Short Communication

Cholera Incidence among Patients with Diarrhea Visiting National Public Health Laboratory, Nepal

Rabindra Karki*, Dwij Raj Bhatta, Sarala Malla†, and Shyam Prakash Dumre‡

Central Department of Microbiology, Tribhuvan University, Kirtipur; and
†National Public Health Laboratory, Kathmandu, Nepal

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SUMMARY: The major objective of this study was to deliver vital statistics related to cholera to health authorities so as to aid in their attempt to prioritize communicable diseases in Nepal. A laboratory-based surveillance was conducted from mid-June 2008 to mid-January 2009 at the National Public Health Laboratory, Nepal. Diarrheal samples alone were processed for *Vibrio cholerae* . Isolation and identification of the organisms were carried out as per standard protocol. Antimicrobial susceptibility tests were done according to the guidelines of the Clinical and Laboratory Standards Institute. The incidence of cholera was found to be 27.1%. Only *V. cholerae* O1 Ogawa biotype El Tor was found during the study. No variation was observed in the percentage of cases between genders (*P* < 0.05). The 15–30 year age group was found to be more susceptible to cholera (*P* < 0.05). The period from mid-June to mid-July had the highest incidence of cholera (*P* < 0.05). Ampicillin, tetracycline, ciprofloxacin, and erythromycin were highly effective, while 100% resistance was observed for furazolidone, nalidixic acid, and cotrimoxazole.

According to the World Health Organization, an estimated 120,000 deaths from cholera occur globally every year (1). A yearly mortality of at least 30,000 and morbidity of 3.3 episodes per child was estimated due to diarrhea in Nepal (2). One of the most important causes of acute diarrhea in Nepal is cholera (3).

*Vibrio cholerae*, the causative agent of cholera is erratic in its nature and nobody knows when a non-toxicogenic strain of this pathogen may be empowered with virulence properties possibly causing havoc or a pandemic throughout the world, like the present day El Tor *Vibrio* (4). A constant vigilance of this etiological agent is of paramount importance. Literature regarding incidence rates of cholera in Nepal are rare, and hence this study is valuable for health authorities involved in prioritizing communicable diseases.

A laboratory-based surveillance was conducted from mid-June 2008 to mid-January 2009 at the National Public Health Laboratory, Nepal. A total of 210 diarrheal samples were processed during the study period. *V. cholerae* was isolated and identified by standard laboratory methods (5,6) and confirmed by serotyping using specific antisera (Denka Seiken, Tokyo, Japan). Resistance to polymyxin B (300 units), positive Voges-Proskauer reaction and hemolysis of sheep erythrocytes were used as criteria for distinguishing El Tor from the classical biotype of *V. cholerae* O1 (7–10). Isolates were tested for susceptibility to antibiotics by the Bauer-Kirby disc diffusion method using commercially available discs (Hi-Media, Mumbai, India). The following antibiotics were used: ampicillin (10 μg), tetracycline (30 μg), erythromycin (15 μg), ciprofloxacin (5 μg), nalidixic acid (30 μg), cotrimoxazole (25 μg), and furazolidone (100 μg). Isolates were characterized as susceptible, intermediate, or resistant based on the size of the inhibition zones in accordance with the manufacturer’s guidelines.

The chi-square test was applied to determine significant differences. A susceptibility percentage for each antimicrobial tested was calculated by dividing the number of susceptible isolates by the total number of tested isolates.

Altogether 210 diarrheal samples were processed for *V. cholerae*. Out of these samples only 57 were positive for *V. cholerae* yielding an incidence of 27.1%. No significant difference of cholera incidence was seen between males (28 cases) and females (29 cases) (*P* < 0.05). The 15–30 year age group had the highest number of cholera cases (*P* < 0.05) (Fig. 1). The period from mid-June to mid-July had the highest incidence of cholera (Fig. 1). The period from mid-June to mid-July had the highest incidence of cholera.

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*Corresponding author: Mailing address: Central Department of Microbiology, Tribhuvan University, Kirtipur, Nepal. Tel: +977-9841173578, E-mail: Ki2rabi2009@yahoo.com

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Fig. 1. Age-wise distribution of cholera cases.
cholera \( (P < 0.05) \). Antimicrobial susceptibility testing of the isolates showed ampicillin, tetracycline, erythromycin, and ciprofloxacin to be effective whereas isolates were found to be 100% resistant to furazolidone, nalidixic acid, and cotrimoxazole (Table 1).

In this study, all 57 isolates belonged to \( V. \) cholerae O1 and no \( V. \) cholerae O139 were isolated. This is consistent with the findings of Kubo and Pokhrel (11), Yamamoto et al. (12), and Ono et al. (13), all of whom were unable to detect \( V. \) cholerae O139.

All of the \( V. \) cholerae O1 belonged to serotype Ogawa and biotype El Tor. Yamamoto et al. (12) also reported isolation of only \( V. \) cholerae O1 biotype El Tor. Ise et al. (14) also reported isolation of \( V. \) cholerae O1 biotype El Tor, Ogawa from the capital only. Kaitha et al. (15) also reported isolation of \( V. \) cholerae O1 Ogawa biotype El Tor only during the year 2002 and 2003 in Chandigarh, India. Mandomando et al. (16) reported isolation of \( V. \) cholerae O1 Ogawa only during the period from November 2002 to April 2003 and from November 2003 to April 2004 in southern Mozambique.

However, in 1996, Kubo and Pokhrel (11) reported isolation of mixed serotypes of \( V. \) cholerae O1, viz. Hikojima and Ogawa, with a preponderance of Hikojima serotype from cholera cases in the capital city of Kathmandu. Also, the National Public Health Laboratory in Kathmandu has reported isolation of \( V. \) cholerae O1 Ogawa in 2004 and before 2004, Inaba strains of \( V. \) cholerae O1 during 2005 and 2006, and isolation of both Ogawa and Inaba during 2007 (unpublished data). In East Delhi, \( V. \) cholerae O1 Ogawa was the only predominant isolate during the period from 2001 to 2003. However, from 2004 to 2006 \( V. \) cholerae O1 Inaba predominated the coexisting Ogawa serotype (17). In Kolkata, India, \( V. \) cholerae O1 Ogawa serotype predominated the Inaba serotype during 2004, while the reverse was true for 2005 (18).

In this study no significant difference in the number of cholera cases between genders was seen \( (P < 0.05) \). The above finding is in concordance with that of Ono et al. (13), who reported no significant difference in the detection rate of enteropathogens between male and female populations.

As reported above, an age-wise distribution study showed that the most prevalent age group for cholera cases was from 15–30 years, with the next most prevalent the age group from 30–45 years, followed by 45 years and above \( (P < 0.05) \). The 15–30 year age group is highly productive and involved in various sorts of daily activities which may lead to increased exposure to cholera agents and increased susceptibility. The decrease in cholera cases from 30–60 years may be due to a propensity of this age group toward a sedentary lifestyle with a lower risk of exposure to etiological agents. Kaitha et al. (15) reported a high percentage of cholera infection in children during 2002 and 2003 in Chandigarh, India. However in this study, the fact that the age group below 15 is seen as the least vulnerable group may be a form of Berkson’s bias, as the children in the age group below 15 years are usually taken to separate children’s hospitals such as the Kanti Children Hospital, Nepal.

Outbreaks of cholera are a regular feature in Nepal. The seasonal outbreaks of cholera are a reminder of the endemic characteristic of the illness and its emergence as an important pathogen of acute watery diarrhea (17).

In Nepal, normally the dry season starts in the month of Chaitra (March/April) and continues until Jestha (May/June). The rainy season starts in Ashad (June/July) and continues until Ashwin (September/October). Waterborne epidemics such as diarrhea, gastroenteritis, typhoid, and cholera occur in these seasons because of insufficient water, poor water quality, and unsanitary conditions. During the dry season, there is an acute scarcity of drinking water, while in the rainy season, although the quantity of water available is large, most water sources are contaminated with excreted microorganisms from surface water runoff (2).

In this study, which was conducted from June 2008 to January 2009, the incidence of cholera was found to be highest (57.14%) during Ashad (June/July) \( (P < 0.05) \). Ise et al. (14) also reported an outbreak of cholera in Kathmandu from July to September (rainy season) in 1994.

In this study the antimicrobial susceptibility patterns of the isolates revealed that the isolates were sensitive to ciprofloxacin, tetracycline, ampicillin, and erythromycin. However, the isolates were 100% resistant to furazolidone, cotrimoxazole, and nalidixic acid. The appearance of resistance to cotrimoxazole is a severe threat to a country such as Nepal, where it is widely used to treat acute gastroenteritis. \( V. \) cholerae O1 Ogawa biotype El Tor were isolated during 1994, and the isolates revealed high sensitivity to tetracycline, ciprofloxacin, and gentamycin and low sensitivity to nalidixic acid, cotrimoxazole, ampicillin, and cephalixin (14).

There is a wide array of mechanisms that lead to the development of resistance to antibiotics in bacteria. The emergence of multiple drug resistance is a serious problem in the treatment and containment of the disease as reflected by the increase in the mortality rate from 1 to 5.3% after the emergence of drug resistant strains in Guinea Bissau during the 1996–97 epidemic of cholera (15).

In conclusion, the high incidence rate of diarrhea due to cholera should not be ignored. The high degree of resistance observed appears to have resulted from the practice of indiscriminate use of antibiotics in Nepal. Concrete action should be taken by the relevant authorities to prevent strains from developing resistance to the paucity of drugs that are effective now.
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REFERENCES