Discernment of *Acinetobacter* Species in World Scenario

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**Abstract**

The morphology of *Acinetobacter* species is Gram-negative, nonmotile, nonfermenting, Strictly aerobic, Oxidase negative, and Catalase positive. It usually results from an infectious agent and is nonpathogenic in healthy people. *A. baumannii* can survive, for a long time and spread quickly in a hospital setting. *Acinetobacter baumannii* can cause many infections, the most common of which are bloodstream infections and nosocomial pneumonia in severe patients. These infections have a high mortality rate & the global emergence of antibiotic-resistant strains from multiple classes has reduced the number of drugs that still have activity against this pathogen. The lack of *A. baumannii* isolates that produce carbapenemase in addition to having a minimal inhibitory concentration of imipenem greater than carbapenem resistance. The overview of the prevalence of *Acinetobacter* in the Indian scenario and world scenario. Comparison between carbapenem resistance and multidrug resistance. According to the studies, carbapenem resistance is rapidly increasing. Infection with *Acinetobacter* is linked to high mortality and morbidity. According to our review, patients who have an infection with *A. baumannii* may be at an increased risk of dying. However, due to the confounding factors of illness severity, inappropriate impractical antimicrobial treatment, and small sample size, cautious interpretations are necessary. We covered the main factor that make *A. baumannii* such a prevalent nosocomial pathogen in this review, including such as its virulence components, desiccation resistance, and carbapenem resistance mechanisms. With the emergence of extended resistance to even more recent antibiotics, *Acinetobacter* species are rapidly proliferating. They can develop resistance much more quickly than other gram-negative organisms.

**Keywords:** *A.baumannii*, Desiccation, Morbidity, Carbapenem, Resistance, Extended, Antimicrobial
INTRODUCTION

Gram-negative, Non-motile, Nonfastidious, Nonfermenting, Oxidase negative, Catalase positive and Strictly aerobic bacteria are the characteristics of Acinetobacter. Acinetobacter species usually appear mucoid, smooth, lemon yellow to greyish-white colonies, though some isolates produce a diffusible brown pigment. It is oxidase negative, which can be used as a quick confirmatory method to distinguish Acinetobacter species from other nonfermenting bacteria. In the traditional nitrate reduction test, most strains are not able to reduce Nitrate-to- Nitrite. Acinetobacter baumannii can cause many infections, the most common of which are bloodstream infections and nosocomial pneumonia in severe patients. These infections have a high mortality rate & the global emergence of antibiotic-resistant strains from multiple classes has reduced the number of drugs that still have activity against this pathogen. One of the most problematic pathogens in healthcare today has just recently been identified as Acinetobacter baumannii. It usually results from an infectious agent and is non-pathogenic in healthy people.

A. baumannii can survive for a long time and spread quickly in a hospital setting. The two ways it is spread are through direct-contact with infected people or through indirect-contact with a contaminated environment. The airborne route is a major factor in the spread of A. baumannii infections in the hospital. Among the ESKAPE pathogens, A. baumannii is one of the most difficult. A. baumannii has a remarkable capacity for developing antibiotic resistance quickly, which within a few decades led to multidrug resistance. Factors that increase Drug Resistance Long-term, i.e. (Central-venous- Catheterization, Urinary- catheterization, Prior- exposure) to potent antibiotics and invasive procedures are all risk factors for Acinetobacter colonization and infection. A. baumannii colonization and infection rates in hospitals in North America increased, going from 1.0% in 2003 to 58.0% in 2008, according to data gathered. Acinetobacter species that are carbapenem-resistant seriously endanger public health in Europe. Higher than 70 percent of any and all invasive Acinetobacter species isolates in Southern and Eastern Europe were carbapenem-resistant. Carbapenem Resistance for A. baumannii is more common than 50% in many hospitals, especially in Intensive care unit settings, as well as emergence & developed quickly in South and Southeast Asia in 2017. Imipenem nonsusceptibility was linked to "ISAba1" upstream of the acquired carbapenemase blaOXA-23, blaOXA-40, blaOXA-51 or the intrinsic carbapenemase blaOXA-51. Eight different clusters of isolates, including European clones First, second, and third, were formed. The most prevalent and significant group, with 246 isolates, was European clone II i.e USA. Prevalence- of specific genes in isolates of A. baumannii resistant to Imipenem of MBL-positive rate of OXA-51 was 44(97.77), OXA-23 was 44(100) and blaNDM were 4(100). The mechanisms that make A. baumannii resistant to carbapenem put the drug's effectiveness in danger.

Mechanism of Acinetobacter baumannii's resistance to carbapenem

The carbapenem resistance mechanism of A. baumannii can be divided into four groups:

Penicillin-binding protein changes

Due to the downregulation of the Penicillin-binding protein, A. baumannii strains exhibit low drug affinities and exhibit carbapenem resistance. In addition to the production of carbapenemases, the absence of 732-kDa PBP in A. baumannii isolates with imipenem minimum inhibitory concentrations (MICs) greater than 4 mg/L was associated with carbapenem resistance. PBPs play a role in only low-level CRAB main fact that is the mutations altering their production level or binding affinity cause resistance in beta-lactam antibiotics.

Outer membrane porins are lost

Membrane permeability caused by reduced porin expression or porin mutation is another way that Acinetobacter species resist carbapenem. OMPs & porin channels are typically responsible for carrying antimicrobial agents into cells. Multiple of OMPs are involved in the transfer of beta-lactams across the membrane of A. baumannii.
Effluent pumps being turned on
Efflux pumps (EP) may also influence A. baumannii susceptibility to carbapenems.\textsuperscript{20} Efflux systems actively remove several antibiotics by pumping them out of the cell, in contrast to OMPs which are linked to antibiotic uptake. This causes multidrug resistance.\textsuperscript{21} Three of the five Efflux Pump families that are known to increase bacterial resistance—the Multidrug & Toxin compound extrusion (MATE) family, the Major facilitator superfamily (MFS), and the Resistance Nodulation cell division (RND) family most frequently found in pathogens.\textsuperscript{18}

Synthesis of carbapenem-hydrolyzing beta-lactamas
The significant Carbapenem resistance mechanism in A. baumannii, entails the inactivation or enzymatic activity of carbapenems. Carbapenemase enzymes, which also are commonly found on plasmids and are highly infectious, usually carry out this process.\textsuperscript{22} Classes A, B, C, and D of A. baumannii molecular b-lactamase enzymes have been identified based on their own preferred substrate and catalytic domain (from Ambler classification system). Class C enzymes hydrolyze cephalosporins, whereas carbapenemase belongs to classes A, B, and D. Metallo-b-lactamases (MBLs), also known as beta-lactamas, are enzymes that activate & disrupt the beta-lactam ring in the presence of an H\textsubscript{2}O molecule & a Zn\textsuperscript{2+}(a divalent cation). Contrarily, non-Metallo carbapenemas such as Beta-lactamas from classes A, C, and D require serine for catalytic activity as shown in Figure.\textsuperscript{23}

Review
Indian scenario of Acinetobacter species and carbapenem-resistant
Neeraj Goel conducted a study on the relationship between the use of antibiotics and the emergence of resistance in non-fermenters in tertiary care hospitals between 2002 and 2008. Blood cultures were positive 15,465 isolates (22% positivity rate) were grown from 69,010 blood samples. The non-fermenters among the 1525 isolates included 754 isolates of A. baumannii. Consuming carbapenem was associated with A. baumannii’s development of resistance (r = 0.756, P = 0.049), but other antimicrobials among non-fermenters. A. baumannii and carbapenem resistance were 74%.\textsuperscript{25}

A study by Jana M Swenson et al. stated that Acinetobacter spp. antimicrobial susceptibility

Figure. Important features in Acinetobacter baumannii such as its virulence factors and mechanisms of carbapenem resistance, as well as important therapeutic options for decreasing the frequency and chances of outbreaks caused by this pathogen (adapted from Lee et al.).\textsuperscript{24}
testing using NCCLS broth microdilution and disc diffusion test. The 196 isolates were identified. Of the 196 isolates, 149 (76%) belonged to the Acinetobacter -calcoaceticus-baumannii complex (genospecies 1, 2, 3, and 13.26

Sadia Shakoor et al. conducted an in vitro study of Tigecycline & another tetracycline against carbapenem-resistant Acinetobacter species in 2006 in a tertiary care facility in Karachi, Pakistan. A total of 100 Acinetobacter spp. isolates were examined. In 98% of cases, Acinetobacter spp. was carbapenem-resistant. 

M. Johanson described the need for improved antimicrobial and infection control stewardship in the Vietnamese intensive care unit in 2007. An average of 811 defined daily doses of antibiotics were consumed. In these studies, antibiotic consumption is correlated with the isolation of gram-negative bacteria is 80% of isolated bacterial strains. The antibiotic most commonly used were third-generation cephalosporins, followed by ampicillin, amoxicillin, and carbapenems. The Acinetobacter species were the most frequently pathogenic in blood cultures. The most frequently isolated bacterium from either the respiratory tract or every another source put together was Acinetobacter. In 79%, 80%, and 89% of cases, the Acinetobacter species were less susceptible to imipenem, ciprofloxacin, and ceftazidime, respectively.28

All Faisal Saleem performed research on pan-resistant Acinetobacter infection in neonates in Karachi, Pakistan in 2008. Acinetobacter was grown in 122 cultures from 78 neonates during the 5 year study. Positive cultures were found in the following locations: (blood n = 57, trachea n = 55, tissue/wound/body fluids n = 4, eye n = 4, urine n = 1, and CSF n = 1.71% )of Acinetobacter isolates (87/122; only sensitive to Polymyxin) had pan-resistance.29

A.Y. Kruse conducted a cohort study on neonatal bloodstream infection in a pediatric hospital in Vietnam in 2009-2010. Pathogenic isolates were responsible for 56% of the BSIs. The majority of pathogenic isolates recovered were gram-negative bacteria, the most common being Acinetobacter spp.30

Murali Alagesan et al. conducted a single-center study from 2009 to 2013 to examine the Gram-negative blood culture isolates over ten years and changes in susceptibility patterns. Only the Critical care unit yielded 4128 of A. baumannii isolates, 75% of which were carbapenem-resistant and only susceptible to polymyxin E and tigecycline.31

In 2010-2011, Gomty Mahajan et al. conducted research on carbapenemase phenotypic detection and carbapenem resistance in clinical isolates of Acinetobacter baumannii. By using the disc diffusion method, meropenem resistance was detected in 42 isolates (31.81%). Using the modified Hodge test, 47.6% of the samples were carbapenemase positive, and the EDTA disc synergy test revealed that 19% of the samples were phenotypical MBL producers (EDS). Most of these 42 isolates, came from patients admitted to ICU. Four A. baumannii complex isolates demonstrated resistance to all known medications, including tigecycline and polymyxin B.32

Nguyen Thi Khanh Nhu determined that carbapenem-resistant Acinetobacter baumannii was the main cause of ventilator-associated pneumonia in ICU patients in 2010 in a hospital for infectious diseases in southern Vietnam. In the first eight years of the time series, 29% of all isolates per year were from Acinetobacter species. This proportion fell to 23% in 2008 before rising to 35% and 45%, respectively, in 2009 and 2010. The percentage of Acinetobacter spp. isolates increased by 6.6% yearly over the course of the study (OR 1.066, P = 0.022, 95% CI 1.02-1.12).33

The Carbapenem-resistant isolates of A. baumannii were molecularly characterized by Atul Khajuria et al. between 2011 and 2013 in the ICU of a tertiary care facility in central India. By using the disc diffusion method, it was discovered that 155 out of 368 (42.11%) isolates of A. baumannii had decreased susceptibility to imipenem. 130 (83.87%) of the 155 tested isolates had MIC values for imipenem & meropenem that ranges from 16 to 64 mg per liter, according to Clinical laboratory standard institute breakpoints. 93 (60%) of the 155 isolates were found to produce carbapenemase, according to the Modified Hodge test. Out of 155 isolates, 89 (57.41%) tested positive for DDST, 73 (47.09%) for CDST, and 105 (67.74%) for MBL (IP/ IPI) E-test. 47/105 (44.76%) of the 105 samples had the blaOXA-51 gene, 55/105 (52.38%) had the blaOXA-23 gene, and 15/105 (14.28%) had the blaOXA-58 gene.34
In 2011, Shahzeera Begum conducted research on the frequency of multidrug-resistant Acinetobacter baumannii in a clinical sample from a tertiary care hospital in Islamabad, Pakistan. MDR prevalence in A. baumannii was found to be 100%. The antibiotic susceptibility profile revealed that tigecycline or minocycline were the most effective antibiotics against A. baumannii. Metallo—lactamase, and carbapenemase were produced by almost all A. baumannii isolates. Although ampC was present in 41.76% of the isolates, none of them produced ESBLs. Tetracycline is moderately effective against A. baumannii, as determined by the antibiogram as well as minimal inhibitory concentrations (MICs).³⁵

At Nepal’s National Institute of Neurological & Allied Science in 2011–2012, Ganesh Thapa investigated nosocomial isolates and their drug-resistant pattern in ICU patients. 149 (79.67%) of the 187 total isolates were Gram-negative, and 121 (81.2%) of them were MDR. Acinetobacter spp. were the most frequently isolated Gram-negative bacteria, representing 58 (38.9%) of all isolates, 46 (79.31%) of which were MDR. With 23 isolates (15.4%), 20 of which were MDR (86.95%), K. oxytoca came in second. Similar to this, of the 38 total Gram-positive isolates, MDR isolates were discovered in 21 (55.2%) of them.³⁶

A systematic review of Acinetobacter species-caused urinary tract infections in hospitalized patients was done by Sanjeev et al. Of the 2240 culture-positive samples, 46 UTI patients had Acinetobacter spp. isolated from them. Imipenem came in second with 69.5%, followed by Tigecycline (91%), Meropenem (67.3%), and Gatifloxacin (63%), which had the lowest susceptibility. Acinetobacter species infection had spread throughout the bodies of the six patients who passed away. The most frequent risk factor for severe and widespread infection was mechanical ventilation.³⁷

According to a 2013 study by Reyes Martin peria et. al., quantitative real-time PCR enables quick detection of antibiotic resistance in A. baumannii. Forty-eight clinical isolates of A. baumannii with a wide range of MICs of amikacin, colistin, ciprofloxacin, & imipenem were examined for growth using a real time PCR assay that targets a highly conserved region of the (outer membrane protein A) gene. 184 of 192 determinants underwent broth microdilution as a result (95.8%).³⁶

In 2013 and 2014, Shirota Shrestha performed molecular epidemiology on isolates of the multidrug-resistant A. baumannii, revealing the emergence of a new epidemic clonal lineage. Among the 246 Acinetobacter spp. C isolates were examined, and 129 distinct XDR/MDR isolates were discovered, including 122 A. baumannii isolates, 6 A. calcoaceticus isolates, and 1 A. Berezina isolate. The 122 A. baumannii isolates included 109 XDR and 13 MDR strains.³⁸

Identification and isolation of Acinetobacter species with an emphasis on antibiotic resistance, according to a Neetu Gupta et al. study in 2015. Of the 3298 infected samples, 111 (3.36%) contained acinetobacter. The most prevalent (72%) was the Acinetobacter calcoaceticus & baumannii (Acb) complex. The most resistant drug was piperacillin, which had a resistance rate of 55 percent, followed by Ceftazidime (46%) & Ceftriaxone (46%). Antibiotic resistance and isolation rates were increased in the hospital’s intensive care units. "Extended-spectrum beta-lactamases and Metallo Beta Lactamases" production was suspected in 31.5% and 14.4%, respectively, of the isolates.³⁹

One of the studies was conducted on an environmental sample. A 2017 study claims that the discovery of antibiotic-resistant Acinetobacter baumannii in a variety of hospital environments as a potential source of Acinetobacter infection transmission Zahra Shamsizadeh et al. The approach Samples of air, water, and inanimate surfaces from four hospitals were examined for the presence of three of the most common OXA type carbapenemase encoding genes. The findings of this study revealed that 2% (1/42) of water samples, 17 percent, (7/42) of surface samples, &11% (7/64) of air samples all contained A. baumannii.⁴⁰

The 2016 study "Emergence of carbapenem-resistant Acinetobacter in a Temperate North Indian State" by N.K. Bali et al. 165 non-duplicate Acinetobacter strains were examined during the study period. The proportion of imipenem-resistant isolates in blood samples (the number is 72) was significantly increased than the proportion of imipenem-sensitive isolates (n=twenty six, 36.1 percent). Acinetobacter
<table>
<thead>
<tr>
<th>No.</th>
<th>Author</th>
<th>Year</th>
<th>% (Acinetobacter resistant isolates)</th>
<th>Acinetobacter isolates</th>
<th>Population screened</th>
<th>Sample type</th>
<th>Ref.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Neeraj Goel</td>
<td>2002-2008</td>
<td>0-74% (754)</td>
<td>1,525</td>
<td>Inpatient</td>
<td>Blood sample</td>
<td>25</td>
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<tr>
<td>2</td>
<td>Jana.M.Swe-nson</td>
<td>2004</td>
<td>76% (149)</td>
<td>196</td>
<td>Inpatient</td>
<td>All clinical sample</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>Sadia Shakoor</td>
<td>2006</td>
<td>98%</td>
<td>100</td>
<td>Inpatient</td>
<td>All clinical sample</td>
<td>27</td>
</tr>
<tr>
<td>4</td>
<td>M.Johansoon</td>
<td>2007</td>
<td>69%</td>
<td>170</td>
<td>Intensive care unit</td>
<td>All clinical sample</td>
<td>28</td>
</tr>
<tr>
<td>5</td>
<td>Ali Faisal</td>
<td>2008</td>
<td>89%</td>
<td>122</td>
<td>Intensive care unit</td>
<td>All clinical sample</td>
<td>29</td>
</tr>
<tr>
<td>6</td>
<td>A.Y.Kruse</td>
<td>2009-2010</td>
<td>43%</td>
<td>58</td>
<td>Inpatient</td>
<td>Blood sample</td>
<td>30</td>
</tr>
<tr>
<td>7</td>
<td>Murali Alagesan</td>
<td>2009-2013</td>
<td>67-74% (332)</td>
<td>4128</td>
<td>Inpatient</td>
<td>Blood sample</td>
<td>31</td>
</tr>
<tr>
<td>8</td>
<td>Gomty Mahajan</td>
<td>2010-2011</td>
<td>42% (132)</td>
<td>42</td>
<td>Inpatient</td>
<td>All clinical sample</td>
<td>32</td>
</tr>
<tr>
<td>9</td>
<td>N.T.K.Nhu</td>
<td>2010</td>
<td>80%</td>
<td>35</td>
<td>Intensive care unit</td>
<td>All clinical sample</td>
<td>33</td>
</tr>
<tr>
<td>10</td>
<td>Atul Khajuria</td>
<td>2011-2013</td>
<td>42% (362)</td>
<td>368</td>
<td>Intensive care unit</td>
<td>All clinical sample</td>
<td>34</td>
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<tr>
<td>11</td>
<td>Shahzeera B</td>
<td>2011</td>
<td>100%</td>
<td>91</td>
<td>Inpatient &amp; outpatient</td>
<td>Wound sample</td>
<td>35</td>
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<td>12</td>
<td>Ganesh Thapa</td>
<td>2011-2012</td>
<td>17%</td>
<td>58</td>
<td>Intensive care unit</td>
<td>All clinical sample</td>
<td>36</td>
</tr>
<tr>
<td>13</td>
<td>Sanjeev H</td>
<td>2013</td>
<td>91% (2240)</td>
<td>2240</td>
<td>Inpatient</td>
<td>All clinical sample</td>
<td>37</td>
</tr>
<tr>
<td>14</td>
<td>Shorita Shrestha</td>
<td>2013-2014</td>
<td>98%</td>
<td>122</td>
<td>Inpatient &amp; outpatient</td>
<td>All clinical sample</td>
<td>38</td>
</tr>
<tr>
<td>15</td>
<td>Neetu Gupta</td>
<td>2015</td>
<td>72% (111)</td>
<td>3298</td>
<td>Intensive care unit</td>
<td>All clinical sample</td>
<td>39</td>
</tr>
<tr>
<td>16</td>
<td>N.K.Bali</td>
<td>2016</td>
<td>36.1% (65)</td>
<td>165</td>
<td>Inpatient</td>
<td>Blood sample</td>
<td>41</td>
</tr>
<tr>
<td>17</td>
<td>Velma Rebica</td>
<td>2018</td>
<td>90% (399)</td>
<td>622</td>
<td>Inpatient</td>
<td>All clinical sample</td>
<td>42</td>
</tr>
</tbody>
</table>
A study titled MDR pattern of Acinetobacter spp. isolated from clinical specimens was published in 2021 by Zeleke Ayenew et al. The total sample from various clinical samples were analyzed as a result. Blood (23.5%), pus (33.3%), urine (15.6%), and bodily fluid (11.7%) were the next most common sources of fluids. The antimicrobial resistance patterns for Pseudomonas aeruginosa, Ceftazidime 82.1%, Ceftriaxone 87.1%, Ceftazidime 80.0%, and Meropenem 12.5% were all significantly ascending. For tobramycin (from 56.5% to 42.8%), Amikacin (from 42.1% to 31.4%), and antimicrobial resistance decreased. Acinetobacter species had average rates of 56.7% multidrug resistance and 71.6% Carbapenem non-susceptibility.

A study on the frequency & mechanism of the carbapenem-resistant gene in Acinetobacter baumannii was done in 2022 by Komal Khalid et al. The OXA-51-like gene was discovered to be present in 45 (97.82%) of the Acinetobacter baumannii strains, and the OXA-23-like gene was discovered to be present in 44 (95.65%) of these strains. Additionally, four (9.09%) Carbapenem-resistant Acinetobacter baumannii (CRAB) isolates tested positive for the New Delhi MBL, or blaNDM gene. All blaNDM isolates co-expressed OXA-23-like, whereas only one carbapenem-resistant Acinetobacter baumannii isolate that has been blaNDM positive lacked OXA-51-like.

A study on Prevalence of multidrug-resistant Acinetobacter baumannii in a critical care setting: A tertiary teaching hospital experience in 2021 by Thabit Alotaibi et al. The total sample were identified by 198 patient with Acinetobacter baumannii. The prevalence of Acinetobacter baumannii is 3.37% and overall mortality rate is 40.81%. According to the analysis of the care given to patients with Acinetobacter baumannii infections, 65 patients received colistin alone, 18 received carbapenems, and 22 received both carbapenems and colistin. Patients with Acinetobacter baumannii infections spent an average of 20.25 days in the hospital. Our research revealed that the survival rates among patients receiving carbapenems had higher rates of death than those receiving colistin.

A study on Epidemiology and outcomes associated with carbapenem-resistant Acinetobacter baumannii and carbapenem-resistant Pseudomonas aeruginosa: a retrospective cohort study in 2022 by Amanda vivo et al. The 90-day mortality rates for CRAB and CRPA were 30.3% and 24.5%, respectively, and the inpatient post-LOS was 26 and 27 days in 1,048 and 8,204 different patients, respectively. In comparison to urine cultures, positive blood cultures in patients with CRAB (OR 6.98, 95% CI 3.55-13.73) and CRPA (OR 2.82, 95% CI 2.04-3.90) were linked to higher odds of 90-day mortality. Higher Charlson scores were related to higher odds of 90-day mortality in patients with CRAB and CRPA blood cultures. Blood cultures were linked to a lower LOS compared to urine cultures among patients from inpatient care settings in CRAB and CRPA. All the above studies are mentioned in Table.

DISCUSSION

The pathogen Acinetobacter is a nosocomial one. Infectious disease experts are worried about its potential to develop antimicrobial drug resistance and infect healthy hosts. A study from India of Acinetobacter species from 2002-2022 ranges from 3% to 100%

Acinetobacter prevalence in Maharashtra was found to be only 3%, according to a 2015 study by Neetu Gupta et al. Blood 41 is (36.9%), pus 25 is (22.5%), respiratory sample 16 is (14.4%), urine 13 is (11.7%), and other clinical samples containing Acinetobacter species isolation profiles. These are all the samples taken from the Intensive care unit. The most common patients with Acinetobacter bacteremia are those who are critically ill and are admitted to intensive care units (ICUs), as these patients frequently need repeated invasive procedures, a prolonged hospital stay, and broad-spectrum antimicrobial therapy.
from our study came from blood samples and intensive care units. A study by Sanjeev et al. in Mangalore isolated a higher percentage, i.e. 100% of *Acinetobacter* isolates in Urinary tract infections of Hospitalized patients. All samples are urine samples.

Hydrolyzing enzymes like Metallo beta-lactamases and OXA carbapenemases may play a role in carbapenem resistance. Imipenem and Meropenem are two examples of the drugs of choice in the past for treating infections caused by *Acinetobacter* species. The Antibiotic sensitivity pattern of Neetu Gupta et al. is Amikacin 47(42%), Ciprofloxacin 26(23%), Imipenem 24(22%), Piperacillin 61(55%), Ceftazidime 51(46%), Cefepime 49(44%) and Ceftriaxone 51(46%). The Antibiotic sensitivity pattern of Sanjeev H et al. is Imipenem 32(69.5%), Meropenem 31(67.3%), Piperacillin Tazobactum 08(18%), Cefepime 08(18%), Ceftazidime 08(18%) and Ceftriaxone 08(18%).

*Acinetobacter* isolates showing Carbapenem resistance from 2002 to 2018 varies between 74-90%, but a study by Bali et al. in Srinagar show less percentage of Carbapenem-resistant, i.e. 36%. They have collected all clinical samples from the ICU. The antibiogram of the 164 different organisms that make carbapenemase. Ceftriaxone, ceftazidime, amikacin, piperacillin-tazobactam, and ciprofloxacin.

In the current study, it was discovered that there were significantly more *Acinetobacter* spp., 40, which is (24.4%); (P<0.009). It has been reported that this organism frequently causes infections and that these infections are becoming harder to treat because the majority of *A. baumannii* recovered from patients is MDR.

The world studies from 2006-2014 show 43% to 100% resistance, whereas a study by Ganesh Thapa et al. 2011-2012 in Nepal shows less carbapenem resistance 17%. *Acinetobacter* isolates from all clinical samples in the Intensive care unit. The Antibiotic profile pattern is Imipenem 17.24, Ciprofloxacin 82.75, Cefepime 86.20, Cefoxitine 82.75, Cotrimaxole 93.83, and amikacin 67.24. The review shows that in all the above studies, Carbapenem resistance of *Acinetobacter* isolates is in the rapidly increasing order.

**CONCLUSION**

Infection with *Acinetobacter* is linked to high mortality and morbidity. According to our review, patients who have an infection with *A. baumannii* may be at an increased risk of dying. However, due to the confounding factors of illness severity, inappropriate impractical antimicrobial treatment, and small sample size, cautious interpretations are necessary.

We covered the main factors that make *A. baumannii* such a prevalent nosocomial pathogen in this review, including such as its virulence components, desiccation resistance, and carbapenem resistance mechanisms. With the emergence of extended resistance to even more recent antibiotics, *Acinetobacter* species are rapidly proliferating. They can develop resistance much more quickly than other gram-negative organisms.

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None.

**CONFLICT OF INTEREST**

The authors declare that there is no conflict of interest.

**AUTHORS’ CONTRIBUTION**

Both authors listed have made a substantial, direct and intellectual contribution to the work, and approved it for publication.

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**DATA AVAILABILITY**

All datasets generated or analyzed during this study are included in the manuscript.

**ETHICS STATEMENT**

Not applicable.

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