Bacteriological profile and drug sensitivity patterns in chronic suppurative otitis media patients at J. L. N. Hospital & Research Centre, Bhilai, Chhattisgarh State, India

Sonam Rathi¹, Ashwin A. Jaiswal²*, Neeta Sharma³, P. K. Banerjee⁴, A. K. Garg⁵

¹DNB Resident, ²Consultant, ³Senior Deputy Director, ⁴Joint Director, ⁵Director & HOD, Dept. of ENT & Head Neck Surgery, Jawaharlal Nehru Hospital Research Centre, Bhilai, Chhattisgarh, India

*Corresponding Author:
Email: ash1978jaiswal@gmail.com

Abstract
Objective: To isolate and identify various bacterial pathogens in positive ear swab cultures of CSOM cases and to determine the antibiotic sensitivity pattern of different bacterial species identified.
Study design: Prospective study
Setting: J. L. N. Hospital & Research Centre, Bhilai (C.G).
Materials and Method: The study was done on the population of Bhilai and surrounding region. A sample size of 120 cases attending the ENT OPD with the diagnosis of Chronic Suppurative Otitis Media and active ear discharge were included in the study. Detailed history, general physical examination, local systemic examination was done along with aural swab for Gram’s staining and aerobic bacterial culture and drug sensitivity. The data were then compared with the relevant & available literature.
Results: Most of the patients were in the age group of 11-20 years (38.33%), followed by 21-30 years age group (31.67%). More males (60%) were affected by the disease than females (40%). Unilateral (59.16%) infection was more common than bilateral (40.83%). Incidence of monobacterial (90%) etiology was more common than polymicrobial (9.1%). Staphylococcus aureus 67 (51.53%) was the most commonly isolated bacteria followed by the Pseudomonas 26 (20%). Antibiogram showed the most effective drugs in the present study are clindamycin, ciprofloxazol, ciprofloxacin, amikacin, chloramphenicol and ceftazidime.
Conclusion: Staphylococcus aureus is the most common pathogen isolated, followed by Pseudomonas. Clindamycin was the most effective antibiotic followed by ciprofloxazol, ciprofloxacin, amikacin, chloramphenicol and ceftazidime. Antibiotic sensitivity of the organisms varies according to geographical area and local practice regarding the choice of antibiotics. A continuous and periodic evaluation of microbiological pattern and their antibiotic sensitivity pattern in local area is helpful in prescribing empirical antibiotics for successful treatment of otitis media and thus minimizing its complications and emergence of resistant strains.

Keywords: Chronic Suppurative Otitis Media (CSOM), antibiotic, Antibiogram, Staphylococcus aureus.

Introduction
Chronic suppurative otitis media (CSOM) is a chronic inflammation of the mucoperiosteum of the middle ear cleft which leads to abundant drainage from the ear and hearing impairment that may have a serious long term effect on language, auditory & cognitive development and on educational progress.¹

The assessment and management of CSOM presents many challenging and fascinating problems. CSOM is a disease of multiple aetiologies and is well known for its persistence and recurrence inspite of treatment. Accordingly the manifestations of CSOM are extremely variable and there may be any lesion from a small healed deformity of the Tympanic Membrane (TM), to a cholesteatoma infiltrating widely throughout the temporal bone.² It is a destructive and persistent disease with irreversable sequelae and can proceed to serious intra and/or extra cranial complications.

The incidence of CSOM appears to depend on race and socio-economic factors. Socio-economic factors such as poor living conditions and overcrowding, poor hygiene and nutrition have been suggested as a basis for the wide spread prevalence of CSOM. CSOM has received considerable attention, not only because of its high incidence and chronicity, but also because of issues such as bacterial resistance and ototoxicity with both topical and systemic antibiotics.³

The widespread indiscriminate, haphazard use of antibiotics and poor follow up of patients has precipitated the emergence of multiple resistant strains of bacteria which can produce both primary and post operative infections. Changes in the microbiological flora following the advent of sophisticated synthetic antibiotics increase the relevance of reappraisal of the modern day flora in CSOM and their in vitro antibiotic pattern is very important for the clinician to plan a general outline of treatment for a patient with a chronically discharging ear.⁴ The principles of treatment such as knowledge of local microbial pattern and their drug sensitivity are essential for effective and low cost treatment.⁵

The changing flora of CSOM and emergence of strains resistant to the commonly employed antibiotics stimulated the study. The purpose of this study is to find the local pattern of bacteria associated with CSOM and to detect the antibiogram of the isolates.

Materials and Method
Patients attending ENT OPD at Jawaharlal Nehru Hospital and Research Centre, Bhilai, Chhattisgarh...
state form the source of the sample for study. The samples of Ear discharge of more than 6 weeks duration coming to department during Study Period of July 2012 to June 2014 constitute the material for study. 120 samples were received during the study period fulfilling the following inclusion and exclusion criterias.

**Inclusion Criteria**
1. Patients presenting with chronic ear discharge for more than 6-12 weeks.
2. Patients with perforated tympanic membrane.
3. Patients must not have received ototopical or systemic antibiotics (>12wks) prior to the inclusion in the study.

**Exclusion Criteria**
1. Patients who have taken systemic or topical antibiotics for CSOM in last 12 wks.
2. Patients with single and first episode of ear discharge will be excluded.
3. No dry ears are included in this study.
4. Patients with serious medical conditions such as immunocompromised states, malignancy or blood dyscrasia.
5. Patients without any informed consent

Detailed history, general physical examination and local systemic examination were done for each case. Clinical data was collected using a preformed questionnaire. Two swabs were collected from patients diagnosed with CSOM using sterile cotton wool swabs and ear specula. All care was taken to avoid surface contamination with contents of External Auditory Canal (EAC). Swabs were collected in a culture tube for Gram’s staining, aerobic bacterial culture and drug sensitivity, while specimen for anaerobic bacteria were taken directly into the Liquid Thioglycollate medium. All the swabs were transported to microbiology department. From the first swab direct gram staining was done followed by immediate inoculation on Blood Agar, Chocolate agar & MacConkey Agar plates which were then kept at 37 degree Celsius for 24-48 hours. The other swab was inoculated immediately in Enriched Thioglycollate medium with indicator and transported to microbiology lab and cultured for anaerobes in it for 24-48 hours. Samples were processed and identification of sample was done by conventional methods which were Gram staining, Colony morphology & Biochemical tests. All the organisms were subjected to antibiogram by Kirby-Bauer disc diffusion method. Antibiotic discs used for the sensitivity study were amikacin, gentamicin, vancomycin, clindamycin, amoxyclov, ciprofloxacin, ceftazidime and roxithromycin.

**Analysis of Data (Statistical Method employed)**

**a. Percentage**

\[
\text{MEAN} = \frac{\sum X}{N} , \text{ SD} = \sqrt{\frac{\sum (X-i-MEAN)^2}{N}}
\]

**b. Mean & SD**

\[
\text{MEAN} = \frac{\sum X}{N} , \text{ SD} = \sqrt{\frac{\sum (X-i-MEAN)^2}{N}}
\]

**c. Unpaired PAIRED “t’ TEST**

\[
t= \frac{\text{Difference of MEANS}}{SE}, \text{ where } SE= \frac{1}{\sqrt{\frac{1}{N_1} + \frac{1}{N_2}}}
\]

**d. Chi square value**

\[
\sum \frac{(O-E)^2}{E} \text{ degree of freedom}= (r-1)(c-1)
\]

O= observed Frequency
E= expected frequency
Level of significance was set at p< 0.05.
P value < 0.05 was considered to be significant.
P value <0.01 was considered to be highly significant

**Results**

In the present study of ‘Bacteriological profile and drug sensitivity pattern of CSOM patients’, conducted from July, 2012 to June, 2014; 120 patients fulfilling the inclusion criteria were randomly selected and analyzed.

**Age and Sex distribution**

Majority of the patients were of the age group 11-20 years (38.33%), among which males were more common. Followed by 21-30 years age group (31.67%). Least number of patients were found in >50 years age group (1.67%). In all the age groups males were more commonly affected, but p value of 0.59 depicted that there was no statistically significant association between age group of ear discharge and distribution of sex. Males (60%) outnumbered the females (40%) in this study with a male to female sex ratio of 1.5:1 (Graph 1). Mean age was 24.07 ± 10.89 in females and 23.04 ± 10.6 for males but no significant association of mean age with sex was noted. (p= 0.61).
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**Graph 1: Age & Sex distribution**

![Age & Sex distribution graph](image)

(n= 120)

Sex Ratio - 1.5:1

- Male - 72 (60%)
- Female - 48 (40%)
- Total - 120 (100%)

**Distribution of Ear Involvement**

In our study, we found that disease most commonly involved unilateral ear (59.16%) in both male (58.33%) and female (60.41%) subjects. (p= 0.88). In cases of unilateral involvement slightly greater predilection for right ear (30.8%) than left ear (28.3%) was noticed (Graph 2). On comparing, p value= 0.46 showed no significant association between the laterality of ear and age.

**Graph 2: Distribution of Ear Involvement**

![Distribution of Ear Involvement graph](image)

(n= 120)

- Unilateral - 71 (59.16%)
- Bilateral - 49 (40.83%)

**Characteristics of Ear discharge**

In most of the cases patient had 1-5 years (33.33%) history of ear discharge, only 11.67% of patients had ear discharge for > 20 years. In most of the cases (73.3%), discharge was of insidious onset. Out of 120 discharging ear, fluctuation was present in 77.5% cases. Discharge was moderate in maximum number (52.5%) of cases, while it was scanty in only 19.17% cases. Mucopurulent discharge was present in most of the cases (90%). In 74.17% it was non-foul smelling while in rest 25.83% discharge were foul smelling. Most of the patients (79.17%) had yellow coloured discharge followed by white colour in 14.17% of cases.

**Culture Results**

Among the 120 patients studied, the bacteriological study was sterile in 1 case (0.833%), a monomicrobial isolate was seen in 108 cases (90%) while 11 (9.1%) cases had polymicrobial growth. (Graph 3)
**Gram Staining of Isolates**

On Gram staining of isolates predominantly gram positive bacteria (Fig. 1(a, b)) were seen in 56.1% whereas gram negative bacteria (Fig. 2(a, b)) were seen in 43.8%. 91.78% of the gram positive isolates cultured Staphylococcus aureus whereas Pseudomonas (45.61%) was the most common gram negative isolate followed by Klebsiella (19.29%) and E. coli (17.54%). (Graph 4)

**Graph 3: Type of Bacterial culture**

![Graph showing type of bacterial culture](image)

**Fig. 1: (a) Blood Agar culture plate showing colonies of staphylococcal growth; (b) Gram staining of Isolates showing Gram positive cocci arranged in clusters**

**Fig. 2: (a) Mac-conkey Agar Culture plate showing colonies of lactose fermenting Gram negative microorganism; (b) Gram staining of Isolates showing Gram negative Bacilli**
Bacteriological profile of the isolates
Total 130 bacterial isolates were recovered from the 119 positive cultures. All the isolates showed aerobic flora (100%) and no anaerobes (0%) were isolated in any of the culture. Staphylococcus aureus was the most common isolated bacteria, seen in 51.5% (67) of isolates followed by the Pseudomonas sp. in 20% (26) of isolates. Among the Staphylococcus aureus isolates, 34.62% (45) were MRSA and 16.92% (22) were MSSA. Other isolates included Klebsiella sp. in 11 (8.46%), E. coli in 10 (7.69%), Acinetobacter in 5 (3.85%), CONS and Proteus sp. in 4 (3.08% each), and α-haemolytic streptococcus, Citrobacter sp. & Enterococci in 1 (0.77% each) isolate. (Graph 4)

Antibiotic Sensitivity Patterns
Antibiotic sensitivity was carried out for 130 isolates by Kirby-Bauer disc diffusion method by using antibiotic discs. Most sensitive antibiotic for gram positives was clindamycin (87.67%) followed by cotrimoxazole (56.16%), whereas gram negative isolates showed maximum sensitivity to amikacin (59.64%) followed by ciprofloxacin.

Antibiotic Sensitivity Patterns of Gram Positive Isolates
Antibiogram showed most of the MRSA isolates were sensitive to clindamycin (88.88%), lincomycin (84.44%) and vancomycin (82.22%). 4.44% were found to be resistant to all antibiotics tested. 40% isolates showed sensitivity to cotrimoxazole and fewer number to roxithromycin (26.66%) and cloxacillin (11.1%). MSSA showed higher sensitivity to most of the drugs, 95.45% were sensitive to clindamycin, 90.90% to ciprofloxacin and cloxacillin, 81.81% to cotrimoxazole and lincomycin. Chloramphenical and roxithromycin showed sensitivity in 77.27% cases. 3 (75%) out of 4 CONS isolates showed sensitivity to cotrimoxazole, amoxicillin-clavulenic acid, cloxacillin, clindamycin. 50% of the isolates were sensitive to ciprofloxacin, chloramphenicol, céftazidine and 25% to roxithromycin & lincomycin. Single isolate of α- haemolytic streptococcus was isolated from the culture, which showed 100% sensitivity to ciprofloxacin, cotrimoxazole, chloramphenicol, cloxacillin, céftazidine, amoxicillin-clavulenic acid, vancomycin, lincomycin. Enterococci showed 100% sensitivity to cotrimoxazole and vancomycin. (Table 1)

Table 1: Antibiotic Sensitivity Patterns of Gram Positive Isolates (Antibiogram) (Number of isolates and percentage of each organism sensitive to various antibiotics)

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>MRSA (N=12)</th>
<th>MSSA (N=17)</th>
<th>CONS (N=1)</th>
<th>α-hemolytic streptococci (N=1)</th>
<th>Enterococci (N=1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roxithromycin</td>
<td>12 (26.66%)</td>
<td>17 (77.27%)</td>
<td>1 (25%)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Vancomycin</td>
<td>37 (82.22%)</td>
<td>16 (72.72%)</td>
<td>2 (50%)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>40 (88.88%)</td>
<td>21 (95.45%)</td>
<td>3 (75%)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Lincomycin</td>
<td>38 (84.44%)</td>
<td>18 (81.81%)</td>
<td>1 (25%)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Cotrimoxazole</td>
<td>18 (40%)</td>
<td>18 (81.81%)</td>
<td>3 (75%)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>20 (90.9%)</td>
<td>20 (90.9%)</td>
<td>2 (50%)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Cloxacillin</td>
<td>5 (11.11%)</td>
<td>20 (90.9%)</td>
<td>3 (75%)</td>
<td>1 (100%)</td>
<td>1 (100%)</td>
</tr>
</tbody>
</table>
Antibiotic Sensitivity Patterns of Gram Negative Isolates

46.15% Pseudomonas isolates were found to be sensitive to amikacin and 30.76% to gentamicin. Ceftazidime and ciprofloxacin were sensitive in 34.61% of isolates. Amoxicillin-clavulanic acid showed lower sensitivity, in 3.84%. 4 (15.38%) of the isolates were found to be resistant to all the antibiotics tested. All the Klebsiella isolates were found to be sensitive to amikacin (100%). 90.90% were sensitive to chloramphenicol and 81.81% to ciprofloxacin. Lesser number of isolates were sensitive to gentamicin (63.63%), cotrimoxazole (45.45%), ceftazidime (36.36%) and amoxicillin-clavulanic acid (18.18%). 90% of the E. coli isolates showed sensitivity to amikacin, 70% to chloramphenicol, 60% to ciprofloxacin and 50% to gentamicin. Lesser number isolates showed sensitivity to ceftazidime and cotrimoxazole (in 40% isolates) & 20% to amoxicillin-clavulanic. All the Acinetobacter isolates were sensitive to ceftazidime and cotrimoxazole (100%). Only 40% isolates showed sensitivity to chloramphenicol. Out of the 4 Proteus isolates 3 (75%) were sensitive to ciprofloxacin, cotrimoxazole, gentamicin and ceftazidime. 50% were sensitive to amikacin and chloramphenicol. Only 25% isolates showed sensitivity to amoxicillin-clavulanic acid and piperacillin. Single Citrobacter isolate which was isolated showed 100% sensitivity to chloramphenicol and amoxicillin-clavulanic acid. (Table 2)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Cotrimoxazole</td>
<td>4 (15.38%)</td>
<td>5 (45.45%)</td>
<td>4 (40%)</td>
<td>5 (100%)</td>
<td>3 (75%)</td>
<td></td>
</tr>
<tr>
<td>Ciprofloxacin</td>
<td>9 (34.61%)</td>
<td>9 (81.81%)</td>
<td>6 (60%)</td>
<td>3 (75%0</td>
<td>2 (50%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Amoxiclav</td>
<td>1 (3.84%)</td>
<td>2 (18.18%)</td>
<td>2 (20%)</td>
<td>2 (25%)</td>
<td>1 (50%)</td>
<td></td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>6 (23.07%)</td>
<td>10 (90.9%)</td>
<td>7 (70%)</td>
<td>2 (40%)</td>
<td>2 (50%)</td>
<td>1 (100%)</td>
</tr>
<tr>
<td>Gentamicin</td>
<td>12 (46.15%)</td>
<td>11 (100%)</td>
<td>9 (90%)</td>
<td>2 (50%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceftazidime</td>
<td>9 (34.61%)</td>
<td>4 (36.36%)</td>
<td>4 (40%)</td>
<td>5 (100%)</td>
<td>3 (75%)</td>
<td></td>
</tr>
<tr>
<td>Piperacillin</td>
<td>4 (15.38%)</td>
<td>1 (10%)</td>
<td></td>
<td></td>
<td>1 (25%)</td>
<td></td>
</tr>
<tr>
<td>Moderate Sensitivity to</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amikacin</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resistant to all</td>
<td>1 (3.84%)</td>
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</tr>
</tbody>
</table>

Table 2: Antibiotic Sensitivity Patterns of Gram Negative Isolates (Antibiogram) (Number of isolates and percentage of each organism sensitive to various antibiotics)

Discussion

Due to changing pattern of bacteriological profile of Otitis media and sensitivity of microorganisms towards antibiotics, it has become very important to find out the organism causing the disease.

High prevalence of culture positive cases of CSOM (91.18%) was seen in the present study. It was found that the prevalence of CSOM was higher in the age group of 11-20 years (38.33%), followed by 21-30 years (31.67%). These findings are in correlation with mentioned workers in Table 3. However Rao B.N. et al,9 Taneja M.K. et al,10 Ishu K.R. et al (75.43%),11 Mariam et al (39.2%),12 have reported maximum number of patients in first decade. According to study of Poorey V K & Iyer A13 common age group was first and second decade of life, but among them 1-10 years age group was more common. Agrawal et al13 also reported highest incidence in 0-20 year age group (62.4%). Vineetha Gupta et al,14 Loy A.H.C. et al,9 Gh Ettehad et al (26.22%)15 and Shanweel Ahmad (31.70%).16 have reported maximum number of patients in third decade. Incidence of CSOM decreases as the age advances.

Males were more affected, 72 (60%) than the females 48 (40%) in the present study. This finding is correlated with other series (Table 4) Shrestha B L. et al20 found the female predominance (55.2%), also supported by Prakash M et al (55%).21 The male predominance may be because of their more exposed way of life.22 In the present study unilateral infection (59.16%) was more common compared to bilateral infection (40.83%). Our findings are correlated with other studies.
(Table 5) Right and left ears were found to be equally affected in our study (30.83% vs 28.33%). The onset of ear discharge was insidious in about 73.33% of patients, while in 26.67% it was of sudden onset. The discharge was fluctuant with intermittent discharge in about 77.5% of cases while fluctuation was not seen in 22.5% of cases. In most of the cases discharge was moderate in amount (52.5%), mucopurulent (90%) in character and non foul smelling (74.17%). In some cases discharge was profuse or scanty. These findings are consistent with as mentioned by Mills, Chowdhury and Alauddin, Hamilton J [30] and Youngs.

In the present study 119 (99.1%) specimens were positive and 1 (0.83%) was negative for the culture. The culture results are variable compared to other workers.

(Table 6) Negative cultures can be attributed to Non-bacterial growth, anaerobic growth, Prior-antibiotic therapy, Presence of antimicrobial enzymes i.e. lysozyme alone or in combination with immunoglobulins that suppress the bacterial growth.

In the present study monomicrobial etiology was 108 (90%) and polymicrobial was 11 (9.1%) which is correlated with the other studies. (Table 7) However Rama Rao M.V. et al. found equal incidence of mixed and pure culture and Baruah P.C. et al. found predominance of mixed culture. Availability and use of topical and systemic broad spectrum antibiotics in the period before consultation was probably responsible for the lower incidence of mixed infection.

All the isolated microorganisms were aerobes (100%), no anaerobes were isolated. Although this is in contrast to most of the previous studies but Gh Ettehad et al. study is coherent with this finding.

The finding of predominant gram positive bacteria in 73 (56.15%) out of 130 isolates is consistent with few of the previous studies such as Marium et al. in their study predominantly reported gram positive bacteria in 30 isolates (65.2%) and Shamweel Ahmad in his study found 102 (62.19%) gram positive isolates.

Among the organisms isolated, Staphylococcus aureus was the predominant organism 67 (51.53%) followed by Pseudomonas spp. 26 (20%). This finding is correlated with other studies. (Table 8) However workers like Arya S.C. et al., Nandy A. et al., Grewal R.S. et al., Urmil Mohan et al., Hiremath S.L. et al., Loy A.H.C. et al. have found Staphylococcus aureus as the second most common organism causing CSOM. Some of the studies conducted by Ballal M. et al., Saurabh V. et al., Hiremath S.L. et al. and Loy A.C. have found Pseudomonas spp. as the predominant organism causing CSOM.

The next most common organism was Klebsiella spp. 11 (8.46%) in the present study and Proteus species were isolated from 4 (3.07%) cases However, Singh N. et al., Rama Rao M.V. et al. and Saurabh V. et al. have found them as the second most leading cause for CSOM.

In the present study Enterococcus spp. was isolated in 1 (0.77%) cases. Other workers who have isolated Enterococci in CSOM are Hiremath S.L. et al. in 0.79% cases and Loy A.H.C. et al. in 2.2% cases. E. coli was isolated in 10 (7.69%) cases in the present study. However Rama Rao M.V. et al. has reported a high incidence of E. coli, i.e. 18.7% cases.

In the present study CONS was isolated in 4 (3.07%) cases. However many workers have found higher incidence of CONS like Srivastava V.K. et al. in 10.2% cases, Rama Rao M.V. et al. in 21.6% cases and Loy A.H.C. et al. in 21.1% cases.

The frequency of Staphylococcus aureus in the middle ear infections can be attributed to their ubiquitous nature and high carriage of resistant strains in the external auditory canal and upper respiratory tract.

The organisms like Pseudomonas spp. and Proteus spp. are considered mostly as secondary invaders from external auditory canal gaining access to the middle ear via a defect in tympanic membrane resulting from an acute episode of otitis media. Organisms like E. coli and Klebsiella spp. become opportunistic pathogens in the middle ear when resistance is low.

Although CONS are generally considered as non-pathogenic, their association in some cases can be attributed to the extreme lowering of resistance in middle ear due to invasion by other organisms. Under these circumstances they assume pathogenic role either singly or more often in combination with other organisms.

In the present study 49.23% of organisms were sensitive to clindamycin, followed by cotrimoxazole (47.69%), ciprofloxacin (38.46%), chloramphenicol (36.92%), ceftazidime (33.07%). The most effective antibiotic against gram positive bacteria was found to be clindamycin (87.67%), followed by cotrimoxazole (56.16%) and cloxacillin (39.7%). Amongst gram negative bacteria most sensitive antibiotic was amikacin (59.64%) followed by ciprofloxacin (47.36%). Thus the most effective drugs in the present study are clindamycin, cotrimoxazole, ciprofloxacin, amikacin, chloramphenicol and ceftazidime. Similar sensitivity pattern was reported by Gulati et al., S.Varshney et al. and Hiremath S.L.et al. However Nandy A. et al. and Rao B.N. et al. have found gentamicin as the most effective drug. In the present study majority of the isolates showed multiple drug resistance for amoxicillin-clavulanic acid and cefixime. 7 (5.3%) isolates showed resistance to all the antibiotics tested.
Table 3: Age wise distribution

<table>
<thead>
<tr>
<th>Study series</th>
<th>Year</th>
<th>Total no. Of patients in 11-20 years age group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Swaroopani N.B. et al(^6)</td>
<td>2013</td>
<td>30</td>
<td>31%</td>
</tr>
<tr>
<td>Rajat Prakash et al(^7)</td>
<td>2014</td>
<td>54</td>
<td>26.47%</td>
</tr>
<tr>
<td>Naz Perween et al(^8)</td>
<td>2014</td>
<td>23</td>
<td>29.8%</td>
</tr>
<tr>
<td>Present study</td>
<td>2012-14</td>
<td>46</td>
<td>38.33%</td>
</tr>
</tbody>
</table>

Table 4: Sex wise distribution

<table>
<thead>
<tr>
<th>Study Series</th>
<th>Year</th>
<th>Total no. of male patients</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arya S C et al(^17)</td>
<td>1966</td>
<td>116</td>
<td>70.13%</td>
</tr>
<tr>
<td>Nandy A et al(^18)</td>
<td>1991</td>
<td>77</td>
<td>52.74%</td>
</tr>
<tr>
<td>Taneja M K et al(^10)</td>
<td>1995</td>
<td>470</td>
<td>71.87%</td>
</tr>
<tr>
<td>Srivastava A et al(^19)</td>
<td>2010</td>
<td>62</td>
<td>56.3%</td>
</tr>
<tr>
<td>Swaroopani N B(^6)</td>
<td>2014</td>
<td>56</td>
<td>56.6%</td>
</tr>
<tr>
<td>Agrawal et al(^11)</td>
<td>2014</td>
<td>67</td>
<td>53.6%</td>
</tr>
<tr>
<td>Present study</td>
<td>2012-14</td>
<td>72</td>
<td>60%</td>
</tr>
</tbody>
</table>

Table 5: Side wise distribution

<table>
<thead>
<tr>
<th>Study series</th>
<th>Year</th>
<th>Affected unilaterally (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Srivastava et al(^23)</td>
<td>1979</td>
<td>92.61%</td>
</tr>
<tr>
<td>Gulati et al(^24)</td>
<td>1997</td>
<td>80%</td>
</tr>
<tr>
<td>Urmil Mohan et al(^25)</td>
<td>1998</td>
<td>86.3%</td>
</tr>
<tr>
<td>Rakesh Kumar et al(^26)</td>
<td>2013</td>
<td>79.13%</td>
</tr>
<tr>
<td>Hirapure P.V. et al(^27)</td>
<td>2014</td>
<td>71.42%</td>
</tr>
<tr>
<td>Present study</td>
<td>2012-14</td>
<td>59.16%</td>
</tr>
</tbody>
</table>

Table 6: Culture results of cases studied

<table>
<thead>
<tr>
<th>Study series</th>
<th>Year</th>
<th>Positive culture no. (%)</th>
<th>Negative culture no. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Srivastava V K et al(^23)</td>
<td>1979</td>
<td>99 (97.05%)</td>
<td>3 (2.94%)</td>
</tr>
<tr>
<td>Nandy A et al(^18)</td>
<td>1991</td>
<td>356 (92.70%)</td>
<td>28 (7.29%)</td>
</tr>
<tr>
<td>Taneja M K et al(^10)</td>
<td>1995</td>
<td>618 (84%)</td>
<td>118 (16%)</td>
</tr>
<tr>
<td>Gulati et al(^24)</td>
<td>1997</td>
<td>78 (78%)</td>
<td>22 (22%)</td>
</tr>
<tr>
<td>Srivastava A et al(^19)</td>
<td>2010</td>
<td>90 (80.3%)</td>
<td>22 (19.7%)</td>
</tr>
<tr>
<td>Singh A H et al(^32)</td>
<td>2012</td>
<td>142 (94.6%)</td>
<td>8 (5.33%)</td>
</tr>
<tr>
<td>Prakash M et al(^21)</td>
<td>2013</td>
<td>75 (93.75%)</td>
<td>5 (6.25%)</td>
</tr>
<tr>
<td>Prakash R et al(^7)</td>
<td>2014</td>
<td>186 (91.18%)</td>
<td>18 (8.82%)</td>
</tr>
<tr>
<td>Present study</td>
<td>2012-2014</td>
<td>119 (99.1%)</td>
<td>1 (0.83%)</td>
</tr>
</tbody>
</table>

Table 7: Incidence of pure and mixed cultures

<table>
<thead>
<tr>
<th>Study series</th>
<th>Year</th>
<th>Monomicrobial no. (%)</th>
<th>Polymicrobial no. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arya S C et al(^17)</td>
<td>1966</td>
<td>129 (83.77%)</td>
<td>25 (16.23%)</td>
</tr>
<tr>
<td>Srivastava et al(^23)</td>
<td>1979</td>
<td>84 (82.3%)</td>
<td>12 (11.7%)</td>
</tr>
<tr>
<td>Taneja M K et al(^10)</td>
<td>1995</td>
<td>594 (80.7%)</td>
<td>24 (3.3%)</td>
</tr>
<tr>
<td>Srivastava et al(^19)</td>
<td>2010</td>
<td>73 (81.1%)</td>
<td>17 (18.9%)</td>
</tr>
<tr>
<td>Singh A H et al(^32)</td>
<td>2012</td>
<td>96 (64%)</td>
<td>46 (30.67%)</td>
</tr>
<tr>
<td>Nageshwarani et al(^15)</td>
<td>2012</td>
<td>84 (69.4%)</td>
<td>37 (30.57%)</td>
</tr>
<tr>
<td>Prakash M et al(^21)</td>
<td>2013</td>
<td>64 (85%)</td>
<td>12 (13%)</td>
</tr>
<tr>
<td>Prakash R et al(^7)</td>
<td>2014</td>
<td>118 (57.84%)</td>
<td>68 (33.33%)</td>
</tr>
<tr>
<td>Present study</td>
<td>2012-2014</td>
<td>108 (90%)</td>
<td>11 (9.1%)</td>
</tr>
</tbody>
</table>
Conclusion

In our geographical area

1. Aerobic bacterial infection is common, with Gram positives out numbering Gram negatives. Staphylococcus aureus is the most common pathogen isolated, followed by Pseudomonas.

2. Clindamycin was the most effective antibiotic followed by cotrimoxazole, ciprofloxacin, amikacin, chloramphenicol and ceftazidime. Thus Sensitivity to older antibiotics is again emerging, as with more and more use of newer antibiotics and in resistant cases, these can be another good option.

3. Antibiotic sensitivity of the organisms varies according to geographical area and local practice regarding the choice of antibiotics. Thus pre-culture antibiotic should be active against both Gram positive and negative bacteria.

4. Timely diagnosis and treatment of upper respiratory tract infections, during childhood can prevent chronic suppurative otitis media and its complications later in life; hence awareness among people for seeking earlier medical opinion & treatment should be created.

5. With the development and widespread use of antibiotics, the types of pathogenic microorganisms and their resistance to antibiotics have changed. Thus Antibiotics should be used judiciously along-with avoiding over the counter antibiotics to prevent development of resistance.

6. The most important factor responsible for the development of antibiotic resistance is human negligence. As soon as, symptoms subside, patients stop taking antibiotics before completion of therapy and allow partially resistant microbes to flourish. Such practice should be discouraged and patients should be educated to avoid the same.

7. A continuous and periodic evaluation of microbiological pattern and their antibiotic sensitivity pattern in local area is helpful in building an antibiotic policy, prescribing empirical antibiotics for successful treatment of otitis media and minimizing its complications and emergence of resistant strains as well as in long term, reduces the burden of the infection and cost of treatment on the patient.

Compliance with Ethical Standards

All the accepted principles of ethical and professional conduct have been followed and compliance is maintained. All the authors have contributed equally in the study.

Disclosure of potential conflicts of interest

All the authors have filled the potential conflict of interest disclosure forms and declare that they have no conflict of interest.

Funding: Nil

Conflict of Interest: Nil

Ethical approval: All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.
Sonam Rathi et al. Bacteriological profile and drug sensitivity patterns in chronic suppurative otitis media...

References
