangal K, Ravishankar J, & Flores C, Citywide clonal outbreak due to a multiresistant Acinetobacter baumannii and Pseudomonas aeruginosa in Brooklyn, NY: the preantibiotic era has returned. *Arch Internal Med*, **162** (2002) 1515–1520.
23. Dubois V, Arpin C, Melon M, Melon B, Andre C, Frigo C, & Quentin C, Nosocomial outbreak due to a multiresistant strain of Pseudomonas aeruginosa P12: efficacy of cefepime–amikacin therapy and analysis of β -lactam resistance. *J Clin Microbiol*, **39**(2001)2072–2078.
24. Livermore D M, Multiple mechanisms of antimicrobial resistance in Pseudomonas aeruginosa: our worst nightmare. *Clin Infectious Dis*, **34** (2002) 634–640.
25. Wood G C, Hanes S D, Croce M A, Fabian T C, & Boucher B A, Comparison of ampicillin–sulbactam and imipenem–cilastatin for the treatment of Acinetobacter ventilator-associated pneumonia. *Clin Infectious Dis*. **34** (2002) 1425–1430.
26. Moellering M C, Emergence of Enterococcus as a significant pathogen. *Clin Infectious Dis*. **14** (1992) 1173–6.
27. Mundy L M, & Sahm D F, Gilmore M. Relationships between Enterococcal virulence and antimicrobial resistance. *Clin Microbiol Reviews*. **13** (2000) 513-22.
28. Arias C A, & Murray B E, Emergence and management of drug resistant Enterococcal infections. *Expert Rev Anti-Inf Therapy*. **6** (2008) 637-55.
29. Yu V L, Kroboth F J, Shonnard J, Brown A, McDearman S, & Magnussen M, Legionnaires' disease: new clinical perspective from a prospective pneumonia study. *Am J Med*, **73** (1982) 357–361.
30. Stout J, Yu V L, Vickers R M, & Shonnard J, Potable water supply as the hospital reservoir for Pittsburgh pneumonia agent. *Lancet*, **1** (1982) 471– 472.
31. Venezia R A, Agresta M.D, Hanley E M, Urquhart K, & Schoonmaker D, Nosocomial legionellosis associated with aspiration of nasogastric feedings diluted in tap water. *Infect Control Hosp Epidemiol*, **15** (1994) 529–533.
32. Grundmann H, Klugman K.P, Walsh T, Pardo P R, Sigauque B, Khan W, Laxminarayan R, Heddini A, & Stelling J, A framework for global surveillance of antibiotic resistance. *Drug Resistance Updates*, **14** (2011) 79–87.
33. Inweregbu K, Dave J, Pittard A, Nosocomial infections. Continuing Education in Anaesthesia, *Crit Care & Pain*, **5** (2005) 14-17.
34. WHO Global Strategy for Containment of Antimicrobial Resistance. Retrieved 20 February, 2011 from <http://www.who.int/drugresistance/> WHO Global Strategy English.pdf. (2001).
35. Streulens M J, The problem of resistance; in Antibiotic and chemotherapy. Chapter 3, 8 Edt. (2003) 25–47
36. Tenover F C, Mechanisms of Antimicrobial Resistance in Bacteria. *The Am J Med*, **119** (2006) S3–S1
37. Raghunath D, Emerging antibiotic resistance in bacteria with special reference to India. *J Biosci*, **33**(4) (2008) 593-603
38. Carbon C, Cars O, & Christiansenle, Moving from recommendation to implementation and audit: Part me, Current recommendations and programs: a critical commentary; *Clin Microbiol Infections*, **8** (2002) 92–10.