Adhesins of Uropathogenic *Escherichia coli* (UPEC)

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Abstract

Uropathogenic *Escherichia coli* (UPEC) is the main pathogen associated with urinary tract infections namely cystitis, pyelonephritis and infectious complications. As a commensal, *E. coli* is mostly harmless in the gut. Some strains diverge and become more pathogenic. They express multiple virulence factors and invade the urinary tract (UT). The important ones are the ‘adhesins’ or specialized proteins with sticky ends, which help to break the inertia of urinary bladder mucosa and help to attach to them. Host immune response trigger inflammatory reactions, resulting in symptoms of urinary tract infections (UTI). Recent studies help to get updated information about the molecular mechanisms behind the adhesins. This knowledge is helpful for better understanding of the pathogenesis of UTI which can then be applied to epidemiological research. It also helps to understand the revolutionary trends, to help with better prognosis and to devise new methods in lab diagnosis & vaccine development. This review is intended to unravel the molecular components that makeup the adhesions of UPEC.

Key words: Adhesins, AFA, Curli, CUP, Pap, SFA, UPEC

Introduction

*Escherichia coli* (*E. coli*) are highly versatile organisms. The commensal *E. coli* peacefully exists in mammalian gut niche. It is a successful competitor at this crowded site. There are other highly evolved strains among *E. coli* that cause broad spectrum of infections with the help of virulence factors. Expression of these factors are through the genetic elements that can be mobilized into different groups to form new combinations. Only the successful combinations persist long to become a Pathotype. (A group of strain of a single species that can cause common disease using a common set of virulence factors)(1).

*E. coli* is categorized into Diarrhoeagenic *E. coli*, the pathotype associated with enteric/diarrhoeal diseases, the Uropathogenic *E. coli* (UPEC), causing UTIs and *E. coli* causing Sepsis/meningitis, Meningitis associated *E. coli* (MNEC). The *E. coli* causing infections outside intestine is also termed as Extra Intestinal Pathogenic *E. coli* (ExPEC). The six categories among diarrhoeic *E. coli* include enteropathogenic *E. coli* (EPEC), enterohaemorrhagic *E. coli* (EHEC), entero invasive *E. coli* (EIEC), enterotoxigenic *E. coli* (ETEC) and diffusely adherent *E. coli* (DAEC). Pathotypes of Diarrhoeagenic *E. coli* give rise to gastroenteritis but not any infection outside intestine. The ExPEC will exist in gut without consequence but will disseminate and colonize other niches causing disease (2). UTI is defined as the presence of significant number of pathogenic organisms in urinary tract, along with symptoms, while recurrent UTI can be defined as two or more episodes within six months or three or more episodes in one year(3).

UPEC are responsible for more than 90% of UTI, in both sexes. *E. coli* is the primary cause for community acquired UTI (70-90%) and to a large part of nosocomial UTIs(50%), accounting for substantial medical costs and morbidity worldwide(4). The women & children are more prone. The incidence of UTI in women increases with age and has a peak in the twenties(5). Sexually active women aged 20-40years and postmenopausal women older than 60 years are the two populations at highest risk of UTI. The life time risk of symptomatic UTI among women has been found to be 60%(6). Factors such as shortness of urethra, sexual activity, contraceptives, estrogen deficiency, diabetes, obstructing lesions and genetic factors such as blood group secretor status increase a woman’s likely-hood of contracting UTI(7).

The prevalence of asymptomatic bacteriuria (ABU) in healthy women has shown to increase with age by about 1% in age group 5 to 14 while about 20% in elderly living in community. In ABU carrier state *E. coli* strains exist without symptoms. For many groups ABU screening is not beneficial, while for other groups like pregnant women and people undergoing traumatic genitourinary procedures ABU screening is useful for better outcome(8).

It is believed that the primary reservoir for UPEC is the intestine and that *E. coli* get introduced into the urethra (ascending hypothesis). *E. coli* strains colonize the bladder after travelling from gut to reach vaginal and periurethral area will cause cystitis, the common form of UTI. It is marked with dysuria, frequency, burning sensation& pain. UTI can proceed from bladder, via ureters to the kidney to cause pyelonephritis. It can damage the kidneys and result in kidney failure. This is associated with flank pain, fever, nausea and vomiting and may even progress to septicemia. Pyelonephritis is less common type of symptomatic UTI than cystitis(3).
In chronic & complicated UTIs bacterial strains are often mixed(9). It has also been found UPEC strains isolated from sexually active patients match with their fecal isolates from their partners(10)(11). There are instances where spread of a specific closed group occurred through contaminated consumables & food (12). E.coli have been phylogenetically grouped into six groups designated as A, B1, B2, C, D & E. It has been shown D & B2 harbor UPEC(13).

Stages of pathogenesis leading to development of UTIs include bacterial adherence to the host tissues, colonization within the host, avoidance of host defense mechanism and causing damage to host tissue(14). After successful attachment and colonization escaping the host defense mechanism will be the next priority. Pili and fimbriae help in attachment while toxins secreted by the pathogen will damage the host tissue and help to establish themselves.

Ascending route is the most common route in UTI. Upon entry into lower UT, UPEC face obstruction to colonize. There is the flushing action of the urine, the mucosal barrier of the urothelium. Host inflammatory response leading to cytokine production, neutrophil influx and exfoliation of the cells. Exfoliation of epithelium helps to clear many bacteria from urinary tract along with the flow of urine (15). At the same time the immature epithelial cells get exposed due to exfoliation, making them susceptible to infection. Infection which began with attachment and colonization of epithelial cells proceeds by invasion, dissemination and will spread to the underlying immature bladder cells.

UPEC binding to host tissues is a paramount step in UTI. The bacteria will break into the host cytosol and will multiply rapidly, forming large biofilm like intracellular communities (ICBs) by binding with actin (16). Though E.coli has been regarded as extracellular pathogen, it has been proposed that UPEC can form quiescent intracellular reservoirs (QIRs), where they persist for long periods (17). Host immune system will fail to detect them at these sites making them less immunogenic(18). As replication of these actin bound bacteria is limited antimicrobials will be less susceptible. These QIRs act as source for recurrent UTIs(2).

Virulence factors of UPEC

Virulence factors(VFs) are specific properties that enable organisms to overcome host defense and cause disease(11). Pathogens causing UTI unlike commensal bacteria possess many different virulence factors which influence the outcome of UTI. There are different virulence genes (VGs) expressed through pathogenicity associated island (PAI) in E.coli. Genes that encode microbial proteins and organelles that specifically aid in pathogenesis are known as virulence genes(17). The high degree of genetic diversity of UPEC isolates is due to the presence of mobile genetic elements called PAIs. PAIs are discrete genetic units flanked by direct repeats, insertion sequences or rRNA genes, which act as sites for recombination into the DNA. Experimental and epidemiological data have shown that no single VF of UPEC is sufficient to cause disease. It is the timely stepwise expression of multiple factors that leads to successful manifestation of disease(19).

Virulence genes (VGs) help to survive in hostile environment and to persist in the UT. The different VFs play role in different steps in UTI pathogenesis and their expression can be versatile depending on the environment and the host. These include adhesins (like p-pili, Type1 fimbriae), toxins (hemolysins Hly, cytotoxic necrotizing factor; CNF), polysaccharide capsules (K1,K5) and siderophores (aerobactin, catecholate siderophores)(20). Other traits include resistance to bactericidal effect of serum, colicinogenicity, production of IgA protease(21),(22). The formation of ‘pod ‘or biofilm like intracellular reservoir acts as a virulence mechanism for persistence and recurrent UTI(15). It has been seen that history of chronic cystitis is a significant risk for recurrence of severe UTI.

**UPEC Genomics:** Genomic data of UPEC strains suggest UPEC are genetically diverse pathotypes without a common virulence plasmid or pathogenicity associated island(PAI) required for infection(23). E.coli got a plastic genome capable of rapid alteration to suit different environments. The immune response and various factors of the host like its physiology, anatomy influences the colonization of E.coli(2). UPEC genome is larger than commensal K12 E.coli genome. This facilitates their existence outside the gut. Whole genome sequencing of multiple E.coli strains have been done, for strains like CFT073, UTI189, 536 (24)(25)(23)(26). UPEC genome got adhesins, iron acquisition systems which help in their survival in bladder. It does not contain have Type III secretion system expressed by intestinal pathotypes of E.coli. Genes encoding VFs have been shown to be located on chromosome or plasmids. Pap & hly genes are exclusively chromosomal while Afaldra can occur in either location and traT gene coding for serum resistance trait in outer membrane is exclusively plasmid mediated(19).

Expression of PAIs varies. They help in horizontal gene transfer. It can be inserted or removed from the genome of E.coli as it contain transposons and integrese(27),(28). There is ‘phase variation’, a process in which cross talk between fimbrial operon result in a switch in expression of one fimbriae type to another(29). This antigenic variation is helpful for the pathogen to overcome host defense.

**Adhesin Assembly and Interactions:** To establish an infection E.coli should attach to host surface. Adherence is mediated by adhesins that help in recognizing and binding to host receptors. The ‘adhesins’ are present on bacterial surface which mediate specific bonding with molecules on host epithelium called ‘receptors’. The adhesins attach to their receptors first by Vander Waal's
forces and hydrophobic attraction, which leads to low affinity binding. During second step the bonds are strengthened by stereo chemical interactions(30). Adhesins are special proteins expressed by many pathogens including UPEC. The important adhesin is the fimbrae which are long surface proteins, extending out from bacterial surface.

Adherence helps the pathogen to prevent from being swept away by normal flow of body fluids. There occur molecular interactions with host and the pathogen. Binding brings many changes in the host and pathogen. The pathogen might express new genes to enhance its virulence. binding to host receptors trigger signal transduction cascades and will activate the immune response .At times it might slow down cellular process and aids in bacterial colonization(31). Synthesis and assembly of the adhesins is a multistep process. The chaperone/ usher pathway (CUP) is the much studied one. CUP pill an extra cellular fibres of a vast family are encoded by this pathway. These are critical virulence markers expressed by E.coli and many gram negative bacteria. CUP pill help to adhere to different niche and also help in biofilm formation. On the outer membrane of the bacteria there is a gated channel-usher which promote the assembly and extension of the pilus fibre to the extra cellular surface of the bacteria with the help of different chaperones. The Type 1 pili, P pili & S pili systems in E.coli are assembled by CUP biogenesis. Various structural protein subunits are organized to form the organelle(32).

This review will focus on the various adhesins of UPEC that enable them to facilitate infection and persist in the urinary tract. The E.coli adhesins are either fimBriae associated or adhesins independent of fimBriae.

**Fimbral Adhesin**

**Type 1 fimBriae:** It is known as mannose sensitive adhesin because of the receptors biochemical characteristic that is mannose sensitive (MS). The adhesion is inhibited by solution of D-mannose. Phenotypically they can agglutinate RBCs (haemagglutination). They produce mannose sensitive haemagglutination (MSHA). RBCs of guinea pig, humans, rabbit etc contain the α-D mannose receptor. Type 1 fimbrae are important virulence determinants expressed in E.coli and most members of Enterobacteriaceae family and mediate binding to mannose oligosaccharides(33).

Receptors for Type 1 fimbrae are present in different cells of humans like RBCs, muscular layers of blood, ureters, Henle’s & proximal tubules. Type 1 fimbral receptors are not present in the epithelium of human bladder or on distal tubules, collecting duct, glomerular endothelium(34).

The Type 1 fimbrae are peritrichously arranged around the bacterial cell and there will be about 100-500 fimbrae. These filamentous organelles are encoded by ‘fim’ gene cluster, with the structural components of the fimBriae composed of fimA, fimF, fimG & fimH and the pilus encoded by fimC & fimD(35). These are subunits of genes for structure, adhesion and accessory proteins involved in transport and assembly of fimbrae. fimB & fimE are the regulatory genes that control phase variation of Type 1 fimbrae (36). At the distal tip of heteropolymeric Type1 Pilus rod, is fimH the adhesin responsible for binding to mannose containing host glycoproteins. The uroplakin1a (an integral membrane glycoprotein) present in bladder surface is the main receptor for fimH(16). FimH are also bound by integrins which are expressed by many host cell types. Integrins are extracellular matrix proteins, providing signaling between ‘intra’ & ‘outer’ cell environment. Pathogens gain entry into host cell by manipulating integrins and signaling reactions.(37)(38). FimH also binds to pattern recognition receptors TLR4.

Attachment by Type 1 through fimH triggers, mast cell activation of bladder epithelium. They release histamine(31)(39). This inflammatory response is presented as the symptoms of UTI, pain &dysuria. Tamm Horse fall protein(THP), are soluble factors found in urine which protect the bladder by offering binding site for Type 1 fimbrae and subsequent elimination of the pathogen without damage. If UPEC manages to adhere to the urothelium using adhesins and especially Type1 fimbrae the acute pathogenesis of UTI starts. UPEC enter the cytoplasm and will form IBCs by multiplying in the intracellular niche. This will be a protective haven from host immune response and thus helps the bacteria to gain foothold(40).

Type1 pili are highly conserved and are common virulence genes among UPEC and commensal isolates. Various studies have shown knockout of fimH diminishes UPEC ability to colonize.(41) The expression of Type1 pili is phase variable. Expression of Type1 pili is phase variable. Expression of Type1 is co-regulated with expression of P fimbrae associated with pyleonephritis. Bacteria switch ‘on’ or ‘off’ the product of virulence genes depending on environment-mental condition. Phase switch ability may account for differential expression of Type1 in different body sites and in pyleonephritis & cystitis(40)(20). Research done on Type1 pili gave varied results, depending on lab conditions, age, sex and location.

The general opinion is that Type 1 fimbrae have no importance in UTI while their role in lower UTI patients are varied. In humans severity of UTI was increased and immunological response was greater in children with infection caused by Type1 pilated UPEC strains(42). A review article by Johnson(24) has analyzed the expression of Type1 fimbrae in urinary (64%) and fecal (60%) samples, to be in similar proportions. The ‘switch off’ of expression of Type 1 by phase variation after invasion of tissues maybe a survival mechanism. The presence of fimbrae may favour human leukocytes to recognize the pathogen and may favor clearance(34).

The tip adhesin fimH has undergone pathoadaptive mutation in clinical isolates(40). Several allelic variation
of fimH has been identified with Phenotypes having different binding ability(70,71). Receptor recognition profile can be affected by minor amino acid sequence alteration in fimH(43). This variation in fimH adhesin enhances its binding to target such as laminin, collagen and fibronectin as well to different mannose derivatives. As UPEC are genetically diverse pathotypes without a common virulence plasmid, Norinder et al; 2011 suggested that the adhesins like fimH of Type1 fimBriae are required to initiate uncomplicated cystitis(44). The antiType1 fimbrial antibodies (62) and D mannopyranoside (a receptor analogue) protect against experimental infection in animals (63). Thus Type 1 pili is an interesting candidate for antiinfective compounds and vaccine.

Type 1 pili are formed on bacterial outer membrane by Chaperone Usher pathway (CUP). The pilus rod of Type 1 is made of FimA subunit arranged helically and to that is attached fibrillar structure Fim G. FimF and distal tip FimH(2). FimH the adhesive tip recognize mannosylated glycoproteins & N-linked oligosaccharides on α3 & β1 integrins. Type 1 pili which is anchored in outer bacterial membrane protrudes out through CUP biogenesis. SurA is a bacterial periplasmic isomerase that helps in insertion of the FimD to outer membrane usher(45).

The receptor for Type 1 pili appears to depend upon the differentiation state of urothelial cells. Mature superficial umbrella cells express uroplakins on their luminal surface and FimH bind to mannosylated UPla(46). Binding to receptor initiates signal transduction cascade and internalization of the UPEC by a zippering mechanism, involving actin rearrangement. (47). In undifferentiated urothelial cells FimH receptor is α3β1 integrins. Experimental UPEC pathogenesis in undifferentiated urothelium shows, bacterial proliferation and IBC formation in limited manner compared to differentiated umbrella cells where UPEC can survive in cytoplasm by vesicular escape. This could be because of the thick actin network present in immature urothelium preventing bacterial spread(48). Type 1 fimbriae/ Type1 pili play a pivotal role in bacterial adhesion, invasion and growth in biofilm communities(16).

**P-Pili:** Expression of P-pili is associated with pyleonephritis(49). It is the mannose resistant adhesin. It was originally identified by their ability to mediate binding to human O type erythrocyte without inhibition by mannose, distinguishing it from Type 1 fimBriae.(50)

Glycolipids containing the gal-gal moiety (α-D galacto pyranosyl-(1-4) β-D galactopyranoside) are the receptors for adhering E.coli strains. Common P blood group antigen contains this receptors (49). This receptor for P fimbriae is present on RBCs of humans pigs, fowls, goats, dogs but not on those from cows, guinea pigs or horses.(51) Gal –gal moiety on the receptor for P fimbriae is found abundantly on surface epithelial cells lining urinary tract(52). P-pili expression is less in asymptomatic bacteriuria than in cystitis and pyleonephritis. The association of P-pili with pyleonephritis could be because of large amount of gal moiety receptors present in renal glycolipids. Studies by Wold et al suggest that P-pili has evolved in E.coli(53). The persistence in gut in enabled by the binding to gal receptors. They bind more to loosely associated substance in the gut and not to colonic cells. These gut strains belong to phylogenetic group B2 and to lesser extent Group D. These groups got superior ability to persist & spread and to cause disease(54). Other studies by Zhang and co-workers found P-pili among young women associated with B2 and D.(55)

The genome of P-pili is coded by Pap gene cluster in the chromosome. They are composed of PapA, which is a polymer, that forms a rigid stalk, that is connected to a flexible tip containing subunits PapE & PapF in limited numbers.(56) PapD transports several pilus subunits from the cytoplasmic membrane to the outer membrane.(57) The outer membrane usher is Pap C which forms a pore through which pili anchors the stalk PapA to outer membrane. PapG is the adhesin. PapE tip is joined to PapG using adapter protein PapF(4).

Three types of PapG adhesins have been identified namely PapGI, II, III iso receptors. The isoreceptors bound PapG variant contain a gal-gal moiety linked to ceramide, which acts as an agonist of TLR4, activating immune cell response. This crosstalk, favors production of pro inflammatory cytokines, chemokines (interleukin-6 and CXCL8 respectively) and recruitment of neutrophils. This initial response IS beneficial in initiating bacterial clearance, but it will also cause damage to the surrounding tissue and is associated with renal complications.(58)

Since Pfimbiae are implicated in triggering inflammation, it can be concluded that they are associated with manifestation of acute pyelonephritis.

Pap DNA exhibit considerable heterogeneity leading to antigenic diversity. The selective pressure from host immune system might account for the expression of hyper variable immune gene domain(44). Pap fimbiae are subjected to rapid random phase variation & environmental influence. Because of this probable characteristic use of Pap fimbiae as vaccine candidate is limited. The P fimbiae donot adhere to human PMNLs as they produce small amount of gal –gal receptors(59). PapG allele II is commonly associated with acute pyelonephritis. PapG allele III is found in cystitis. The role of PapG allele I is debated. The exact role of P pili during course of UTI has remained elusive(60).

Melican & co workers have defined previously unknown synergistic functions for Type I & Pap fimBriae, which facilitate bacterial colonization in dynamic invivo condition. P fimBriae enhance early colonization of tubular epithelium, while Type 1 mediate colonization of the centre of the proximal & distal tubule.
via a mechanism that involve inter bacterial binding and biofilm formation. This subsequently leads to obstruction and affects renal filtration and contribute to patho physiology of pyelonephritis.(61)

There is a structurally related gene cluster Prs (Pap related cluster). They have different adhesion moieties. Prs G is the adhesin tip. Genomic studies have shown UPEC containing PapGII bind to globo triaoyl-ceramide or GbO3 (present in human uroepithelial cells), PapGII bind to GbO4 (abundant on human uroepithelialcells) and PapGIII adhesins or PrsG that bind to forssman antigen or Gb05 (present in canine uroepithelium)(62).

UPEC Strains 536 and UTI189 contain one copy of Pap encoding operon while CFT073 has two copies with separate pathogenicity associated island(PAI)(2). The P fimbriae are not only associated with UPEC causing UTI but also related to new born menenigitis E.coli (NMEC) & Avian pathogenic E.coli (APEC)(63).

S fimbriae: S fimbriae coded by sfa genes are detected from UTI, meningitis in newborns and septicemia. The sfa adhesins bind to epithelial and endothelial cell lines and endothelial cell lines derived from bovine UTI and kidney.(64). S fimbriae help in bacterial dissemination within host tissues. 22.5% strains isolated from UTI showed sfa. In 18% cases they were associated with pap operon(65). The adherence gene of S fimbriae is distinct and codes for protein located at the tip.

The S-fimbriae recognizes neuraminic acid (sialic acid) containing structures other than mannose or P antigen on human erythrocytes.(66) The specifically binds to sialyl galactoside, from which it got the name S fimbriae. This fimbriae is morphologically similar to Type 1and P fimbriae. sfa gene cluster consists of sfaA as major subunit protein and three minor units of proteins namely sfaS, sfaG and sfa H.(67) Regulation of sfa determinants is mediated by two regulatory proteins sfaB & sfaC. The S fimbriae also undergo phase variation. Depending on temperature, osmolarity, presence of glucose and other environmental factors(26). The S fimbriae are shown to bind to epithelial cells of the proximal & distal tubules collecting ducts and glomerulus, renal interstitium and renal vascular endothelium are known to be binding site for S. fimbriae(68). They bind to sialo-glycoproteins on brain micro vascular endothelial cells which could be the reason why S fimbriae containing E.coli, causes menenigitis. Various genotyping studies have reported prevalence of S fimbriae among ExPEC isolates.(66)

FIC fimbriae: These fimbriae do not mediate haemagglutination to erythrocytes from human, guinea pig, horse ox and chicken. But they contribute to the adhesive properties of the UPEC(65). The FIC fimbriae are encoded by foc gene cluster. Biogenesis of FIC is by focA genes, which encodes an important product required for fimbrial formation. focG & foc H encode for minor subunits and focF encodes a protein similar to protein of focA, focH is the tip located adhesin(28). The receptor for FIC has been revealed. It include glucosyl ceramid and gal-gal sequence of asialoGM1(69). Foc genetic cluster is related to S fimbriae genetic cluster. Though sfa & FIC antigen differ in their receptors for attachment. It is seen that receptor specificity varies with ceramide compounds. (70) In response to FIC attachment to human epithelial cell, innate immune response is triggered to produce proinflammary cytokines& interleukin8(71).

AfimBrial Adhesins

Dr Fimbriae: Dr. fimbriae are implicated in UTI especially in those with gestational pyleonephritis & recurring cystitis(72)(73). This is a heterogeneous group consisting of different but related adhesins. (≥70% homology). Dr adhesins can result in MRHA. They recognize different portions of the Dr blood group antigen, a component of IFC (Inab-Friberger Cromer) blood group complex(72). D祠/DrAfa adhesins recognize decay-accelerating factor (DAF) as a receptor which is a complement regulatory protein present on the surface of many human epithelial cells (including epithelial cells of the urinary tract). Dr Blood group substance was found on tubular basement membrane and Bowman’s capsule of the human kidney. Dr fimbriae binds to a lesser extent to the bladder epithelium.(74). The genetic organization of Dr adhesin operon (dra) consists of five genes draA, draB, draC, draD, and draE. Four genes, draA, draC, draD, and draE, promote the expression of full, mannose-resistant haemagglutu-tination. draE of dra operon bind to DAF. The group include AfaI, AfaIII( afimbral adhesins) and O75X (also known as AfaI1). During pregnancy E.coli bearing dr adhesins pose a threat to patients because of its invasive nature(75). Binding of Dr adhesins is accompanied by the activation of signal transduction cascades, including activation of PI-3 kinase(1). Dr fimbriae is found in a lower proportion than Pap, Sfa, and foc fimbriae. Strains of diarrheogenic E.coli also harbor Dr adhesin.

Afa Adhesin: ‘Afimbral’ adhesins are associated with UTI. Purification of Afa-1 protein showed that they exist on the bacterial surface. They are free as macro molecular aggregare in spent culture medium. Afa protein can agglutinate human erythrocytes in the presence of D- mannose(76). For Afa there is Afa gene cluster, which consists of AfaA, AfaE, AfaD, AfaB, and AfaC. AfaE-I is the adhesin tip. (77)The products of Dra and AfaA are similar to chaperone usher product of PapD chaperone.(2) There exist at least four different Afa operons Afa-1, Afa-2, Afa3, Afa-4 which encode protein AFA-I, AFA-II, AFA-III, AFA-IV. AFA1 & AFAIII belong to Dr family of adhesins.(78) AfaC & AfaD genes are highly conserved. AfaE codes for adhesin and it is heterogenous in nature. Afa adhesins were isolated more from patients with cystits (26-65%) than with pyelonephritis (6-26%) and with ABU (6%) (34).
Curli Fibres: They may be involved in the colonization of fibronectin coated surfaces. Curli are the third type of organelles expressed by E.coli, made of protein Curli. They are expressed as curled surface structure and is encoded by Curli subunit gene (csg) cluster. Curli have been studied to attach to the proteins of extracellular matrix such as plasminogen, fibronectin and laminin thereby promoting adhesion of the bacteria to different human cells(79)(80) studies suggest that most of the pathogenic E. coli strains do not express Curli at higher temperature of 37°C but at temperatures below 30°C and under low nutrients and low media osmolarity, during the stationary growth phase. Assembly of Curli includes self-assembly of subunits csg. A sub-unit, to csgB which is a specific nucleator protein. csgD is the transcriptional activator and csgG is involved with stabilization.(81)

Newer Adhesins: A trimeric autotransporter adhesin UpaG was recently identified, which mediate aggregation of E.coli as well as adhesion to abiotic surfaces, T24 bladder epithelial cells and extra cellular membrane proteins.(82) Yqi is another adhesin found in UPEC & in ExPEC(83).

Role of Upec Adhesins in the Intestine: In gut we do find resident strains and transient strains. The former are those present in gut for many years, while transient strains are passed only for a short period(84). Resident strains include the commensal E.coli while the UPEC (ExPEC), Diarrhogenic E.coli form transient strains. E.coli is a normal inhabitant of the gut microbiota. It colonises the Gastrointestinal tract of human infants within few hours after birth and is acquired either from environment or from mother during parturition.(85) Commensal E.coli have a beneficial role by supporting digestion and producing Vitamin K and competing with other microbes and hindering colonization of pathogenic agents(86). Commensal strains are derived from phylogenetic groups A & B1 which don’t have specialized virulence attributes.

Colonization of the large intestine is the preliminary step in development of urinary tract infection. Among UPEC adhesins P-pili and Type1 fimbriae are found to enhance colonization within the gut.(87) There is also studies where expression of adhesins among fecal flora were found to be low. As adherence ability shown by bacteria helps to manipulate normal flora and considering the ascending route of UTI possibility of manipulating the relative composition of fecal, vaginal flora offers interesting possibilities in the prophylaxis of UTI(88).

Conclusion
Therapeutic use of receptor analogs to competitively inhibit attachment by UPEC is one possibility, in vaccine development. Moieties of adhesins expressed by UPEC has shown promising results. The Pap subunit vaccine to protect against pyleonephritis is under trial(89). Protective studies with animal models using E.coli adhesins gave encouraging results. Antibodies against Pap & Type1 Fimbriae prevented UPEC from binding to uroepithelium. Pilicides, novel inhibitors for pili biogenesis are being developed. Also research is into developing FimH vaccine, which will trigger formation of Anti–FimH antibodies. Targeted development of therapeutic molecules, to block CUP pilus assembly is underway. By increasing the immunogenicity of the adhesins through technology, vaccines look like an important alternative to treatment with antibiotics.

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