Identification and molecular characterization of mannitol salt positive, coagulase-negative staphylococci from nasal samples of medical personnel and students

Adebayo Shittu,1 Johnson Lin,1 Donald Morrison2 and Deboye Kolawole3

Correspondence
Johnson Lin
linj@ukzn.ac.za

1School of Biochemistry and Microbiology, University of KwaZulu-Natal, Private Bag X54001, Durban 4000, Republic of South Africa
2Scottish MRSA Reference Laboratory, Microbiology Department, Stobhill Hospital, Glasgow G21 3UW, UK
3Department of Microbiology, Obafemi Awolowo University, Ile-Ife, Nigeria

Received 4 March 2005
Accepted 21 October 2005

The identification of mannitol salt positive, coagulase-negative staphylococci (CNS) is often disregarded when Staphylococcus aureus is screened in clinical samples using mannitol salt agar. However, the emergence of CNS as important human pathogens has indicated that reliable methods for the identification of clinically significant CNS are of great importance in understanding the epidemiology of infections caused by them. The identification and molecular characterization of mannitol salt positive CNS from nasal samples of medical personnel and students is reported here. A total of 84 mannitol salt positive staphylococcal isolates were obtained from 240 nasal samples, of which 15 were CNS. The API STAPH system classified the CNS isolates into six species, and one-third of the isolates were identified with confidence levels of < 80 %. 16S–23S rRNA intergenic spacer length polymorphism analysis (ITS-PCR) identified only two species (Staphylococcus haemolyticus and Staphylococcus saprophyticus). This identification was confirmed by antibiotyping, species-specific PCR and PFGE. The results from this study indicate that ITS-PCR is a potentially useful and reliable tool, enabling hospital laboratories to obtain rapid, full and accurate identification of CNS at the species level.

INTRODUCTION

The identification of bacterial pathogens in human infection plays a key role in the management of patients in health care institutions. In many clinical laboratories, Staphylococcus aureus is usually isolated on nonspecific media (e.g. blood agar) and then presumptively identified before definitive overnight characterization (Kloos & Bannerman, 1995). In an attempt to achieve presumptive isolation in a single step, mannitol salt agar (MSA) was developed in 1945 for the selective isolation of pathogenic staphylococci in the clinical microbiology laboratory (Chapman, 1945; Blair et al., 1967). The growth and production of yellow colonies, due to the high salt content of the medium and fermentation of mannitol, is regarded as a presumptive tool in the identification of S. aureus. It is also described as a characteristic for the differentiation of coagulase-positive staphylococci from coagulase-negative staphylococci (CNS) (Duguid, 1989). However, there are reports that some CNS can also produce yellow colonies on MSA (Martinez et al., 1992; Merlino et al., 1996; Mit et al., 1998; Jayaratne & Rutherford, 1999; Simor et al., 2001; Zadik et al., 2001). Mannitol salt positive CNS impede and delay the isolation and subsequent identification of S. aureus in clinical samples on the primary plate. Nevertheless, they have attracted very little attention and in most cases are not identified to species level.

As a group, the CNS are among the most frequently isolated bacteria in the clinical microbiology laboratory. They are becoming increasingly important as causative agents of hospital-acquired bacteraemia, with the increasing use of prosthetic devices and other invasive technologies in medical institutions (von Eiff et al., 2002). Furthermore, CNS are nosocomial pathogens associated with multiple antimicrobial-resistance mechanisms including, in particular, methicillin resistance (Hanberger et al., 2001). Therefore, the full and accurate identification of CNS species, which is still difficult in most clinical laboratories, is of diagnostic value, and of clinical and epidemiological importance (Varaldo & Biavasco, 1997; Couto et al., 2001; De Paulis et al., 2003).

Abbreviations: CNS, coagulase-negative staphylococci; ITS-PCR, 16S–23S rRNA intergenic spacer length polymorphism analysis; MSA, mannitol salt agar.
The aim of this study was to identify mannitol salt positive CNS to the species level, using a commercial identification kit (API STAPH) and 16S–23S rRNA intergenic spacer length polymorphism analysis (ITS-PCR), a PCR-based method. Characterization of the isolates based on biotyping, antibiotyping and PFGE was also investigated.

**METHODS**

This investigation was part of a surveillance programme on staphylococcal nasal carriage among medical personnel and students in a referral hospital in Nigeria. The surveillance programme was conducted from January to February 2001. A total of 60 individuals (20 medical doctors, 20 preclinical students and 20 clinical students) at the Obafemi Awolowo University Teaching Hospitals Complex, Ile-Ife, Nigeria, were included in the study after obtaining permission from the Hospital Authority and informed consent from the volunteers. This hospital is a major referral centre for more than one million people living within a 40 km radius from Ile-Ife.

The medical personnel were new graduates of the medical profession, and the preclinical group were first and third year medical students. Furthermore, the clinical cohort that participated in this study were fourth and final year students.

Nasal swabs were taken from each individual every week, for a period of 4 weeks. The swabs were immediately streaked on MSA (Biolife) and incubated at 37 °C for 48 h. Thereafter, distinct well-separated yellow colonies on MSA were noted and used for further characterization. Staphylococci were identified based on Gram reaction (Gram-positive cocci in clumps), catalase, coagulase (tube method using rabbit plasma) and DNase tests. Biotyping was based on the hydrolysis of urea, Tween 80 and pigmentation on Isosensitest agar (Coia et al., 1990). Pigmentation was classified as yellow (Y), cream (C) or white (W). The biotyping tests were incubated at 35–37 °C and read after 48 h. Coagulase and DNase-negative staphylococcal isolates were identified by the API STAPH system (bioMérieux) according to the manufacturer’s instructions. Identification profiles using the API STAPH system were categorized based on the following confidence levels: ‘excellent’, 90–99%; ‘very good’, 80–90%; ‘good’, 70–80%; ‘not definitive’, 50–70%.

**Antibiotyping of mannitol salt positive CNS.** Susceptibility testing was performed using the agar disc diffusion technique following the recommendations given by the National Committee for Clinical Laboratory Standards (NCCLS, 2000). The antibiotics ( Mast Diagnostics) included penicillin (10 U), oxacillin (1 μg), streptomycin (30 μg), erythromycin (15 μg), gentamicin (10 μg), kanamycin (30 μg), tobramycin (30 μg), tetracycline (30 μg), ciprofloxacin (5 μg), chloramphenicol (30 μg), trimethoprim (5 μg), muromycin (200 μg), novobiocin (5 μg) and fusidic acid (10 μg). Isolates with zone diameters ≤16 mm for novobiocin and ≤18 mm for fusidic acid (antibiotics not included in the NCCLS guidelines) were adjudged resistant to these compounds (Goldstein et al., 1983; Skov et al., 2001).

**Molecular identification of mannitol salt positive CNS.** A multiplex PCR assay was conducted to confirm phenotypic identification of the isolates as CNS and oxacillin resistant. Primers mec-1 (5′-GGCGATTGATGGTATAAGTTT-3′) and mec-2 (5′-AGCCAGCTTGAAGACTAAAAAC-3′), and mecAl (5′-CTCAAGTACTGCGATCACCAC-3′) and mecA2 (5′-CAGTCTGATAATGCTCACC-3′), which amplified a 280 bp segment of the S. aureus species-specific mec gene and the 449 bp mecA gene, were employed (MacKenzie et al., 2002). Molecular identification was performed by ITS-PCR (Couto et al., 2001; Lee & Park, 2001) using the primers described by Jensen et al. (1993). Three to five colonies were resuspended in NET buffer (10 mM Tris, 1 mM EDTA, 10 mM NaCl) containing 10 U achromopeptidase (Sigma), and incubated at 50 °C for 10–15 min. Extracted DNA (2 μl) was added to 12.5 μl Reddy Load (Abgene) PCR mix (0.2 mM dATP, dCTP, dGTP and dTTP, 3 mM MgCl2, 0.625 U Taq polymerase, 20 mM Tris base, 50 mM KCl) (Abgene) and 25 pmol primers (MWG-Biotech) G1 (5′-GAAGATCTGAAACGAGG-3′) and L1 (5′-GAAGGATCCAGGAGCTG-3′). Tissue culture-grade water (Sigma) was added to give a final volume of 25 μl. Cycling conditions consisted of 34 cycles of 95 °C, 55 °C and 72 °C for 1 min each, followed by a final cycle of 72 °C for 7 min. PCR products (6 μl) were loaded into 1.5 % Mastigel GP agarose (Mast Diagnostics) gels. Electrophoresis was performed in 0.5× TBE buffer pH 8 (45 mM Tris-borate, 5 mM EDTA) at 100 V for 10-5 h. The patterns of the PCR products were visually compared with previously characterized clinical isolates obtained in the health facility, and NCTC (National Collection of Type Cultures) reference strains. A representative of each pattern by ITS-PCR was further tested by appropriate species-specific primers as described by Gribaldo et al. (1997).

**PFGE typing.** PFGE typing of Smal (Fermentas) digested DNA was carried out by a modification of the protocol described by Bannerman et al. (1995). A colony was inoculated in brain heart infusion broth and incubated overnight at 37 °C without agitation. The pellet from 0.4 ml culture was washed in 0.8 ml NET buffer (10 mM Tris, 1 mM EDTA, 10 mM NaCl) and resuspended in 0.2 ml NET buffer. An aliquot of 50 μl lysozyme (500 μg ml−1) (Sigma), 50 μl lysisophen (400 μg ml−1) (Sigma) and 100 μl 2 % agarose (Bio-Rad), at 50 °C, was then added. The cell/agarose suspension was loaded into block moulds (Bio-Rad) and allowed to solidify at 4 °C. Cells were lysed by incubation at 37 °C overnight in lysis buffer (6 mM Tris base, 100 mM EDTA, 1 M NaCl, 0.5 % Brij 58, 0.2 % sodium deoxycholate, 0.5 % lauroylsarcosine). This was followed by a second overnight incubation at 50 °C in 1 ml proteolyis buffer (1 % lauroylsarcosine, 75 μg Proteinase K, 0.5 % EDTA). The blocks were washed three times, with shaking, at 37 °C for 30 min in 1 ml TE buffer (10 mM Tris base, 1 mM EDTA). Thereafter, one quarter of each agarose block was washed four times at 37 °C for 30 min in 1 ml sterile distilled water. The agarose blocks were then digested with 30 U Smal for 3 h, according to the manufacturer’s instructions, and loaded into the wells of a 1 % PFGE certified agarose gel (Bio-Rad). Electrophoresis was performed in 0.5× TBE buffer (pH 8) (Invitrogen) by the contour-clamped homogeneous electric field method with a CHEF system (Bio-Rad). The fragments were separated with a linear ramped pulse time of 6–8–63–8 s over a period of 23 h at 14 °C. The agarose gel was stained in 1 μg ethidium bromide ml−1 solution (Sigma) for 1 h, visualized under UV and photographed (SynGene bioimaging system). The banding patterns of the isolates were compared and analysed based on the classification of CNS species by Snopkova et al. (1994).

**RESULTS**

A total of 84 mannitol salt positive staphylococcal isolates were recovered from 240 nasal samples obtained in this study. A total of 69 isolates (82 %) were confirmed as *S. aureus* based on positive coagulase and DNase tests. The remaining 15 (18 %) were coagulase and DNase negative. The absence of the *S. aureus* species-specific *mec* gene product further confirmed phenotypic identification as CNS. The mannitol salt positive CNS were assigned by the API STAPH system into six species: *S. haemolyticus* (7
Identification of mannitol salt positive CNS isolates into two main groups (Table 1). All the isolates identified as *S. haemolyticus* by ITS-PCR were susceptible to fusidic acid and novobiocin, and isolates classified as *S. saprophyticus* were resistant to these antibiotics. One of the isolates, S11 (4), identified as a novobiocin-susceptible CNS (*S. hominis*) by the API STAPH system, was resistant to novobiocin. The five *S. haemolyticus* isolates, which exhibited resistance to oxacillin by the disc diffusion method, were *meca* positive by PCR. However, oxacillin-resistant *S. saprophyticus* isolates were *meca* negative.

There was excellent correlation between the PFGE patterns and ITS-PCR (Fig. 3). In particular, a single large fragment (>674 kb) distinguished the banding patterns of the *S. saprophyticus* and *S. haemolyticus* isolates.

### DISCUSSION

The ability of various media to isolate *S. aureus*, differentiate coagulase-positive and -negative staphylococci or inhibit CNS has been the basis of a number of studies. These media include mannitol salt oxacillin tellurium medium (Martinez et al., 1992), lipovitellin salt mannitol agar (Merlino et al., 1996), soft salt mannitol agar-cloxacillin (Mir et al., 1998), methicillin aztreonam MSA (Perry et al., 1998), mannitol salt oxacillin agar (Jayaratne & Rutherford, 1999),

**Table 1.** Identification of nasal mannitol salt positive CNS isolates based on the API STAPH system and ITS-PCR, and characterization by antibiotyping, biotyping and *meca* gene detection

<table>
<thead>
<tr>
<th>Isolate</th>
<th>Source of specimen*</th>
<th>API code</th>
<th>API STAPH (confidence level)</th>
<th>ITS-PCR</th>
<th>Antibiotyping‡</th>
<th>Biotype‡</th>
<th><em>meca</em> gene by PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>S8</td>
<td>Medical doctor</td>
<td>2622051</td>
<td><em>S. haemolyticus</em> (99-8 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxTe</td>
<td>NNW</td>
<td>+</td>
</tr>
<tr>
<td>S3 (2)</td>
<td>Medical doctor</td>
<td>6632051</td>
<td><em>S. haemolyticus</em> (93-3 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxErGnCpTrTeKmSt</td>
<td>NNW</td>
<td>+</td>
</tr>
<tr>
<td>S5 (3)</td>
<td>Medical doctor</td>
<td>2622050</td>
<td><em>S. haemolyticus</em> (99-8 %)</td>
<td><em>S. haemolyticus</em></td>
<td>TeKmSt</td>
<td>NNW</td>
<td>-</td>
</tr>
<tr>
<td>S11 (4)</td>
<td>Medical doctor</td>
<td>2614051</td>
<td><em>S. haemolyticus</em> (93-2 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxGnTrTeKm</td>
<td>NNW</td>
<td>+</td>
</tr>
<tr>
<td>S10 (3)§</td>
<td>Medical doctor</td>
<td>6636071</td>
<td><em>S. haemolyticus</em> (89-2 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnChCpTrTe</td>
<td>NNW</td>
<td>-</td>
</tr>
<tr>
<td>S10 (4)§</td>
<td>Medical doctor</td>
<td>6636171</td>
<td><em>S. haemolyticus</em> (83-3 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxChTrTe</td>
<td>NNW</td>
<td>+</td>
</tr>
<tr>
<td>M3T3II</td>
<td>Medical student (pre)</td>
<td>6622051</td>
<td><em>S. haemolyticus</em> (96-2 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxErGnTrTeKmTb</td>
<td>NNW</td>
<td>+</td>
</tr>
<tr>
<td>M6O2</td>
<td>Medical student (clin)</td>
<td>6626013</td>
<td><em>S. epidermidis</em> (66-1 %)</td>
<td><em>S. haemolyticus</em></td>
<td>Fully susceptible</td>
<td>NNW</td>
<td>-</td>
</tr>
<tr>
<td>M3T4II</td>
<td>Medical student (pre)</td>
<td>6606113</td>
<td><em>S. epidermidis</em> (97-8 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnGnTeKm</td>
<td>NNW</td>
<td>-</td>
</tr>
<tr>
<td>M1B4</td>
<td>Medical student (pre)</td>
<td>6216153</td>
<td><em>S. hominis</em> (92-4 %)</td>
<td><em>S. haemolyticus</em></td>
<td>Tr</td>
<td>NNW</td>
<td>-</td>
</tr>
<tr>
<td>S2 (3)</td>
<td>Medical doctor</td>
<td>6334111</td>
<td><em>S. warneri</em> (78-3 %)</td>
<td><em>S. haemolyticus</em></td>
<td>TeKmSt</td>
<td>NNW</td>
<td>-</td>
</tr>
<tr>
<td>S9 (3)</td>
<td>Medical doctor</td>
<td>6374140</td>
<td><em>S. cohnii</em> (99-8 %)</td>
<td><em>S. saprophyticus</em></td>
<td>PnOxCpFdTrTeNv</td>
<td>NNW</td>
<td>-</td>
</tr>
<tr>
<td>S1 (4)</td>
<td>Medical doctor</td>
<td>6634112</td>
<td><em>S. saprophyticus</em> (71-4 %)</td>
<td><em>S. saprophyticus</em></td>
<td>FdNv</td>
<td>PNY</td>
<td>-</td>
</tr>
<tr>
<td>S11 (4)</td>
<td>Medical doctor</td>
<td>6230153</td>
<td><em>S. hominis</em> (52-1 %)</td>
<td><em>S. saprophyticus</em></td>
<td>FdNv</td>
<td>NNC</td>
<td>-</td>
</tr>
<tr>
<td>M4Y3</td>
<td>Medical student (clin)</td>
<td>6276152</td>
<td><em>S. saprophyticus</em> (74-3 %)</td>
<td><em>S. saprophyticus</em></td>
<td>FdOxNv</td>
<td>PNY</td>
<td>-</td>
</tr>
</tbody>
</table>

*Pre, preclinical student; clin, clinical student.

‡Antibiograms classified the mannitol salt positive CNS isolates into two main groups (Table 1). All the isolates identified as *S. haemolyticus* by ITS-PCR were susceptible to fusidic acid and novobiocin, and isolates classified as *S. saprophyticus* were resistant to these antibiotics. One of the isolates, S11 (4), identified as a novobiocin-susceptible CNS (*S. hominis*) by the API STAPH system, was resistant to novobiocin. The five *S. haemolyticus* isolates, which exhibited resistance to oxacillin by the disc diffusion method, were *meca* positive by PCR. However, oxacillin-resistant *S. saprophyticus* isolates were *meca* negative.

<table>
<thead>
<tr>
<th>Source of specimen*</th>
<th>API code</th>
<th>API STAPH (confidence level)</th>
<th>ITS-PCR</th>
<th>Antibiotyping‡</th>
<th>Biotype‡</th>
<th><em>meca</em> gene by PCR</th>
</tr>
</thead>
<tbody>
<tr>
<td>S8</td>
<td>Medical doctor</td>
<td>2622051</td>
<td><em>S. haemolyticus</em> (99-8 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxTe</td>
<td>NNW</td>
</tr>
<tr>
<td>S3 (2)</td>
<td>Medical doctor</td>
<td>6632051</td>
<td><em>S. haemolyticus</em> (93-3 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxErGnCpTrTeKmSt</td>
<td>NNW</td>
</tr>
<tr>
<td>S5 (3)</td>
<td>Medical doctor</td>
<td>2622050</td>
<td><em>S. haemolyticus</em> (99-8 %)</td>
<td><em>S. haemolyticus</em></td>
<td>TeKmSt</td>
<td>NNW</td>
</tr>
<tr>
<td>S11 (4)</td>
<td>Medical doctor</td>
<td>2614051</td>
<td><em>S. haemolyticus</em> (93-2 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxGnTrTeKm</td>
<td>NNW</td>
</tr>
<tr>
<td>S10 (3)§</td>
<td>Medical doctor</td>
<td>6636071</td>
<td><em>S. haemolyticus</em> (89-2 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnChCpTrTe</td>
<td>NNW</td>
</tr>
<tr>
<td>S10 (4)§</td>
<td>Medical doctor</td>
<td>6636171</td>
<td><em>S. haemolyticus</em> (83-3 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxChTrTe</td>
<td>NNW</td>
</tr>
<tr>
<td>M3T3II</td>
<td>Medical student (pre)</td>
<td>6622051</td>
<td><em>S. haemolyticus</em> (96-2 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnOxErGnTrTeKmTb</td>
<td>NNW</td>
</tr>
<tr>
<td>M6O2</td>
<td>Medical student (clin)</td>
<td>6626013</td>
<td><em>S. epidermidis</em> (66-1 %)</td>
<td><em>S. haemolyticus</em></td>
<td>Fully susceptible</td>
<td>NNW</td>
</tr>
<tr>
<td>M3T4II</td>
<td>Medical student (pre)</td>
<td>6606113</td>
<td><em>S. epidermidis</em> (97-8 %)</td>
<td><em>S. haemolyticus</em></td>
<td>PnGnTeKm</td>
<td>NNW</td>
</tr>
<tr>
<td>M1B4</td>
<td>Medical student (pre)</td>
<td>6216153</td>
<td><em>S. hominis</em> (92-4 %)</td>
<td><em>S. haemolyticus</em></td>
<td>Tr</td>
<td>NNW</td>
</tr>
<tr>
<td>S2 (3)</td>
<td>Medical doctor</td>
<td>6334111</td>
<td><em>S. warneri</em> (78-3 %)</td>
<td><em>S. haemolyticus</em></td>
<td>TeKmSt</td>
<td>NNW</td>
</tr>
<tr>
<td>S9 (3)</td>
<td>Medical doctor</td>
<td>6374140</td>
<td><em>S. cohnii</em> (99-8 %)</td>
<td><em>S. saprophyticus</em></td>
<td>PnOxCpFdTrTeNv</td>
<td>NNW</td>
</tr>
<tr>
<td>S1 (4)</td>
<td>Medical doctor</td>
<td>6634112</td>
<td><em>S. saprophyticus</em> (71-4 %)</td>
<td><em>S. saprophyticus</em></td>
<td>FdNv</td>
<td>PNY</td>
</tr>
<tr>
<td>S11 (4)</td>
<td>Medical doctor</td>
<td>6230153</td>
<td><em>S. hominis</em> (52-1 %)</td>
<td><em>S. saprophyticus</em></td>
<td>FdNv</td>
<td>NNC</td>
</tr>
<tr>
<td>M4Y3</td>
<td>Medical student (clin)</td>
<td>6276152</td>
<td><em>S. saprophyticus</em> (74-3 %)</td>
<td><em>S. saprophyticus</em></td>
<td>FdOxNv</td>
<td>PNY</td>
</tr>
</tbody>
</table>
The identification of clinically significant CNS at the species level is needed to provide a better understanding of the pathogenic potential of various CNS species (Heikens et al., 2005).

In a surveillance programme on staphylococcal nasal carriage among medical personnel and students in a referral hospital in Nigeria, 15 (18 %) out of a total of 84 mannitol salt positive (yellow) staphylococcal isolates were confirmed as CNS by the absence of the S. aureus species-specific nuc gene product. Previous investigations have indicated that 40–50 % of mannitol salt positive isolates on oxacillin resistance screening agar were in fact CNS (Becker et al., 2002; Blanc et al., 2003). In our study, a total of 11 isolates of S. haemolyticus and 4 of S. saprophyticus utilized mannitol, producing yellow colonies on MSA. Surprisingly, three of the isolates (S13-4, M1B4 and M3T4) did not utilize mannitol in the API STAPH system. We have also observed atypical biochemical profiles for some S. aureus isolates in which mannitol-negative methicillin-resistant S. aureus isolates (on MSA) produced acid from mannitol in the API STAPH system. The reason for this finding is unclear and warrants further investigation. Several studies have reported mannitol fermentation on various media by S. haemolyticus (Martinez et al., 1992; Mir et al., 1998; Becker et al., 2002; Blanc et al., 2003) and several CNS species, including S. epidermidis (Jayaratne & Rutherford, 1999; Blanc et al., 2003), S. saprophyticus (Mir et al., 1998), S. warneri, S. hominis, S. cohnii (Becker et al., 2002; Blanc et al., 2003), Staphylococcus simulans, Staphylococcus chromogenes (Becker et al., 2002) and Staphylococcus sciuri (Becker et al., 2002; Shittu et al., 2004).

A variety of methods have been proposed for the identification of CNS. These include conventional laboratory techniques, commercial identification systems and molecular biology-based methods (Lee & Park, 2001). Commercial identification kits are used in most clinical laboratories to identify CNS. However, these diagnostic systems appear not to be able to make a reliable distinction.
between the different species of CNS because of the variable expression of phenotypic characters (Birnbaum et al., 1991; Bannerman et al., 1993; Grant et al., 1994; Ieven et al., 1995; Rennerberg et al., 1995; Calvo et al., 2000). Misidentification of CNS species using commercial identification systems, in comparison with the reference (conventional) (De Paulis et al., 2003; Cunha et al., 2004) and molecular methods (Couto et al., 2001; Lee & Park, 2001; Becker et al., 2004; Sivadon et al., 2004; Ben-Ami et al., 2005; Carretto et al., 2005; Fujita et al., 2005; Heikens et al., 2005; Skow et al., 2005), have been reported. In this study, the API STAPH system classified the 15 CNS isolates into 6 species, whereas the ITS-PCR identified only 2 species. The overall agreement of the API STAPH system and ITS-PCR was 60% (9 out of 15 isolates). However, four isolates identified as S. haemolyticus by ITS-PCR were classified by the API STAPH system as S. epidermidis (2), S. hominis (1) and S. warneri (1). Similarly, two S. saprophyticus isolates (ITS-PCR identification) were grouped as S. cohnii and S. hominis by the API STAPH system (Table 1). Several investigators have assessed the ability of various molecular methods to identify CNS species (Mendoza et al., 1998; Martineau et al., 2001; Poyart et al., 2001; Yugueros et al., 2001; Drancourt & Raoult, 2002; Becker et al., 2004; Carretto et al., 2005; Skow et al., 2005). ITS-PCR is a recognized method for typing and identification of various bacterial species, including the staphylococci, and has been applied successfully to identify CNS to the species and subspecies level (Gurtler & Stanisich, 1996; Couto et al., 2001; Lee & Park, 2001; Shittu et al., 2004; Fujita et al., 2005; Stepanovic et al., 2005). We confirmed the reliability of the ITS-PCR method by testing representatives of each pattern with species-specific primers as described by Gribaldo et al. (1997). PCR assays using species-specific primers confirmed the ITS-PCR species identification of three isolates that produced DNA patterns with minor differences from characterized NCTC strains. Snopkova et al. (1994) described the classification of CNS species based on the overall similarity of their Smal PFGE restriction patterns. The PFGE patterns observed in this study correlated well with the ITS-PCR species identification. Antibiograms based on the susceptibility of CNS to novobiocin have been an important diagnostic tool in differentiating species of CNS (Goldstein et al., 1983; Freney et al., 1999; Marsou et al., 2001). The 15 CNS in this study were divided into two main groups based on susceptibility to fusidic acid and novobiocin, supporting the ITS-PCR identification.

Resistance to oxacillin in CNS has become a problem, as CNS express resistance to all β-lactam antibiotics, and leads to a significant limitation in therapeutic options (York et al., 1996). In this study, five oxacillin-resistant S. haemolyticus isolates were mecA positive, while the two S. saprophyticus isolates...
isolates, which exhibited resistance to oxacillin using the disc diffusion method, lacked the mecA gene. York et al. (1996) and Bogado et al. (2001) have observed this trend, and suggested that a mechanism other than the production of PBP2a may be involved in methicillin resistance in S. saprophyticus. It also reaffirms the problematic nature in screening for methicillin resistance and the need for reliable methods for its detection in this species. The hyper-production of β-lactamase has been suggested as a major factor in false-positive detection of oxacillin resistance in CNS (Ghoshal et al., 2004).

This investigation, along with earlier studies, confirms that additional tests are needed to differentiate between S. aureus and CNS mannitol-fermenting (yellow) colonies on MSA (Simor et al., 2001; Becker et al., 2002). Molecular methods, such as ITS-PCR, are more reliable for identification of CNS than the API STAPH system, and ITS-PCR is a potentially useful tool enabling hospital laboratories to obtain full and accurate identification of CNS.

ACKNOWLEDGEMENTS

The National Research Foundation, Republic of South Africa, supported the project. We thank Bongi Sigwebela (University of Zululand, Republic of South Africa) for assistance in the acquisition of research articles and Dr Srdjan Stepanovic for valuable comments and suggestions.

REFERENCES


