Case report

A male preterm infant of 26 weeks and 4 days gestation was born by spontaneous vaginal delivery weighing 1140 g. The mother was admitted to hospital 10 days before labour because of fever and rupture of membranes. She was suspected of having chorioamnionitis and given ampicillin and gentamicin after collection of blood cultures. The infant was born in good condition with good Apgar scores. Because of fever and rupture of membranes, she was admitted to hospital 10 days before labour.

Pregnancy and delivery

The mother was admitted to hospital 10 days before labour because of fever and rupture of membranes. She was suspected of having chorioamnionitis and given ampicillin and gentamicin after collection of blood cultures. The infant was born in good condition with good Apgar scores. Because of fever and rupture of membranes, she was admitted to hospital 10 days before labour.

The child’s course was further complicated by bronchopulmonary dysplasia, severe anaemia, intraventricular hemorrhaging and retinopathy of prematurity. He was discharged home on the 88th day after birth weighing 3190 g and with a favourable outcome for ocular and respiratory problems.

Microbiology

Maternal vaginal and rectal swab cultures were obtained immediately after the culture report of the infant, yielded ESBL-producing E. coli (isolates P354 and P355, 9th day after delivery). Cultures from vaginal and rectal swabs were both grown on selective MacConkey agar with 2 mg cefotaxime l−1. MICs and species identification of all three E. coli isolates were determined using standard methods. ESBL production was confirmed by the double-disc synergy test (CLSI, 2005).

The three E. coli isolates were resistant to amoxicillin (MIC >16 mg l−1), cefotaxime (MIC ≥8 mg l−1), ceftazidime (MIC >16 mg l−1) and gentamicin (MIC ≥8 mg l−1) and showed synergy between clavulanic acid and cefotaxime/ceftazidime compatible with ESBL production. β-Lactamase characterization was carried out by isoelectric focusing of the sonicated extract (Matthew et al., 1975) and by PCR of the bla genes with specific primers for the CTX-M-1 ESBL group (Oteo et al., 2006). Amplicons were further sequenced for the final characterization of the bla gene. Strains were assigned to a phylogenetic group by a multiplex PCR method based on three DNA marker fragments (chuA, yjaA and TspE4.C2), as described elsewhere (Clermont et al., 2000).

All three E. coli isolates demonstrated a closely related XbaI PFGE pattern (http://www.cdc.gov/pulsenet/protocols/ecoli_salmonella_shigella_protocols.pdf) (Fig. 1) and were assigned to the A1 phylogenetic group (chuA−, yjaA+, TspE4.C2−). These strains expressed a β-lactamase with a pI of 9.0, suggesting the presence of a CTX-M-1-type enzyme. Sequence analysis of the PCR products obtained identified β-lactamase CTX-M-32, a recently identified variant of the CTX-M-1 group (Cartelle et al., 2004). The bla_CTX-M-32 gene was successfully transferred to E. coli J53 Az R (Romero et al., 2004) from H344, P354 and P355.

Neonatal sepsis caused by a CTX-M-32-producing Escherichia coli isolate

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We describe what we believe to be the first case of neonatal sepsis caused by CTX-M-producing Escherichia coli, in a low-weight preterm infant, born to a colonized mother who had received antibiotic treatment antepartum. Increased dissemination of extended-spectrum β-lactamase-producing E. coli in the community should be borne in mind for empirical therapy of sepsis in high-risk newborns.
EcoRI restriction patterns of the plasmids of the three isolates were extremely similar (Fig. 2).

**Discussion**

The present report, to our knowledge, provides the first evidence of ESBL-producing *E. coli* spreading from mother to child and causing neonatal sepsis. Neonatal sepsis by ESBL-producing *E. coli* isolates used to occur as nosocomial infections in intensive care units (Jain et al., 2003). Recently, in our area, ESBL-producing *E. coli* isolates have tended to emerge as community infections (Romero et al., 2005) and a significant number of community faecal carriers have been detected (Miro´ et al., 2005). Our case is unique in indicating the possibility of vertical transmission of a drug-resistant strain that was probably community-acquired. This is suggested by the clonal relatedness between isolates and the ESBL enzyme type. At present, isolates expressing CTX-M-32 have barely been detected in our country and every case has been in a non-hospitalized patient (Oteo et al., 2006). Similarly, this enzyme was not identified in our hospital until this case.

Vertical confirmed neonatal sepsis is generally defined in terms of a positive blood culture along with clinical signs and laboratory abnormalities consistent with infection diagnosed within the first 3 days of life (López-Sastre et al., 2005). Although, in the present report, the infection was diagnosed after 3 days, the criteria for vertical neonatal sepsis were met: risk factors for vertical transmission, a positive blood culture for traditional pathogens of vertical transmission, absence of similar cases at the unit and the same strain of *E. coli* isolated in both mother and her newborn. Mothers are educated to follow exhaustive contact precautions. Although we cannot completely discard the possibility that the strain was transmitted by direct contact between mother and child, we consider that vertical transmission was much more likely.

It has been suggested that, in the absence of evidence for group B streptococcus disease, clinicians should consider the possibility of ampicillin-resistant *E. coli* infection in critically ill newborn of women with a history of intrapartum fever and ampicillin treatment (Stoll et al., 2005). The problem is made worse because of the increasing dissemination of ESBL-producing *E. coli* in our area and a high rate of co-resistance to aminoglycosides observed for these strains (Romero et al., 2005).

The increasing prevalence of community-acquired ESBL-producing *E. coli* suggests that further epidemiological surveillance is required in order to monitor the aetiology and management of vertical transmission of neonatal sepsis when obstetric risk factors are present.

**Acknowledgements**

This work was supported by the Ministerio de Sanidad y Consumo, Instituto de Salud Carlos III – FEDER, Spanish Network for the Research in Infectious Diseases (REIPI RD06/0008).

**References**


