Investigation of Various Virulence Factors and SCCmec Types in the Healthcare-associated and Community-associated Methicillin Resistant Staphylococcus aureus Strains

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ABSTRACT

Objective: The objective of this study was to investigate some virulence genes and SCCmec types of methicillin-resistant Staphylococcus aureus (MRSA) isolates and to determine their relationship with virulence factors.

Methods: A total of 100 MRSA strains, 64 from healthcare-associated and 36 from community-associated infections, were included in the study. The presence of mecA gene was investigated by PCR. SCCmec types and efb, clfB, agrA gene were detected by multiplex PCR and their relationship with virulence factors has been analysed.

Results: All of the isolates contain the mecA gene. At the same time, in 66 strains (66%) agrA gene, in 58 strains (58%) clfB gene, and in 47 strains (47%) efb gene were positive. In terms of SCCmec types, the distribution of these types among the 64 HA-SA strains was 53% similar-to-type-III, 16% type IV, 2% type I and 30% unclassified. The distribution of the types among the 36 CA-SA strains was 19% similar-to-type-III, 25% type IV, 8% type I and 47% unclassified, respectively. When SCCmec types were evaluated according to clinical sample type, similar-to-type-III isolates were found to be dominant in wound samples. efb (78%), clfB (85%), agrA (100%) were the main genes detected in the type IV strains.

Conclusion: It is of clinical and epidemiological importance to know the origin of MRSA strains because this affects the empirical treatment choice.

Keywords: Methicillin-resistant Staphylococcus aureus, PCR typing, SCCmec, virulence factors

INTRODUCTION

Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium that causes epidemics and endemics worldwide and leads to infections with high morbidity and mortality (1).

S. aureus is the most commonly isolated bacterium in both community-associated (CA-SA) and healthcare-related (healthcare-associated-HA-SA) infections. S. aureus can cause serious infections, such as life-threatening pneumonia and toxic shock syndrome from skin and soft tissue infections (2). The first MRSA strains associated with healthcare delivery were identified in 1960 and CA-MRSA was first described in 1980. These strains are primarily associated with skin and soft tissue infections, but now also cause health-related infections (1, 3).

In addition to the increase in the prevalence of hospital infections caused by CA-MRSA, there is the issue that it cannot be easily differentiated from HA-MRSA, based on clinical and epidemiological criteria. For this reason, the use of genetic indicators in their classification has gained importance (4). MRSA strains isolated from community-associated infections, have been observed to be different from HA-MRSA both genotypically and phenotypically (3).


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Polymerase chain reaction (PCR) is frequently used in the detection of methicillin resistance, genotyping of MRSA strains and determining virulence factors (5).

The mecA gene encoding the methicillin resistance is located on a mobile genetic element called mec (SCCmec) of the staphylococcal cassette chromosome. SCCmec consists of mec gene complex (mecA and regulating genes) and ccr complex. To date, 13 (I-XIII) main types have been defined in different SCCmec types. Of these, SCCmec type I, II and III were mostly detected in HA-MRSA; Type IV, V, VI, and VII were associated with CA-MRSA strains (3, 6).

In S. aureus infections, virulence factors that are found on the cell surface and secreted out of the cell also play an important role. The virulence of S. aureus strains does not depend on any of these biological factors alone but is caused by several effects (7). Different virulence markers are observed at different stages of staphylococcal infections. Agr (accessory gene regulator) is a core sensor system that plays a critical role in the systemic infection process. Agr, a quorum-sensing system, plays a role in the regulation of transcription of genes encoding some surface proteins and enzymes released outside the cell (8).

Whether all MRSA strains have an equal potential for disease or whether invasive and chronic diseases are associated with virulent genotypes is still unknown. The identification of virulence genes may explain this issue (1).

The aim of this study was to determine the SCCmec types of MRSA strains isolated from outpatients and outpatients by multiple PCR and to determine the distribution of some important virulence genes among these types.

METHODS

Patient Groups and Bacterial Strains
One hundred MRSA strains from various polyclinics/services from the Microbiology Laboratory in 2014-2016 were included in our study. The strains were identified by the Phoenix ™ 100 (Becton Dickinson, USA) automated system and confirmed by the coagulase test. If more than one MRSA was isolated from one patient, only one was included in the study. The strains were stored at -80 °C in a Brain-Heart Infusion medium with 10% glycerin.

Infection origin types were defined according to CDC criteria (9). Thirty-six of all strains were isolated from patients admitted to various polyclinics of the hospital and these strains were accepted as ‘community-acquired’. The other 64 strains were isolated from the different infection sites of patients in the hospital and in the intensive care units, and these strains were accepted as ‘healthcare-associated’. The clinic, sample type and date information of patients were recorded. When evaluated in terms of sample type, 58 of the strains were blood, 20 were wound, 9 were nasal, 7 were urine and 6 were sputum samples.

Determination of Methicillin Resistance
Methicillin resistance in strains was determined by detecting the minimum inhibitory concentration (MIC) of cefoxitin by the Phoenix™ 100 (Becton Dickinson, USA) automated system. Data were confirmed by the cefoxitin disc diffusion (DD) test according to the European Committee on Antimicrobial Susceptibility Testing (EUCAST) (10) standards. S. aureus ATCC 25923 was used as a control group.

Antibiotic Susceptibility Testing
The in-vitro susceptibilities of the strains to gentamicin, levofloxacin, tetracycline, erythromycin, clindamycin, trimethoprim-sulfamethoxazole, rifampicin, vancomycin, teicoplanin, daptomycin, quinupristin-dalfopristin, and linezolid were also determined by the Phoenix™ 100 (Becton Dickinson, USA) automated system.

DNA Isolation
Prior to PCR experiments, genomic DNA was isolated as in the Merlino et al. (11) study.

Investigation of Virulence Genes and MecA Gene
The presence of the mecA gene in resistant strains was investigated. In addition, the presence of the agrA regulatory gene, responsible for the regulation of various toxins, enzymes and surface proteins and efb (extracellular fibrinogen binding protein) clfB (cloning factor B) virulence genes were investigated using the multiplex PCR method. The thermal cycling conditions were applied using the primers indicated in Table 1 for 1 minute at 94°C, 1 minute at 42°C and 1.5 minutes at 72°C, following 5 minutes initial denaturation at 94°C. Finally, multiplex PCR was completed with final elongation for 10 minutes at 72°C.

Molecular Typing with Multiplex PCR
In order to determine the SCCmec types of strains, primers given in the study performed by Milheiricho et al. (12) were used. Thermal cycling conditions were also applied as given in the same study. S. aureus HPV107 (SCCmec type IA), BK2464 (SCCmec type II), HUSA304 (SCCmec type III), HSJ216 (SCCmec type IIIA) and GRE14 (SCCmec type IV) were used as a positive control.

Analysis of Results
Statistical significance was analyzed by Fisher’s exact chi-square test using the GraphPad Prism (California, USA) program. If p-value ≤0.05, the results were considered significant.

RESULTS
45 (45%) of the strains included in the study were isolated from females and 55 (55%) were from males. The mean age was 62.25 (24-99) years. S. aureus strains were isolated from blood (58; 58%), wound (20; 20%), nasal (9; 9%), urine (7; 7%) and sputum (6; 6%) samples. Hospital-associated strains were most frequently isolat-
ed from blood samples (50/64, 78.12%) and community-acquired strains were isolated from wound samples (20/36, 55.55%). 29 (29%) of the strains were from intensive care units (anesthesia, neurology, internal medicine, brain surgery, cardiology), 24 (24%) from internal medicine clinic/polyclinic, and 22 (22%) other services / polyclinics (neurology), dermatology, chest, infectious diseases, 17 (17%) from surgical services / polyclinics (general surgery, neurosurgery, urology, orthopedics, otolaryngology, cardiovascular surgery) and 8 (8%) from emergency services obtained from clinical samples sent from the observation unit.

Prevalence of Virulence Genes and mecA Resistance Gene

According to the multiplex PCR results, it was observed that all of the strains (100) included in the study carried the mecA resistance gene. The distribution rates of virulence genes investigated in HA and CA strains are given in Table 2.

Statistically, there was no significant difference in terms of the distribution rates of these virulence genes between the two groups (p>0.05).

Distribution of SCCmec Types

In 41 (41%) of all strains, in addition to bands of 414, 243, 209 and 162 bp, which form the type III pattern, a band of the size of 342 bp,
which normally corresponds to the dcs region of type I, II, IV and V was observed. Gülmez et al. (13) who benefited from the previous study of the same author group (14) identified 342 band size bands corresponding to the dcs region and named the similar-to-type III pattern. In addition, 19 (19%) strains were classified as type IV and 4 (4%) as type I, 4 of whom belonged to type IV subtype.

In this study, a variety of patterns have been observed in 14 of the 36 strains with non-detectable SCCmec types, such as the absence of some loci that cause the pattern of a particular type to be missing or the combination of specific loci of different types, a band with only 162 bp internal positive control amplicon (mecA) was observed. The patterns shown by non-groupable strains are shown in Table 3.

The distribution of SCCmec types in 64 hospital-associated strains was determined as 53% similar-to-type-III, 16% type IV, 2% type I and 30% non-groupable. The distribution of SCCmec types in 36 community associated strains was determined as 19% similar to type III, 25% type IV, 8% type I and 47% non-groupable.

Upon examining the distribution of types in terms of strain type, similar-to-type-III strains were found to be frequent in the wound samples (p <0.05), and there was no statistically significant difference between the groups in the distribution of other types (p> 0.05).

Similar-to-type-III strains were found to have efb (78%), clfB (85%) and agrA (88%) genes. For type IV strains, on the other hand, clfB (74%) and agrA (100%) genes was detected. The distribution of these genes was found to be much less frequent in Type I strains and non-grouped strains.

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**Antibiotic susceptibility testing**

All *S. aureus* strains were susceptible to vancomycin, teicoplanin, daptomycin, quinupristin-dalfopristin and linezolid. Other antibiotic resistance rates of *S. aureus* strains with HA/CA were; gentamicin 50.0%/33.3%, levofloxacin 64.06%/26.7%, tetracycline 46.7%/33.3%, erythromycin 64.06%/53.3%, clindamycin 46.7%/20%, trimethoprim-sulfamethoxazole 34.4%/33.3%, rifampicin 48.4%/20%.

**DISCUSSION**

Methicillin-resistant *S. aureus* infections continue to be a significant threat to human health in the second decade of the 21st century. Despite significant progress in understanding MRSA infections and virulence mechanisms, there are continuing challenges that need to be addressed. Knowledge of the prevalence of genetic markers and virulence factors contributing to the success of MRSA will be useful for the control and treatment of community and hospital induced *S. aureus* infections.

HA-MRSA is seen to occur in different rates in our country in relation to the regions. Alp et al. (15) reported that HA-MRSA prevalence ranged between 12-75% in a multicentered study they carried out in Turkey, in eight university hospitals, in six different geographic regions, where they had isolated MRSA. The prevalence of CA-MRSA was reported to be 1-3% in our country (16).

In addition to the genotypic differences between HA-MRSA and CA-MRSA, the strains affect different populations and cause different clinical syndromes. CA-MRSA infections tend to occur in healthy children and young adults and are associated with skin and soft tissue infections including necrotizing fasciitis and severe invasive infections such as pneumonia and sepsis. In contrast, HA-MRSA strains are most commonly seen in patients who are under antibiotic treatment, have a weakened immune system and who have been treated using invasive medical devices. HA-MRSA strains commonly cause pneumonia, bacteremia and invasive infections (17).

In our study, MRSA strains were first isolated from blood (58%) and secondly from wounds (20%) according to sample types. HA-strains were most frequently isolated 78.12% from blood samples and 55.55% CA-strains were isolated from wound samples.

The risk of bacteremia due to MRSA in inpatients varies according to the services. The highest risk is stated to be in intensive care units (18). In our study, when the distribution of MRSA strains according to services was examined, it was seen that 29% of them were isolated from intensive care. This may be due to a more invasive procedure, more severe underlying disease and/or the presence of immunosuppression.

The monitoring of the SCCmec has been carried out around the world for many years. In MRSA strains, it has been confirmed that methicillin resistance gained through the ccr and mec gene complex (mecA and new homologs; mecB, mecC, mecD), influences the concentration of beta-lactam antibiotic resistance and antimicrobial minimal inhibitor, which has been found to lead to multiple drug resistance (19). HA-MRSA strains are resistant to multiple drugs due to drug-resistant genes integrated into SCCmec (20, 21). CA-MRSA strains are generally susceptible to non-beta-lactam antibiotics because they do not carry the resistance gene other than mecA (3).

A thorough understanding of the prevalence and occurrence of SCCmec may help further to identify, control, prevent and treat staphylococcal-mediated human diseases (19). In the studies in order to type SCCmec in MRSA strains in Turkey, more than 80% of HA-MRSA strains were reported to be SCCmec type III, rarely SCCmec type IIIB, CA-MRSA strains were reported to be SCCmec type IV and V more frequently, SCCmec type I and II have been reported less frequently (15). Karahan et al. (22), reported SCCmec type I or II or III and subtypes in 99% of HA-MRSA strains, SCCmec type IV in 1%; In 60% of CA-MRSA strains, SCCmec type I or II or III and 40% SCCmec type IV or V; Tekeli et al. (23) reported 84% SCCmec type III in MRSA strains isolated from blood cultures of hospitalized patients; Kliç et al. (16), reported SCCmec type I or II in 3.6% of MRSA strains, SCC mec type III in 82.1%, SCCmec type IV in 5.1% and SCCmec type V in 5.1% of MRSA strains; Gülmez et al. (13) SCCmec type IVa in CA-MRSA strains, similar to SCCmec type III in HA-MRSA strains; Akoglu et al. (5), 61.8% SCCmec type IIb in HA-MRSA strains, 34.5% SCCmec type IIIB and 2.7% SCCmec type III.
mec type IV; Baran et al. (24) found SCCmec type III in 24 (85.7%) of the HA-MRSA strains and 100% SCCmec type IV in all CA-MRSA strains, 1 (3.6%), SCCmec type IV, and 3 (10.7%) HA-MRSA strain could not be typed by the method used. In 2013, Oksuz et al. (25) SCCmec type III in MRSA clones; Yilmaz et al. (26) in the HA-MRSA strains, 90% SCCmec type III, 2.2% (1 isolate) SCCmec type IV and 40% SCCmec type IV were detected in CA-MRSA strains and they could not make the typing of the remaining strains. Similar to other studies conducted in our country, 53% SCCmec type III strains were found most frequently in HA-MRSA, while 25% type IV strains and 47% non-groupable strains were found to be the most common in CA-MRSA. Similar-to-type-III strains were found to be predominant in wound samples.

It was thought that community-associated MRSA was initially from nosocomial strains and was spreading from hospitals to the community. However, paradoxically, the sensitivity of CA-MRSA to non-beta-lactam antimicrobial agents and their association with clinical syndromes typical for Methicillin-sensitive Staphylococcus aureus (MSSA) are strong evidence that CA-MRSA is different from the strains seen in health care units. After the introduction of genotypic differences that differentiate CA-MRSA from HA-MRSA, the idea that CA-MRSA develops from MSSA, which is endemic in the community, has started to be accepted generally. The beta-lactams, once effective in community-associated S. aureus strains, have transformed into unreliable therapeutic agents. CA-MRSA is often more sensitive than HA-MRSA to non-beta-lactam antibiotics such as clindamycin, TMP / SMX, and doxycycline (2). Many MRSA clones have gained resistance to antibiotics such as erythromycin, clindamycin, ciprofloxacin, tetracycline. Multi drug resistance exists (27). Most of the CA-MRSA strains were not resistant to additional antibiotics except for the limited outbreaks of multidrug-resistant CA-MRSA (28). In studies conducted in our country, Akoglu et al. (5) reported a high (> 90%) resistance to gentamicin, ciprofloxacin, and rifampicin, sensitivity to TMP-SMX 90%, clindamycin 53% and erythromycin 32%. Öksüz et al. (25) found penicillin 100%, tetracycline 100%, rifampicin 100%, kanamycin, tobramycin, 93%, levofloxacin 93%, erythromycin 75%, lincomycin 49%, phosphomycin 58% and fusidic acid 4% multidrug resistance. Baran et al. (24) found susceptibility to vancomycin, linezolid and TMP-SMX in all strains, whereas in HA-MRSA / CA-MRSA strains respectively; rifampicin 89.3% / 0%, ciprofloxacin 89.3% / 50%, gentamycin 89.3% / 0%, erythromycin 50% / 50% and clindamycin 28.6 / 0% rates of resistance were found. Tekeli et al. (29); found susceptibility to vancomycin in all strains, 97.7% in tetracycline, 97% in ciprofloxacin, 100% in rifampicin and 94.7% in gentamicin.

In our study, all S. aureus strains were found to be sensitive to glycopeptides. Other antibiotic resistance rates of S. aureus strains in hospital/community associated strains were 50.0% / 33.3% gentamicin, 64.06%/26.7% levofloxacin, 46.7% / 33.3% tetracycline, 64.06% / 53.3% erythromycin, 46.7% / 20% clindamycin 34.4% / 33.3%, 48.4% / 20%. TMP-SMX rifampicin. It was observed that our resistance rates were lower than other centers.

In recent years, CA-MRSA strains may also have played a role as a nosocomial infectious agent (30). Type IV SCCmec is primarily associated with MRSA infections in patients without risk factors for HA-MRSA. However, according to recent data on patients who do not have risk factors for HA-MRSA, most of the hospitalized patients in the US now have SCCmec IV (31). Gonzalez et al. (32) found SCCmec type IV in 60% of the HA-MRSA strains isolated from blood.

The virulence factors in S. aureus infection have gained importance. There are studies on the activity of agr, clf, efb virulence genes (28,33,34). The host factors that affect the severity of the disease remain an unexplained subject. In understanding virulence factors regulators more research is needed to determine how virulence factors are transmitted between MRSA strains (1).

In our study, it was observed that in type III strains efb78%, clfB 85% and agrA 88% genes, whereas in type IV strains clfB and 74% and agrA 100% genes were found to be frequent respectively. The distribution of these genes was found to be much less frequent in Type I strains and non-grouped strains.

CONCLUSION

The selective pressure of antimicrobial agents, together with the acquisition of genetic markers, allows MRSA to adapt to different environmental conditions, leading to a global spread of MRSA. Genetic backgrounds that can allow for the development of the MRSA clones can be determined through population studies and post-genomic investigations. The response of regulatory systems to external signals is a significant element in the epidemiologic success of a particular clone. Thus, as has been suggested by many recent studies, these events could be major areas for the development of future therapeutic interventions. Despite the fact that the relationship between endurance, virulence and antibiotic resistance is still to be fully understood, an understanding of how molecular markers can allow the spread of pathological processes will help in the development of prevention and treatment strategies aimed at overcoming the growing challenges associated with MRSA.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Non-Interventional Ethics Committee (1700049757/31.07.2017).

Informed Consent: Due to the in-vitro design of the study, informed consent was not taken.


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