The antibacterial activity of blue light against nosocomial wound pathogens growing planktonically and as mature biofilms

Halstead, Fenella D; Thwaite, Joanne E; Burt, Rebecca; Laws, Thomas R; Raguse, Marina; Moeller, Ralf; Webber, Mark A; Oppenheim, Beryl A

DOI:
10.1128/AEM.00756-16

Document Version
Peer reviewed version

Citation for published version (Harvard):
Halstead, FD, Thwaite, JE, Burt, R, Laws, TR, Raguse, M, Moeller, R, Webber, MA & Oppenheim, BA 2016, 'The antibacterial activity of blue light against nosocomial wound pathogens growing planktonically and as mature biofilms', *Applied and Environmental Microbiology*, vol. 82, no. 11. https://doi.org/10.1128/AEM.00756-16

The antibacterial activity of blue light against nosocomial wound pathogens growing planktonically and as mature biofilms

Fenella D. Halstead,[a,b,c]# Joanne E. Thwaite,[d] Rebecca Burt,[a,c*] Thomas R Laws,[d] Marina Raguse,[e] Ralf Moeller,[e] Mark A Webber,[b,c] and Beryl A Oppenheim[a,b]

Clinical Microbiology, Queen Elizabeth Hospital, University Hospitals Birmingham NHS Foundation Trust, Birmingham, UK[a]; NIHR Surgical Reconstruction and Microbiology Research Centre, Queen Elizabeth Hospital, Birmingham, UK[b]; Institute of Microbiology and Infection, University of Birmingham, Birmingham , UK[c]; Chemical, Biological and Radiological Division, DSTL, Porton Down, Salisbury, Wiltshire, UK[d]; German Aerospace Center (DLR e.V.), Institute of Aerospace Medicine, Radiation Biology Department, Space Microbiology Research Group, Cologne (Köln), Germany[e]

Running Head: Activity of 400 nm light against nosocomial pathogens

Address correspondence to: Fenella D. Halstead, fenellahalstead@nhs.net
* Present address: Aston University, Birmingham, UK
F.D.H and J.E.T contributed equally to the work.

ABSTRACT

Background

The blue wavelengths within the visible light spectrum are intrinisically antimicrobial, and can photodynamically inactivate the cells of a wide spectrum of bacteria (Gram-positive and -negative) and fungi. Furthermore, blue light is equally effective against both drug sensitive and resistant members of target species, and (in contrast to UV radiation), is less detrimental to mammalian cells.

Blue light is currently used for treating acnes vulgaris, and *Helicobacter pylori* infections; the utility for decontamination and treatment of wound infections is in its infancy. Furthermore, limited studies have been performed on bacterial biofilms; the key growth mode of bacteria involved in clinical infections.

Here we report the findings of a multicentre *in vitro* study performed to assess the antimicrobial activity of 400 nm blue light against bacteria in both planktonic and biofilm growth modes.

Methods

Blue light was tested against a panel of 34 bacterial isolates (clinical and type strains) comprising: *Acinetobacter baumannii*, *Enterobacter cloacae*, *Stenotrophomonas maltophilia*, *Pseudomonas aeruginosa*, *Escherichia coli, Staphylococcus aureus, Enterococcus faecium*, *Klebsiella pneumoniae*, and *Elizabethkingia meningoseptica.*

Results

All planktonic phase bacteria were susceptible to blue light treatment, with the majority (71%) demonstrating a ≥5 log_{10} decrease in viability after 15-30 minutes exposure (54 J/cm^2 to 108 J/cm^2). Bacterial biofilms were also highly susceptible to blue light, with significant reduction in seeding observed for all isolates at all levels of exposure.

Conclusions

These results warrant further investigation of blue light as a novel decontamination strategy for the nosocomial environment, as well as additional wider decontamination applications.

Importance

Blue light shows great promise as a novel decontamination strategy for the nosocomial environment, as well as additional wider decontamination applications (e.g. wound closure during surgery). This warrants further investigation.

1 INTRODUCTION

Antimicrobial resistance (AMR) is rapidly evolving and emerging to be a large threat to modern medicine. Although only affecting a minority of admissions, healthcare

63 associated infections are associated with increased mortality, prolonged hospital stays
64 and increased treatment costs (1). With the rise in resistance to the carbapenem class
65 of antibiotics in Gram-negative organisms (2), there is a significant threat of infections
66 becoming wholly untreatable with current treatment regimens (3,4).

67 **M**uch research is now focussed on alternatives to the conventional antimicrobial agents.
68 These mostly involve topical agents (with the aim to reduce surface contamination and
69 therefore lower the risks of sepsis and infection progression) with research to date on a
70 large number of agents. Since the environment is a key source of nosocomial
71 pathogens (5), there has also been renewed focus on hospital cleaning and disinfection,
72 especially *via* antimicrobial chemicals delivered in a novel way, including antimicrobial
73 light sources (1,6). These novel strategies capable of decontaminating both the patient's
74 wound and the environment, offer to be highly beneficial in the fight against AMR and
75 nosocomial infections.

76 **T**he blue wavelengths within the visible light spectrum (especially wavelengths between
77 400 nm to 470 nm) are intrinsically antimicrobial and do not require additional
78 exogenous photosensitizers to exert an antimicrobial effect (4). Photodynamic
79 inactivation of both bacterial and fungal cells occurs as a result of photo-excitation of
80 intracellular porphyrins (1) by blue light, leading to energy transfer and the production of
81 highly cytotoxic reactive oxygen species (ROS); primarily singlet oxygen ($^1O_2$) (4, 7-9).
82 All wavelengths from 400-425 nm can be used for microbial inactivation; however the
83 optimal antimicrobial activity occurs at 405 nm, since this is the point in the
84 electromagnetic spectra where maximum porphyrin excitation occurs (10). Although
85 less germicidal compared to ultra-violet light (1), pathogens can be selectively

inactivated without damaging human cells and consequently blue light is considered much less detrimental to mammalian cells than ultra-violet (11,12). One potential benefit of light-based antimicrobial therapies is an equal efficacy against drug sensitive and resitant members of target species (13,14).

Blue light has been shown to exhibit a broad spectrum of antimicrobial effect against bacteria and fungi, although, generally the Gram-positive bacteria are considered to be more susceptible to blue light than the Gram-negatives (15,16). Successful inactivation has been demonstrated *in vitro* against *Staphylococcus aureus* (including MRSA), *Clostridium difficile* (both spores and vegetative cells)*, Acinetobacter baumannii, Escherichia coli, S. epidermidis, Pseudomonas aeruginosa*, *Klebsiella pneumoniae, Streptococcus pyogenes,* and *Mycobacterium* spp. (14-15, 17, 18). In addition to the key nosocomial pathogens, blue light is also effective against *Propionibacterium acnes*, and has been used topically to treat acne vulgaris (19, 20), and *Helicobacter pylori*, where blue light is used internally as a 'light string' to treat stomach infections (21). Owing to the mechanism of action of blue light, it is unlikely that viruses will be susceptible unless photosensitizers are added to enhance virucidal activity (22).

The use of blue light for treatment of wound infections *in vivo* is an emerging technology. To date blue light therapy has been shown to significantly reduce the bacterial burden of wounds infected with *P. aeruginosa* (23), MRSA (24), and *A. baumannii* (25), and saved the lives of mice subjected to potentially lethal burns contaminated with *P. aeruginosa* and *A. baumannii* (23, 25).

107 **A**s well as clinical application for patient treatment, blue light is also a promising
108 candidate for the control of problematic microorganisms in the clinical setting (e.g. the
109 disinfection of air and exposed surfaces). In this regard, Bache *et al* (26) and Maclean
110 *et al* (1) have performed studies with a new disinfection technology termed the HINS-
111 light environmental decontamination system (EDS) which delivers low-irradiance 405nm
112 light continuously and is suitable for use in patient occupied settings. Evaluation studies
113 performed by the latter authors showed that there was a statistically significant 90%
114 reduction in numbers of culturable *Staphylococci* spp. following 24 hours of use in an
115 unoccupied room (5), and reductions of 56-86% when used in burns isolation rooms
116 occupied by MRSA-positive patients. Furthermore, when the system was no longer
117 used, the room became recontaminated to levels similar to those pre-treatment.

118 **T**he vast majority of research on blue light has been carried out on bacteria in their
119 planktonic phase, dispersed evenly in a liquid medium. In nature this is rarely the case,
120 since most bacteria aggregate to form complex communities within a matrix of
121 extracellular polymeric substances termed a biofilm. There are many advantages for
122 this compared to planktonic growth which include: increased resistance to killing *via*
123 antimicrobials, immune cells, chemicals and environmental stresses (27). Furthermore,
124 once a biofilm has become established on a surface they are extremely hard to
125 eradicate. Medically, biofilms have been associated with a myriad of chronic infections,
126 acute infections, colonisation of in-dwelling medical devices, and wound infections (27-
127 29).

128 **S**ince we know that the majority of clinical infections and environmental contamination
129 involve microbial biofilms (30), this multi-centre *in vitro* study was performed to assess

130 the antibacterial activity of blue light against biofilms of a range of important nosocomial
131 pathogens.

132

133 ## 2 MATERIALS AND METHODS

134 **A** series of *in vitro* experiments were conducted with a panel of organisms (Table 1) to
135 determine the efficacy of blue light (400 nm) against bacteria in a planktonic (free-
136 floating in broth) and biofilm (attached to a surface) mode of growth. The panel
137 comprised well-characterised control and clinical isolates (in terms of their antibiogram
138 and ability to form biofilms *in vitro*) and concentrated mostly on *A. baumannii* strains
139 from a protracted outbreak at the Queen Elizabeth Hospital in Birmingham (QEHB) (31).
140 ***A****. baumannii* is a key nosocomial pathogen which survives in hospital and healthcare
141 environments despite conditions such as desiccation, nutrient starvation and
142 antimicrobial chemicals (e.g. disinfectants) (332, 33). Despite stringent infection control
143 practices, a large outbreak of *A.baumannii* occurred at QEHB where 65 patients tested
144 positive during the outbreak period (July 2011 to February 2013). The strains from this
145 outbreak demonstrated a high degree of resilience to survival in the hospital
146 environment and there was also evolution amongst the isolates over time to increase
147 dessication resistance and biofilm formation capacity. Additional *A. baumannii* isolates
148 (representing genetically diverse strains) were tested in this panel to add some diversity
149 to the strains, including strains ACI_AYE (a representative of International Clone I; a
150 major globally relevant lineage), ACI_C60 (a control strain of a unique PFGE type), and
151 ACI_19606 (a control strain of a further unique PFGE type) (typing data not shown).

152

153 **W**e also tested a small range of other 'comparator' organisms commonly causing
154 hospital acquired infection including *Enterobacter cloacae*, *Stenotrophomonas*
155 *maltophilia*, *P. aeruginosa*, *E. coli, S. aureus,* and *Enterococcus faecium* and included
156 control strains (PS_6749 and MSSA_10788) recognised in the EN standards for
157 assessing the efficacy of chemical disinfectants (e.g. EN 13727 (34)). The panel
158 comprised isolates that in previous tests had demonstrated ability to form relevant
159 quantitities of biofilm *in vitro*, and furthermore included two carbapenem (multi-drug)
160 resistant isolates of *K. pneumoniae*, and a single isolate of *Elizabethkingia*
161 *meningoseptica* from a wound swab. This is an intrinsically highly resistant organism,
162 usually resistant to extended-spectrum ß-lactam agents (due to production by most
163 strains of two betalactamases: one ESBL and one Class B carbapenem-hydrolyzing
164 metallolactamase), aminogylcosides, tetracycline, and chloramphenicol (35).

165

166 **A**ll isolates were stored at -80°C on Protect™ beads, and were routinely cultured on
167 cysteine lactose electrolyte deficient (CLED) or blood agar prior to each experiment.

168

169 **E**xperiments were designed to assess the antibacterial activity of blue lightagainst
170 planktonic and biofilm growth forms of the panel of bacteria described above. Testing
171 was performed at the Defence Science Technology Laboratory (DSTL) (planktonic) and
172 the Surgical Reconstruction and Microbiology Research Centre (biofilms), and blue light
173 of 400 nm wavelength was used for all experiments.

174

175 **2.1 Blue light equipment**

176 **H**igh intensity blue light was provided by a LED Flood array (Henkel-Loctite, Hemel
177 Hempstead, UK). This array utilises 144 reflectorized LEDs which produce a
178 homogeneous illuminated area of 10 cm x 10 cm. The emission spectrum of the LED
179 array was determined using a USB2000 spectrophotometer (Ocean Optics, Oxford,
180 UK). Two identical platforms were used for the testing, both of which were calibrated at
181 DSTL using a PM100D radiant power meter (Thorlabs, Newton, New Jersey, USA) prior
182 to *in vitro* testing to ensure a reproducible irradiance of 60 mW/cm^2 when the LED array
183 is positioned 15.5cm above the test area. All of the experimental conditions (except
184 wavelength) adhere to the optimal criteria outlined by Coohill and Sagripanti (36) for the
185 assessment of bacterial sensitivity to UV-C radiation.

186

187 **2.2 Impact of blue light on planktonic bacteria**

188 **B**acterial isolates were grown overnight in Luria Broth (LB) [Sigma-Aldrich, UK], then
189 diluted in sterile PBS to produce a starting concentration of approximately 1 x 10^6
190 bacteria per ml. Test samples (2ml) were inoculated into a 12-well microtitre plate
191 [Corning, New York, USA], sealed with an optically clear ABsolute qPCR sealer
192 [Thermo Fisher Scientific, Paisley, Scotland] to prevent evaporation, then exposed to
193 blue light for 30 minutes (samples were taken for viable counting at 5 minute intervals).
194 If the strains still showed viability after 30 minutes of blue light exposure, the test was
195 repeated over 180 minutes, with samples taken at 20 minute intervals. An identical dark

196 control plate was set up, wrapped in aluminium foil and placed in the flood array
197 adjacent to the blue light irradiated samples.

198 **A**t time increments during the experiment blue light exposed and dark incubated
199 samples were removed and viable bacteria enumerated by serial dilution and growth on
200 LB agar plates. The blue light sensitivity for each strain was determined from the mean
201 of three independent biological replicates, with two technical replicates within each
202 experiment.

203 **T**he blue light dose (J/cm^2) received by the bacteria was calculated by multiplying the
204 irradiance of light (W/cm^2) to which the sample was exposed, by the exposure time
205 (seconds).

206

207 **2.3 Impact of blue light on pre-formed biofilms**

208 **T**he antibacterial activity of blue light against pre-formed biofilms was assessed by
209 conducting 'minimum biofilm eradication concentration' (MBEC) experiments (37) on
210 each isolate. Overnight LB cultures of the test strains (made by inoculating
211 approximately three to five colonies into 5ml of fresh LB broth and incubating at 37°C
212 overnight) were diluted in fresh antibiotic-free Mueller-Hinton (MH) broth to an OD_{600} of
213 0.1 and then 200µl seeded into wells of a 96-well microtiter tray (MTT). Positive (200µl
214 0.1 OD_{600} diluted organisms) and negative (200µl MH broth) controls were included per
215 blue light time point to be tested.

To produce a 'transferable biofilm', a 96 well polypropylene plate [Starlabs, UK] was then placed into the MTT so that each well contained a 'peg', on which biofilms could form, before the plates were sealed, and statically incubated at 33°C for 72 hours. After 72 hours, the pegs (±biofilm) were removed and washed in a MTT containing sterile water (to remove any unbound cells). The positive (bacteria only) and negative control (sterile broth only) 'peg plate' was placed in a clean, empty MTT and wrapped in foil. Following this, both the control and the test peg plate were placed in the test area (15.5.cm beneath the light source) and exposed to the blue light for time points of 15, 30, 45 or 60 minutes (corresponding to a blue light dose of 54, 108, 162 and 216 J/cm^2 respectively). The foil around the control plate prevented the pegs from receiving any blue light treatment (and hence these positive control biofilms were not exposed to the blue light), but the control plate biofilms would have most likely been exposed to the same amount of heating and drying as the blue light exposed test plate.

After the treatment, the peg plates were carefully placed into a MTT containing 200µl sterile MH broth (herein referred to as 'reporter broth') for overnight incubation. After 18 hours, the OD of the reporter broth was measured to assess the viability (seeding) of the biofilms following blue light exposure.

To demonstrate the presence of biofilms on the pegs, crystal violet (CV) assays were additionally performed on the pegs after the OD of the reporter broth had been measured. This involved placing the pegs into MTTs containing 200µl of 1% CV (which binds to any present microbial biomass of biofilm), followed by washing (to remove unbound CV) and subsequent solubilisation of the CV in 200µl of 70% ethanol. The peg biofilm biomass could then be measured using OD readings as previously and the

239 presence of the biofilm confirmed. Two biological and 10 technical replicates were
240 performed for each strain and blue light exposure duration, respectively.

241

242 **2.4 Statistical analysis**

243 **2.4.1 Planktonic tests**

244 For the planktonic data, the surviving fraction was determined from the quotient N/N_0,
245 with N = the number of colony formers of the irradiated sample and N_0 that of the non-
246 irradiated controls. Plotting the logarithm of N/N_0 as a function of dose (blue light fluence
247 in J/cm²), allowed survival curves to be obtained.

248 To determine the curve parameters, the following relationship was used: $\ln N/N_0 = IC \times$
249 $F + n$ where: N = the number of colony formers after blue light irradiation; N_0 = the
250 number of colony formers without irradiation; IC = inactivation constant (cm^2/J); and n =
251 extrapolation number, (i.e. the intercept with the ordinate of the extrapolated semi-log
252 straight-line). The inactivation constant and the reciprocal lethal dose (LD) values were
253 determined from the slope of the dose–effect-curves (linear portion of the curve).

254 To allow for comparison with other bactericidal radiation sources in the literature, blue
255 light mediated killing was calculated in terms of the inactivation constant slope (IC), and
256 the kill kinetics shown as both the LD_{37} and LD_{90}. The significance of the difference of
257 the dose–effect-curves was statistically analyzed using student's t-test. Differences with
258 P values <0.05 were considered statistically significant.

LD_{90} values were analysed using the statistical software package IBM SPSS V21.0, were found to be log normal by QQ plot (data not shown), and were consequently transformed to the logarithm of 10 prior to parametric analysis. Differences between bacterial species was investigated using a 1 way ANOVA, and the suitability of the data for parametric analysis was further established with the use of a Levene's test for unequal variance (P=0.165). Where only one bacterial strain of species was available, this species was taken out of the analysis. Multiple comparisons were made using the Bonferroni's correction. Similarly, the effect of pigmentation of *S. aureus* strains on susceptibility to blue light was tested by using T-tests without Welches correction and suitability was further tested using Levene's test for unequal variance (P=0.984).

2.4.2 Biofilm tests

The ability of biofilms to seed new growth following exposure to blue light was assessed by comparing the OD values at each blue light time point verses the untreated (positive) control, and significance was determined using the student's t test. In order to investigate any possible link between biofilm size/depth (colourimetry), and blue light sensitivity, these two parameters were investigated through QQ plots in SPSS (version 21.0; SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp). Initial analysis suggested a transformation of both parameters by the logarithm of 10 was needed to render the data suitable for parametric analysis (analysis not shown). Very little difference between the technical replicates was observed with regards to either parameter and therefore the median of the $\log_{10}$ of the technical replicates was used for

281 analysis. The capacity for each strain to form a biofilm was taken from the average of
282 the OD values over the 4 time points for the positive control. Comparisons of biofilm
283 values were made using 1 way ANOVA and students' 't' tests (without Welch's
284 correction) and comparisons of variances were made with F tests and Brown-Forsythe
285 tests. The viability of each strain of bacteria in biofilm was analysed by Bonferroni's
286 posts tests across each time point (SPSS). Where significant differences between the
287 positive control and the blue light occurred, the blue light was regarded as having an
288 effect from there on leading to an ordinal score for each strain of 15 min (54 J/cm^2), 30
289 min (108 J/cm^2), 45 min (162 J/cm^2), 60 min (216 J/cm^2), or >60 min. Comparisons of
290 biofilm sensitive scores were made using Kruskal-Wallis tests.

291 **I**n order to characterise whether correlation existed between measured parameters, the
292 Spearman's method was used. In order to determine the statistical power of the
293 correlations, the computer program SPSS sample power V3.0 (IBM) was used and
294 power was calculated for one sample correlations using the derived R value and the
295 sample size (N = 34).

296

297 **3 RESULTS**

298 **B**lue light was tested against 34 bacterial isolates; including clinical isolates from QEHB
299 and culture collection type strains. The results of the spectral output testing of the blue
300 light platform (with an Ocean Optics USB2000 spectrometer), determined the emission
301 peak of the blue light produced was at 400nm, with a full-width half maximum value of
302 ±8.5 nm (Fig. S1).

3.1 Sensitivity of isolates to blue light when grown in planktonic culture

All 34 isolates were sensitive to blue light treatment, and there was no significant decay in the dark incubated controls. In contrast, rapid and substantive loss of viability was observed where all test bacteria were exposed to blue light (Figure 1A-F).

Twenty four of the isolates (71%) demonstrated at least a 5 $\log_{10}$ decrease in viability following 15 (54 J/cm^2) to 30 minutes (108 J/cm^2) of blue light exposure (Table 2), and for the majority of these isolates (*A. baumannii* (12/12), *S. aureus* (4/5), *S. maltophilia* (2/3), *E. meningoseptica* (1/1)), there was a greater than 6 $\log_{10}$ decrease in viability. Ten of the 34 isolates showed <5 $\log_{10}$ decrease in viability. The isolates concerned included *E. cloacae* (ENTCL_525, ENTCL_801, ENTCL_804), *E. coli* (EC_073, EC_042), *K. pneumoniae* (MDR_A, MDR_B), *S. aureus* (MSSA_10788), *S. maltophilia* (STEMA_551), and *E. faecium* (EFM_513). Four of the 34 isolates (*E. cloacae* (ENTCL_525, ENTCL_801, ENTCL_804) and *E. faecium* (EFM_513)), took longer to kill than the majority of isolates, requiring extended timepoints up to 120 minutes (432 J/cm^2) to obtain 2-3 $\log_{10}$ decrease in viability.

Loss of bacterial viability associated with blue light was calculated as previously described to give LD_{90} values in terms of J/cm^2. Investigation of these LD_{90} values indicated that differences between LD_{90} values were very likely driven by differences in the blue light susceptibility of different bacterial species ($P<0.001$). We found that the highest LD_{90} values belonged to *E. cloacae* and *K. pneumoniae* strains which had values statistically higher than all other species included in the analysis (where more

than one representative strain was tested) ($P<0.05$ in all cases) (Figure 2). The exception to this was *E. coli* which had moderate blue light tolerance, but no statistical differences were seen between the strains tested . *A. baumannii*, *S. aureus*, *P. aeruginosa* and *S. maltophilia* all had similar and low levels of resistance to the blue light exposure.

In the initial assay of planktonic cell resistance to blue light, we observed that the *S. aureus* strains demonstrated different colony pigmentation; appearing either as pale yellow (MRSA_508, MRSA_520, MRSA_531 and MSSA_F77) or orange (MSSA_10788) when grown on LB agar. We hypothesised that this pigmentation may be responsible for the variability seen in both the survival fraction curves and LD_{90} values when exposed to blue light (Figures 1B and 2). Four additional culture collection strains of *S. aureus* were assessed for blue light sensitivity, including two pale yellow (MSSA_29213, MSSA_10442) and two orange (MSSA_33807, MSSA_4163) strains. In total nine strains of *S. aureus* were tested, six yellow and three orange. We determined that the orange pigmentation correlated with increased resistance to blue light in both the survival fraction curves and in LD_{90} values (Figures 3A and B). The LD_{90} values were statistically significantly higher in the orange pigmented strains than in their yellow counterparts ($P=0.003$).

3.2 Sensitivity of isolates to blue light when grown in biofilms

346 **B**lue light treatment resulted in reductions in biofilm seeding for all isolates tested
347 (Figure 4A-C), and the majority of these reductions (apart from timepoint 15 minutes for
348 MSSA_10788) were statistically significant (p-values <0.05 in student's t-tests
349 compared to the positive control). The percentage reductions are shown in table 3 with
350 the single non-significant result denoted by a ^.

351 **T**he most susceptible isolates were the Gram negative organisms, and in particular
352 ACI_19606, where there was a 93.5% reduction in biofilm seeding ($p<0.001$) after 15
353 minutes (54 J/cm^2) of blue light exposure. As a group, the other Gram negative
354 comparator organisms were the most susceptible, with 10/16 (63%) showing greater
355 than 80% reductions in biofilm seeding (average = 86%) at 15 minutes, compared to
356 1/12 for *A. baumannii* and 1/6 for the Gram positive organisms. Although ENTCL_804
357 responded well to blue light treatment at 30 minutes/108 J/cm^2 (46.6% reduction), 45
358 minutes/162 J/cm^2 (88.2% reduction), and 60 minutes/216 J/cm^2 (87.8% reduction), the
359 treatment actually resulted in increased biofilm seeding at 15 minutes of 18.7%. This
360 result was repeatable and was seen in a number of replicates.

361 **A**s mentioned, the Gram positive biofilms were less susceptible to blue light treatment,
362 with only two isolates (33%) achieving at least 90% reductions in seeding. It is important
363 to note however the small sample size. One isolate of *S. aureus* (MSSA_10788), which
364 is recognised in the EN standards for assessing the efficacy of chemical disinfectants
365 was the least sensitive to blue light, achieving a maximum reduction in biofilm seeding
366 of 36% at 45 minutes (162 J/cm^2). This result was again repeatable and was seen in
367 48replicate pegs. This is further evidence towards the hypothesis that bacterial

368 pigmentation attenuates the sensitivitiy to blue light, in biofilms as well as in planktonic
369 cells.

370 In order to characterise how the different biofilm forming properties (seeding ability and
371 biofilm size) of each bacterial species relate to each other, a series of correlations were
372 performed. We found no evidence for significant correlations existing between i)
373 median biofilm size (CV assay) and median sensitivity of biofilm to blue light (P =
374 0.133), or ii) median biofilm size and LD_{90} (P = 0.912). For these reasons we feel that
375 any differences between species in biofilm resistance to blue light are likely to be
376 intrinsic differences rather than a function of the biofilm. However, we are not able to
377 dismiss the alternative hypothesis that correlations do exist as these analyses were
378 insufficiently powered. We found the statistical power to be 21% when considering the
379 potential correlation between planktonic and biofilm killing (R = 0.200) and 33% when
380 considering the correlation between biofilm killing and biofilm formation (R = -0.263). In
381 this respect, we must actually conclude that real correlations between these parameters
382 might exist; however, if they do exist, they are likely to less apparent in comparison to
383 the correlation observed between biofilm formation and planktonic killing.

384

385 We found a significant correlation between the sensitivity of strains to blue light in the
386 planktonic state and their ability to form biofilms (Spearman's Coefficient = 0.369, P =
387 0.032). This indicated that strains that demonstrated greater resistance to blue light in
388 planktonic state were more likely to produce thicker biofilm.

389

4 DISCUSSION

In this study, we have shown blue light (400 nm) to be effective at inactivating both planktonic cells and biofilms of important nosocomial wound pathogens. Contrary to published research (1,15,16), we found Gram negative organisms to be more susceptible to blue light. There are a number of differences between these published studies and our study which may contribute to these conflicting findings. Firstly, we tested a number of isolates per species (most of the studies test one strain of each species) comprising both clinical and control strains (most of the published studies use control strains which may have been passaged many times), and our light box exposed the bacteria to higher doses (60mW/cm^2) than the 10mW/cm^2 used by Maclean et al (15). Although we only tested a small number of isolates, the Gram positive biofilms appeared less sensitive to blue light treatment, with one strain (MSSA_10788) consistently resisting the effects of blue light.

Analyzing blue light susceptibility against multiple clinical strains from the same species has permitted us to assess the heterogeneity of intra-species kill rates. In some species such as *A. baumannii* the rate of blue light mediated killing was extremely homogeneous; however, *S. aureus* strains display a much more heterogeneous response to blue light stress.

It has long been recognised that bacterial cells have utilised pigmentation as a virulence factor (38). One of the most easily recognisable bacterial pigments are the triterpenoid carotenoids, which impart the eponymous golden colour to *S. aureus* strains. Various

412 authors have identified a correlation between strains containing the carotenoid pigment
413 staphyloxanthin and the ability to survive on surfaces exposed to natural sunlight (39),
414 and it is well known that carotenoids function as antioxidants.
415 Furthermore, staphyloxanthin has been shown to provide protection for pigmented *S.*
416 *aureus* strains against ROS produced by phagocytes (40, 41).

417 **A**ugmentation of the clinical isolates of *S. aureus* with a series of well characterized
418 strains from culture collections allowed us to correlate increased blue light killing times
419 (as seen with MSSA_10788) with colony pigmentation. Planktonic testing and
420 assessment of the LD_{90} values per colour group, show that the light sensitivity of the
421 strongly orange pigmented strains is significantly different to the standard pale yellow
422 strains (p-value <0.003) (Figure 3B). Therefore, although all species of *S. aureus* tested
423 were susceptible to blue light, it is important to consider the effects of bacterial
424 pigmentation when determining the required blue light exposure for effective
425 decontamination.

426 **A**s well as differences in sensitivity, there were also several instances where blue light
427 treatment increased the planktonic growth and biofilm seeding. For example, with
428 ENTCL_804, there was an increase of 18.7% in seeding after 15 minutes of blue light
429 treatment. Light has been shown to facilitate growth when the wavelengths and dose
430 are not appropriate (42), and Nussbaum *et al* (43) found that 810 nm and 905 nm
431 improved the growth of *E. coli* and *S. aureus*, respectively. Furthermore, Mussi et al (44)
432 reported that blue light treatment decreased motility and biofilm formation in *A.*
433 *baumannii*, and increased pathogensis when co-cultured with *Candida albicans* (a
434 model for apoptosis in human alveolar macrophages) (45). However, there are several

435 important differences between studies; the fluence was considerably lower than in this
436 study (1.32-1.89 mW/cm^2 verses 60 mW/cm^2) and the light wavelength peaked at 460
437 nm verses 400 nm, while the exposure was measured over 4 days verses 30 minutes.
438 However, it does raise interesting questions on the effects of suboptimal light exposure
439 on bacterial cells which should be looked into in future studies. Furthermore, the
440 enhanced growth in our study warrants further investigation.

441 We found that, a correlation existed between the strains which were sensitive to blue
442 light in planktonic state and those which produced larger amounts of biofilm in the CV
443 assay. The reason for this observation is not clear in this investigation; however we
444 hypothesise that this indicates that blue light selective pressure may exist in
445 environmental niches where protection as a biofilm might provide benefits against other
446 stimuli that are likely to co-exist with blue light. The fact that we were unable to observe
447 a correlation between biofilm and planktonic resistance to blue light might indicate that
448 these mechanisms are functionally independent. Planktonic cells need to rely on their
449 intrinsic transparency, pigmentation and repair to protect against blue light. In biofilm
450 bacteria can rely on more extracellular exudate and neighbours to protect against blue
451 light.

452 **T**o the best of our knowledge, our work is one of the first to show the antibacterial
453 activity of 400 nm light against a range of clinically relevant bacterial strains (as well as
454 control strains), and one of just a handful to look at non-dental biofilms. The inclusion of
455 multiple isolates is an additional strength of the paper as it allows correlations between
456 phenotypic characteristics and blue light resistance to be explored. Although there are
457 several limitations (monomicrobial biofilms tested instead of polymicrobial, no formal

assessment of the potential for the development for resistance, the relatively small number of isolates tested, and the potential biasing effect of the included resistant isolates), our work nonetheless provides valuable insights into this technology, and especially how it relates to the eradication of biofilms for environmental decontamination.

The findings in this paper demonstrate that high intensity blue light can be used to inactivate a wide range of clinical pathogens, not only in the planktonic state but also as mature biofilms. This technology has many practical applications within healthcare settings, as blue light may ameliorate opportunistic infections indirectly by reducing the bacterial load on environmental surfaces and directly within wounds. Future studies are warranted to investigate this further, and especially whether the exposure times of the 400 nm blue light can be reduced for a range of different clinical applications. As blue light is equally efficacious against antibiotic resistant pathogens, this technology may prove an important weapon in the future fight against antimicrobial resistance.

5 Funding Information

M.R. and R.M. were supported in parts by the DLR grant DLR-FuE-*Projekt* "*ISS-Nutzung in der Biodiagnostik*" ("Use of the ISS for biodiagonstics"), "*Programm RF-FuW, Teilprogramm 475*" and the German Research Foundation (DFG) Paketantrag (PlasmaDecon PAK 728) grant (MO 2023/2-1).

6 Acknowledgements

This work was supported by the NIHR Surgical Reconstruction and Microbiology Research Centre, the Institute of Microbiology at the University of Birmingham, and Aston University (RB a student on secondment during the project). The Loctite LED Flood System was provided free of charge by DSTL to the SRMRC for the duration of the project.

7 Disclaimer

"**T**his paper presents independent research funded by the National Institute for Health research (NIHR). The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health."

8 References

1. **Maclean M, McKenzie K, Anderson JG, Gettinby G, MacGregor SJ.** 2014. 405 nm light technology for the inactivation of pathogens and its potential role for environmental disinfection and infection control. J. Hosp. Infect. **88(1):**1-11.

2. **Mochon AB, Garner OB, Hindler JA, Krogstad P, Ward KW, Lewinski MA, Rasheed JK, Anderson KF, Limbago BM, Humphries RM.** 2011. New Delhi metallo-beta-lactamase (NDM-1)-producing

Klebsiella pneumoniae: case report and laboratory detection strategies. J. Clin. Microbiol. **49(4):**1667-1670.

3. **Nordmann P, Poirel L, Toleman MA, Walsh TR.** 2011. Does broad-spectrum beta-lactam resistance due to NDM-1 herald the end of the antibiotic era for treatment of infections caused by Gram-negative bacteria? J. Antimicrob. Chemother. **66(4):**689-692.

4. **Dai T, Gupta A, Murray CK, Vrahas MS, Tegos GP, Hamblin MR.** 2012. Blue light for infectious diseases: *Propionibacterium acnes, Helicobacter pylor*i, and beyond? Drug Resist.Updat. **15(4):**223-236.

5. **Maclean M, Macgregor SJ, Anderson JG, Woolsey GA, Coia JE, Hamilton K, Taggart I, Watson SB, Thakker B, Gettinby G.** 2010. Environmental decontamination of a hospital isolation room using high-intensity narrow-spectrum light. J. Hosp. Infect. **76(3):**247-251.

6. **Dancer SJ.** 2014. Controlling hospital-acquired infection: focus on the role of the environment and new technologies for decontamination. Clinical Microbiology Reviews **27:**665-690.

7. **Ashkenazi H, Malik Z, Harth Y, Nitzan Y.** 2003. Eradication of *Propionibacterium acnes* by its endogenic porphyrins after illumination with high intensity blue light. FEMS Immunol. Med. Microbiol. **35(1):**17-24.

8. **Hamblin MR, Hasan T.** 2004. Photodynamic therapy: a new antimicrobial approach to infectious disease? Photochem. Photobiol. Sci. **3:**436-450.

9. **Maclean M, Macgregor SJ, Anderson JG, Woolsey GA.** 2008. The role of oxygen in the visible-light inactivation of *Staphylococcus aureus*. J. Photochem. Photobiol. B **92(3):**180-184.

10. **Goldoni A.** 2002. Porphyrins: fascinating molecules with biological significance. ELETTRA Laboratory, research highlights 2001-2002: atomic, molecular, and supramolecular studies**:**2.

11. **McDonald R, Macgregor SJ, Anderson JG, Maclean M, Grant MH.** 2011. Effect of 405-nm high-intensity narrow-spectrum light on fibroblast-populated collagen lattices: an *in vitro* model of wound healing. J. Biomed. Opt. **16(4):**048003.

12. **Kleinpenning MM, Smits T, Frunt MH, van Erp PE, van de Kerkhof PC, Gerritsen RM.** 2010. Clinical and histological effects of blue light on normal skin. Photodermatol. Photoimmunol. Photomed. **26(1):**16-21.

13. **Wainwright M.** 1998. Photodynamic antimicrobial chemotherapy. J. Antimicrob. Chemother. **42(1):**13-28.

14. **Enwemeka CS, Williams D, Hollosi S, Yens D, Enwemeka SK.** 2008. Visible 405 nm SLD light photo-destroys methicillin-resistant *Staphylococcus aureus* (MRSA) *in vitro*. Lasers Surg. Med. **40(10):**734-737.

15. **Maclean M, MacGregor SJ, Anderson JG, Woolsey G.** 2009. Inactivation of bacterial pathogens following exposure to light from a 405-nanometer light-emitting diode array. Appl. Environ. Microbiol. **75(7):**1932-1937.

16. **Murdoch LE, McKenzie K, Maclean M, Macgregor SJ, Anderson JG.** 2013. Lethal effects of high-intensity violet 405-nm light on *Saccharomyces cerevisiae, Candida albicans*, and on dormant and germinating spores of *Aspergillus niger*. Fungal Biol. **117(7-8):**519-527.

17. **Murdoch LE, Maclean M, Endarko E, MacGregor SJ, Anderson JG.** 2012. Bactericidal effects of 405 nm light exposure demonstrated by inactivation of *Escherichia, Salmonella, Shigella, Listeria,* and *Mycobacterium* species in liquid suspensions and on exposed surfaces. The Scientific World Journal **2012:**137805.

18. **Maclean M, Murdoch LE, MacGregor SJ, Anderson JG.** 2013. Sporicidal effects of high-intensity 405 nm Visible Light on endospore-forming bacteria. Photochem. Photobiol. **89(1):** 120-6.

19. **Kawada A, Aragane Y, Kameyama H, Sangen Y, Tezuka T.** 2002. Acne phototherapy with a high-intensity, enhanced, narrow-band, blue light source: an open study and in vitro investigation. J. Dermatological Sci. **30(2):**129-135.

20. **Noborio R, Nishida E, Kurokawa M, Morita A.** 2007. A new targeted blue light phototherapy for the treatment of acne. Photodermatol. Photoimmunol. Photomed. **23(1):**32-34.

21. **Ganz RA, Viveiros J, Ahmad A, Ahmadi A, Khalil A, Tolkoff MJ, Nishioka NS, Hamblin MR.** 2005. *Helicobacter pylori* in patients can be killed by visible light. Lasers Surg. Med. **36(4):**260-265.

22. **Yin R, Dai T, Avci P, Jorge AE, de Melo WC, Vecchio D, Huang YY, Gupta A, Hamblin MR.** 2013. Light based anti-infectives: ultraviolet C irradiation, photodynamic therapy, blue light, and beyond. Curr. Opin. Pharmacol. **13(5):**731-762.

23. **Dai T, Gupta A, Huang YY, Yin R, Murray CK, Vrahas MS, Sherwood ME, Tegos GP, Hamblin MR.** 2013. Blue light rescues mice from potentially fatal P*seudomonas aeruginosa* burn infection: efficacy, safety, and mechanism of action. Antimicrob. Agents Chemother. **57(3):**1238-1245.

24. **Dai T, Gupta A, Huang YY, Sherwood ME, Murray CK, Vrahas MS, Kielian T, Hamblin MR.** 2013. Blue light eliminates community-acquired methicillin-resistant *Staphylococcus aureus* in infected mouse skin abrasions. Photomed. Laser Surg. **31(11):**531-538.

25. **Zhang Y, Zhu Y, Gupta A, Huang Y, Murray CK, Vrahas MS, Sherwood ME, Baer DG, Hamblin MR, Dai T.** 2014. Antimicrobial blue light therapy for multidrug-resistant *Acinetobacter baumannii* infection in a mouse burn model: implications for prophylaxis and treatment of combat-related wound infections. Journal Infect. Dis. **209(12):**1963-1971.

26. **Bache SE, Maclean M, MacGregor SJ, Anderson JG, Gettinby G, Coia JE, Taggart I.** 2012. Clinical studies of the High-Intensity Narrow-Spectrum light Environmental Decontamination System (HINS-light EDS), for continuous disinfection in the burn unit inpatient and outpatient settings. Burns **38:**69-76.

27. **Percival SL, Hill KE, Williams DW, Hooper SJ, Thomas DW, Costerton JW.** 2012. A review of the scientific evidence for biofilms in wounds. Wound Repair Regen. **20(5):**647-657.

28. **Percival SL, Kite P.** 2007. Intravascular catheters and biofilm control. J. Vasc. Access **8(2):**69-80.

29. **Burmolle M, Thomsen TR, Fazli M, Dige I, Christensen L, Homoe P, Tvede M, Nyvad B, Tolker-Nielsen T, Givskov M, Moser C, Kirketerp-Moller K, Johansen HK, Hoiby N, Jensen PO, Sorensen SJ, Bjarnsholt T.** 2010. Biofilms in chronic infections - a matter of opportunity - monospecies biofilms in multispecies infections. FEMS Immunol. Medical Microbiol. **59(3):**324-336.

30. **Høiby N, Bjarnsholt T, Moser C, Bassi GL, Coenye T, Donelli G, Hall-Stoodley L, Hola V, Imbert C, Lebeaux D, Oliver A, Ullmann AJ, Williams C.** 2015. ESCMID guideline for the diagnosis and treatment of biofilm infections 2014. Clin Microbiol Infect, **21:** S1-S25.31.

31. **Halachev MR, Chan JZ, Constantinidou CI, Cumley N, Bradley C, Smith-Banks M, Oppenheim B, Pallen MJ.** 2014. Genomic epidemiology of a protracted hospital outbreak caused by multidrug-resistant *Acinetobacter baumannii* in Birmingham, England. Genome Med. **6(11):**70.

32. **Villegas MV, Hartstein AI.** 2003. Acinetobacter outbreaks, 1977-2000. Infect. Control Hosp. Epidemiol. **24(4):**284-295.

33. **Borer A, Gilad J, Smolyakov R, Eskira S, Peled N, Porat N, Hyam E, Trefler R, Riesenberg K, Schlaeffer F.** 2005. Cell phones and *Acinetobacter* transmission. Emerg. Infect. Dis. **11(7):**1160-1161.

34. **BSI Standards Publication. BS EN13727.** 2012. Chemical disinfectants and antiseptics – quantitative suspension test for the evaluation of bactericidal activity in the medical area – test methods and requirements (phase 2, step 1). .

35. **Torok E ME, Cooke F.** 2009. Oxford Handbook of Infectious Diseases and Microbiology, 1 ed. Oxford University Press.

36. **Coohill TP, Sagripanti J-L.** 2008. Overview of the inactivaton by 254 nm ultraviolet radiation of bacteria with particular reference to biodefence. Photochem. Photobiol. **84:**1084-1090.

37. **Ceri H, Olson M, Morck D, Storey D, Read R, Buret A, Olson B.** 2001. The MBEC Assay System: multiple equivalent biofilms for antibiotic and biocide susceptibility testing. Methods Enzymol. **337:**377-385.

38. **Liu GY, Nizet V.** 2009. Color me bad: microbial pigments as virulence factors. Trends Microbiol. **17(9):** 406-413.

39. **Beard-Pegler MA, Stubbs E, Vickery AM.** 1988. Observations on the resistance to drying of staphylococcal strains. J. Med. Microbiol. **26:**251-255

40. **Liu GY, Essex A, Buchanan JT, Datta V, Hoffman HM, Bastian JF, Fierer J, Nizet V.** 2005. *Staphylococcus aureus* golden pigment impairs neutrophil killing and promotes virulence through its antioxidant activity. J. Exp. Med. **202(2):**209-215.

41. **Clauditz A, Resch A, Wieland K-P, Peschel A, Götz F.** 2006. Staphyloxanthin plays a role in the fitness of *Staphylococcus aureus* and its ability to cope with oxidative stress. Infect. Immun. **74(8):** 4950-4953.

42. **Guffey JS, Payne W, Jones T, Martin K.** 2013. Evidence of resistance development by *Staphylococcus aureus* to an *in vitro*, multiple stage application of 405 m, light from a supraluminous diode array. Photomed. Laser Surg. **31(4):**179-182.

43. **Nussbaum EL, Lilge L, Mazzulli T.** 2002. Effects of 630-, 660-, 810-, and 905-nm laser irradiation delivering radiant exposure of 1-50 Jcm^{-2} on three species of bacteria *in vitro*. J. Clin. Laser Med. Surg. **20(6):**325-333.

44. **Mussi MA, Gaddy JA, Cabruja M, Arivett BA, Viale AM, Rasia R, Actis LA.** 2010. The opportunistic human pathogen *Acinetobacter baumannii* senses and responds to light. J Bacteriol. **192(24):**6336-6345.

618 45. **Gaddy JA, Actis LA.** 2009. Regulation of *Acinetobacter baumannii* biofilm formation. Future
619 Microbiol. **4:**273-278.

620

621

622

623 **Figure Legends:**

624 **Figure 1.** Survival of planktonic bacteria after exposure to 400 nm blue light.

625 Strains: *A. Acinetobacter baumannii* strains: closed circles (• ACI_616; open circles ACI_618; closed
626 triangles up ACI_AYE; open triangles up ACI_665; closed triangles down ACI_19606; open triangles down
627 ACI_648; closed diamonds ACI_659; open diamonds ACI_C60; closed squares ACI_671; open squares
628 ACI_672; closed hexagons ACI_698; open hexagons ACI_642.

629 *B. Staphylococcus aureus:* open circles MSSA _10788; closed triangles up: MSSA_F77; closed squares
630 MRSA_520; open triangles up MRSA_531; closed circles MRSA_508

631 C. *Stenotrophomonas maltophilia*: circles STEMA_ 558; triangles up STEMA_551; squares STEMA_529

632 D. *Enterobacter cloacae:* circles ENTCL_804; triangles up ENTCL_801; squares ENTCL_525

633 E. *Pseudomonas aeruginosa*: closed circles: PSE_1586; open circles PSE_PAO1; closed triangles up
634 PSE_568; closed squares PSE_1054; open squares PSE_6479

635 F. Other: *E. coli* EC_042 open circles: *E. coli* EC_073 closed circles; *K. pneumoniae* MDR-A open squares:
636 *K. pneumoniae* MDR-B closed squares; *Elizabethkingia meningoseptica* open triangles up EKIN_502;
637 *Enterococcus faecium* EFM_513 open triangles down

638 Data are averages ± standard deviations (n = 3).

639 **Figure 2.** Comparison of blue light LD_{90} values between strains and species. Each
640 individual circle represents the average LD_{90} for each strain ± standard deviations (*n* =
641 3). The average LD_{90} value for each species is shown by horizontal lines.
642

643 **Figure 3. A.** Correlation between survival of planktonic *S. aureus* strains following blue
644 light exposure, and cell pigmentation.

645 Orange carotenoid producing strains: closed circles MSSA_4163; closed triangles down MSSA-33807;
646 closed triangles up MSSA_10788. Yellow non-carotenoid producing strains: open circles MSSA_10442;
647 open squares MSSA_F77; open diamonds MRSA_520; open triangles down MRSA_531; open triangles
648 up MRSA_508; open hexagons MSSA_29213. Data are averages ± standard deviations (*n* = 3).
649

650 **B.** Comparison of blue light LD_{90} values between yellow and orange pigmented *S.*
651 *aureus* strains.

652 Each individual circle represents the average LD_{90} for each strain ± standard deviations (*n* = 3). The
653 average LD_{90} value for yellow and orange pigmented strains is shown by horizontal lines.
654

655 **Figure 4, A-C:** Graphs showing the biofilm seeding results for all isolates.

656 Optical density on the y axis refers to the average biofilm seeding for the isolates tested after
657 exposure to blue light (BL) at the range of durations tested (in minutes) on the x axis. Positive
658 control: refers to the average biofilm seeding of the dark incubated, non blue light exposed

isolates. Negative control: refers to a negative (broth only) control. The error bars represent the standard error.

Tables:

Table 1: List of the clinical and control isolates used in this study.

Table 2: Antimicrobial effects of blue light on planktonic cells

Table 3: Average percentage change in biofilm seeding in isolates exposed to blue light compared to non-exposed dark incubated controls

Supplementary:

Figure S1: Emission spectrum of Henkel Loctite blue light array determined using an Ocean Optics USB2000 spectrometer

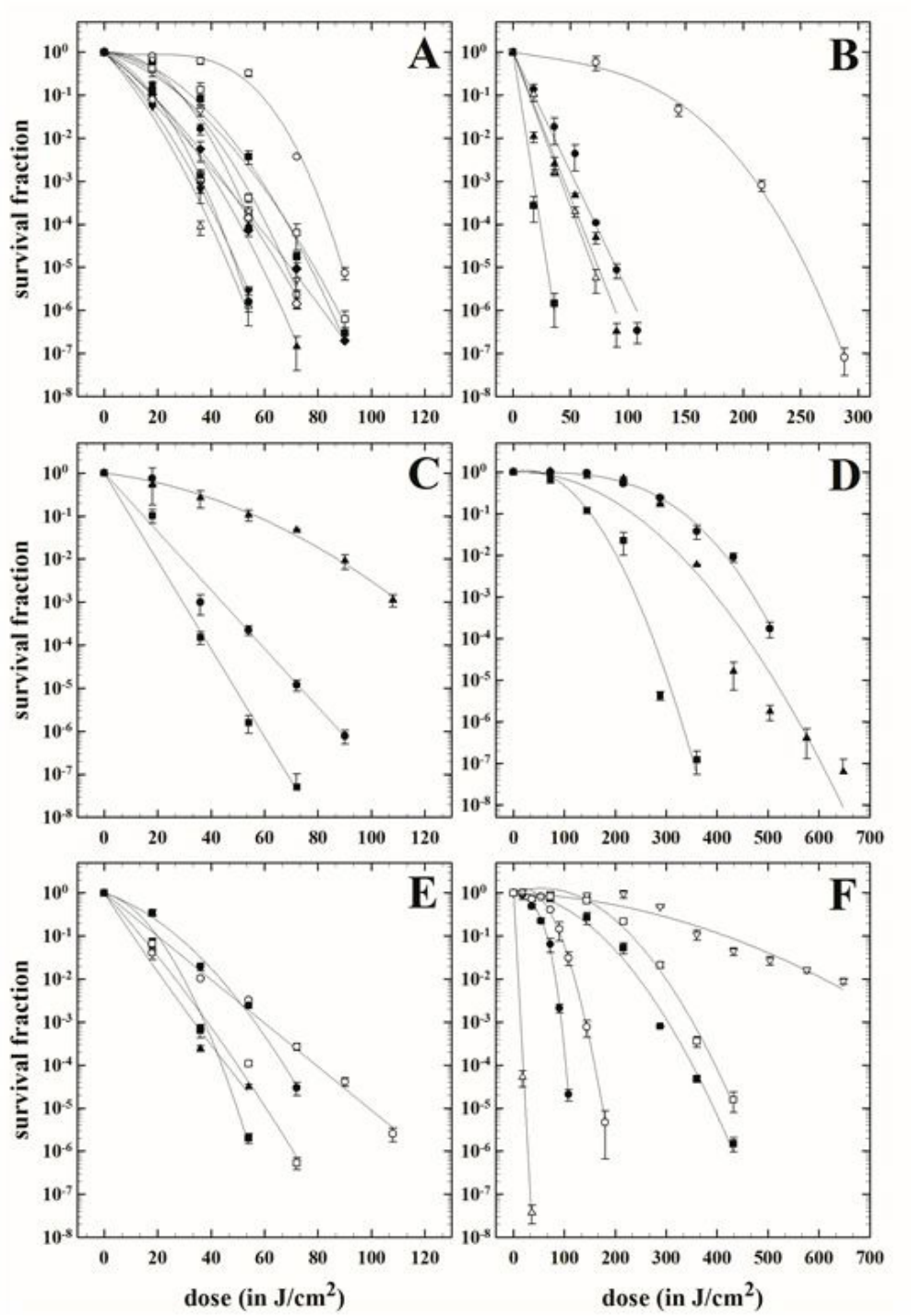

Figure 1. Survival of planktonic bacteria (in terms of survival fraction) after exposure to 400 nm blue light. **A:** *A. baumannii,* **B:** *S. aureus,* **C:** *S. maltophilia,* **D:** *E. cloacae,* ***F:*** Other Gram negative organisms.

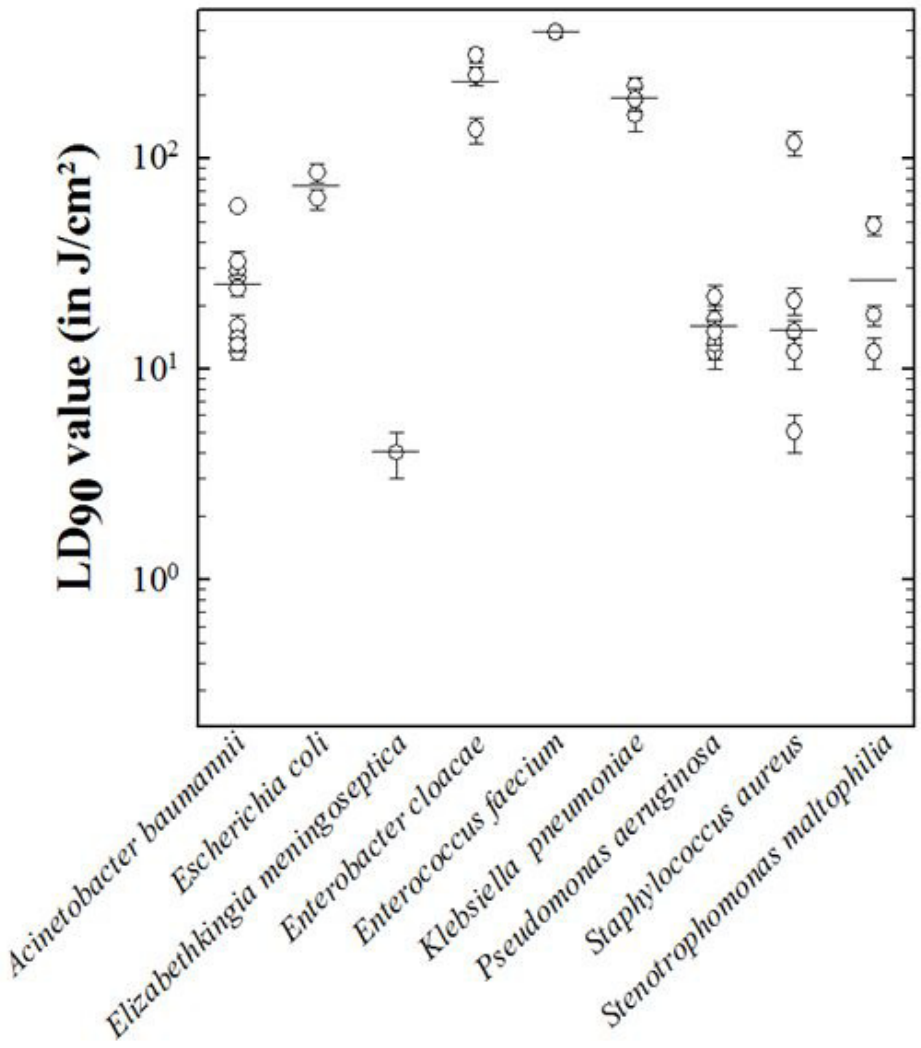

Figure 2: Comparison of blue light LD_{90} values between strains and species. Each individual circle represents the average LD_{90} for each strain ± standard deviations (n = 3). The average LD_{90} value for each species is shown by horizontal lines.

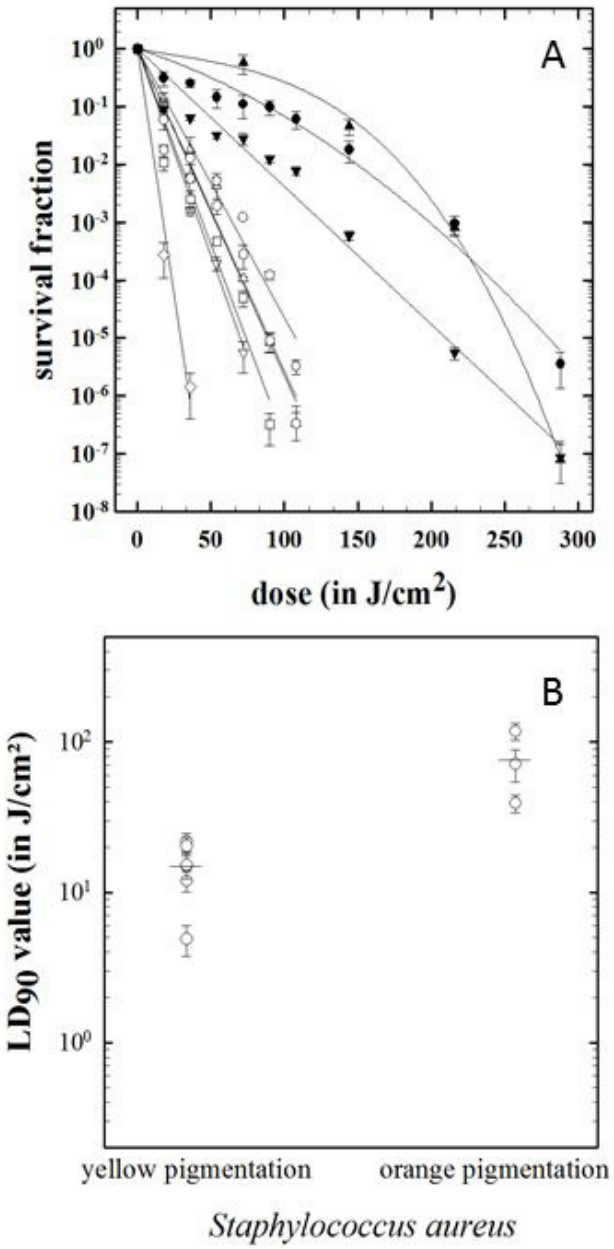

Figure 3. A: Correlation between survival of planktonic *S. aureus* strains following blue light exposure, and cell pigmentation, **B:** Comparison of blue light LD_{90} values between yellow and orange pigmented *S. aureus* strains.

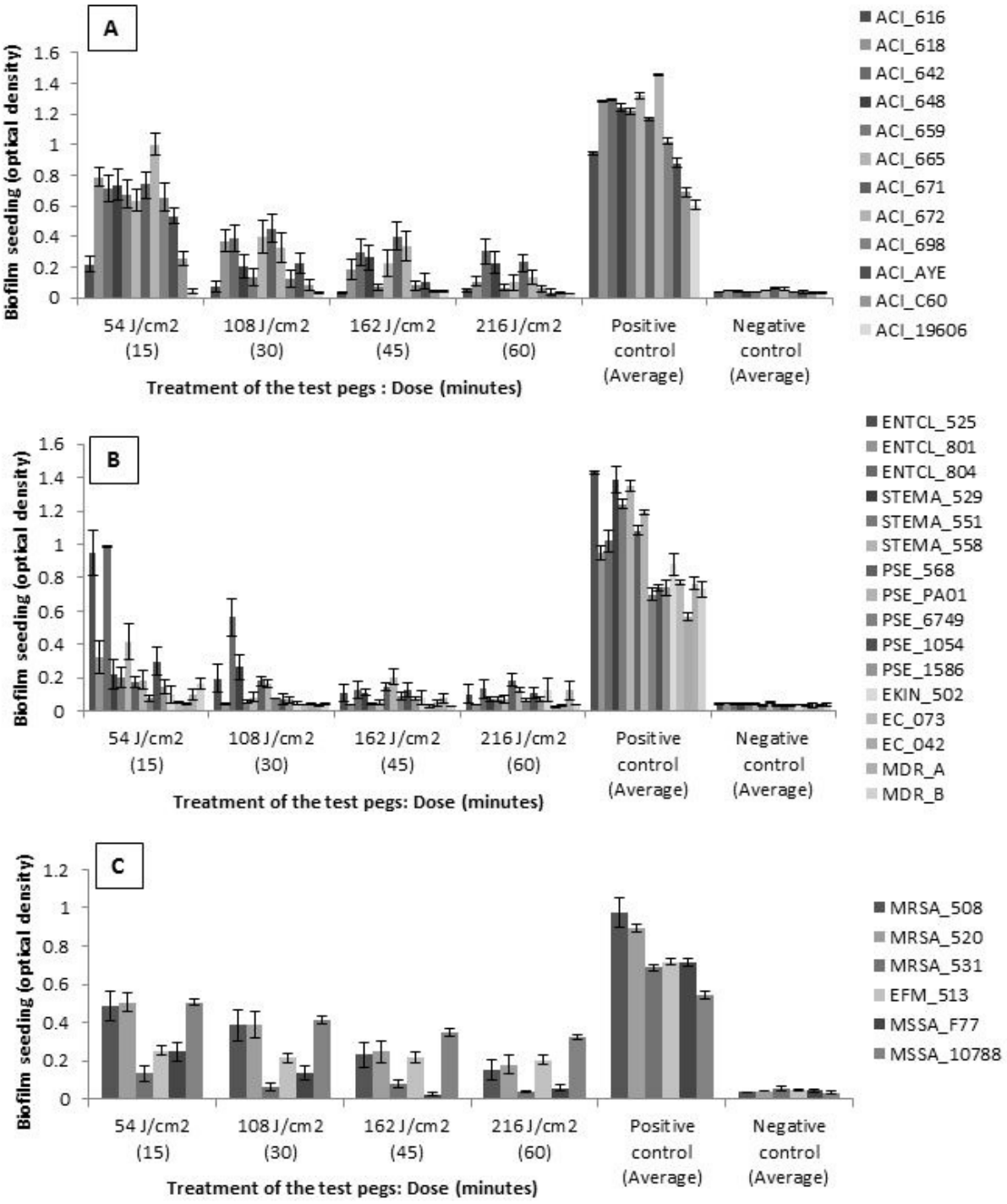

Figure 4, A-C: Graphs showing the biofilm seeding results for all isolates. Optical density on the y axis refers to the average biofilm seeding for the isolates tested after exposure to blue light at the range of durations tested (in minutes) on the x axis. Positive control: refers to the average biofilm seeding of the dark incubated, non BL exposed isolates. Negative control: refers to a negative (broth only) control. The error bars represent the standard error.

Table 1: List of the clinical and control isolates used in this study.

Study Identifier	Organism	Description
ACI_616	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_618	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_642	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_648	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_659	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_665	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_671	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_672	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_698	*Acinetobacter baumannii*	QEHB clinical outbreak isolate
ACI_AYE	*Acinetobacter baumannii*	MPR Clinical Isolate (unique)
ACI_C60	*Acinetobacter baumannii*	NCTC_13424 (unique)
ACI_19606	*Acinetobacter baumannii*	ATCC_19606 (unique)
ENTCL_525	*Enterobacter cloacae* complex	QEHB clinical isolate
ENTCL_801	*Enterobacter cloacae* complex	QEHB clinical isolate
ENTCL_804	*Enterobacter cloacae* complex	QEHB clinical isolate
STEMA_529	*Stenotrophomonas maltophilia*	QEHB clinical isolate
STEMA_551	*Stenotrophomonas maltophilia*	QEHB clinical isolate
STEMA_558	*Stenotrophomonas maltophilia*	QEHB clinical isolate
PSE_568	*Pseudomonas aeruginosa*	QEHB clinical isolate
PSE_PA01	*Pseudomonas aeruginosa*	ATCC_15692
PSE_6749	*Pseudomonas aeruginosa*	NCTC_6749
PSE_1054	*Pseudomonas aeruginosa*	QEHB Clinical burn isolate
PSE_1586	*Pseudomonas aeruginosa*	QEHB Clinical burn isolate
EKIN_502	*Elizabethkingia meningoseptica*	QEHB clinical isolate
EC_073	*Escherichia coli*	EPEC CFT_073
EC_042	*Escherichia coli*	EAEC_042
MDR_A	CPE^ *Klebsiella pneumoniae* (NDM-1^{+} positive)	QEHB Clinical isolate
MDR_B	CRE* *Klebsiella pneumoniae* (ESBL positive with additional permeability changes)	QEHB Clinical isolate
MRSA_508	*Staphylococcus aureus*	QEHB Clinical isolate
MRSA_520	*Staphylococcus aureus*	QEHB Clinical isolate
MRSA_531	*Staphylococcus aureus*	QEHB Clinical isolate
MSSA_10788	*Staphylococcus aureus*	NCTC_10788
MSSA_F77	*Staphylococcus aureus*	NCTC_8532
EFM_513	*Enterococcus faecium*	QEHB Clinical isolate
MSSA_29213	*Staphylococcus aureus*	ATCC_29213
MSSA_10442	*Staphylococcus aureus*	NCTC_10442
MSSA_33807	*Staphylococcus aureus*	ATCC_33807
MSSA_4163	*Staphylococcus aureus*	NCTC_4163

Table 2: Antimicrobial effects of blue light on planktonic cells

Isolate	Exposure time (minutes)	Irradiance mW/cm^2	Dose J/cm^2	Log_{10} reduction	P-value	LD_{37} value + J/cm2	LD_{90} value + J/cm2
ACI_616	30	60	108	7.06	0.006	21 ± 2	27 ± 2
ACI_618	30	60	108	5.78	0.007	55 ± 4	59 ± 3
ACI_642	30	60	108	6.73	0.006	9 ± 1	16 ± 2
ACI_648	30	60	108	6.14	0.007	21 ± 2	29 ± 3
ACI_659	30	60	108	6.55	0.006	8 ± 1	16 ± 2
ACI_665	30	60	108	6.14	0.006	7 ± 1	12 ± 1
ACI_671	30	60	108	6.34	0.006	25 ± 2	32 ± 4
ACI_672	30	60	108	6.22	0.006	16 ± 2	24 ± 2
ACI_698	30	60	108	6.39	0.008	9 ± 1	14 ± 2
ACI_AYE	30	60	108	6.70	0.006	10 ± 1	16 ± 2
ACI_C60	30	60	108	6.76	0.007	7 ± 1	14 ± 1
ACI_19606	30	60	108	6.81	0.006	7 ± 1	13 ± 1
ENTCL_525	100	60	360	6.76	0.006	113 ± 12	136 ± 19
ENTCL_801	180	60	648	6.61	0.009	212 ± 20	246 ± 25
ENTCL_804	160	60	576	6.24	0.007	258 ± 18	306 ± 24
STEMA_529	30	60	108	7.21	0.006	7 ± 1	12 ± 2
STEMA_551	30	60	108	2.97	0.006	26 ± 3	48 ± 5
STEMA_558	30	60	108	7.33	0.006	8 ± 1	18 ± 2
PSE_568	30	60	108	6.48	0.002	6 ± 1	12 ± 2
PSE_PA01	30	60	108	5.59	0.001	6 ± 1	17 ± 3
PSE_6749	30	60	108	6.55	0.009	7 ± 1	13 ±
PSE_1054	30	60	108	6.01	0.002	9 ± 1	15 ± 2
PSE_1586	30	60	108	6.07	0.002	13 ± 2	22 ± 2
EKIN_502	15	60	54	6.79	0.006	1 ± 0.5	4 ± 3
EC_073	30	60	108	4.71	0.006	56 ± 4	64 ± 7
EC_042	30	60	108	1.55	0.006	74 ± 8	85 ± 9
MDR_A	140	60	504	6.88	0.002	124 ± 18	159 ± 25
MDR_B	140	60	504	6.61	0.007	185 ± 16	219 ± 22
MRSA_508*	30	60	108	6.17	0.002	12 ± 1	21 ± 3
MRSA_520*	15	60	54	6.82	0.002	1 ± 0.5	5 ± 1
MRSA_531*	30	60	108	6.41	0.001	7 ± 1	15 ± 2
MSSA_10788 ^	80	60	288	7.07	0.001	99 ± 12	118 ± 15
MSSA_ F77*	30	60	108	6.76	0.006	3 ± 1	12 ± 2
EFM_513	180	60	648	1.86	0.007	277 ± 16	393 ± 20
Additional *S. aureus* isolates (for pigmentation investigation)							
ATCC_29213*	30	60	108	6.76	0.002	5 ± 1	15 ± 2
NCTC_10442*	30	60	108	6.69	0.002	8 ± 1	20 ± 2
ATCC_33807 ^	80	60	288	7.01	0.002	15 ± 2	40 ± 5
NCTC_4163 ^	80	60	288	6.07	0.003	38 ± 5	71 ± 6

Where * yellow pigmentation, ^ orange pigmentation, + LD37 and LD90 values are expressed ± standard deviation

Table 3: Average percentage change in biofilm seeding in isolates exposed to blue light compared to non-exposed dark incubated controls

Study Identifier	Average change in biofilm seeding (%) with blue light exposure			
	15 minutes (54 J/cm^2)	30 minutes (108 J/cm^2)	45 minutes (162 J/cm^2)	60 minutes (216 J/cm^2)
ACI_616	-75.9	-92.4	-96.5	-94.5
ACI_618	-39	-71.1	-85.6	-91.3
ACI_642	-45.6	-69.8	-77.3	-76.3
ACI_648	-43.7	-83	-78.2	-81.4
ACI_659	-47.1	-88.6	-94.1	-94.3
ACI_665	-53.9	-69.9	-82.5	-92
ACI_671	-37.4	-60.6	-65.7	-79.9
ACI_672	-31.1	-77.7	-76.5	-90.7
ACI_698	-36.7	-87.3	-92.2	-93.7
ACI_AYE	-41.9	-76.2	-86.7	-95.5
ACI_C60	-60.4	-89	-93.3	-94.8
ACI_19606	-93.5	-94.6	-93.2	-94.3
ENTCL_525	-34.9	-86.1	-92.2	-92.6
ENTCL_801	-61.3	-94.6	-95.6	-96.4
ENTCL_804	+18.7	-46.6	-88.2	-87.8
STEMA_529	-80.7	-81	-92.4	-95.1
STEMA_551	-84.5	-95.1	-96.2	-94
STEMA_558	-71	-93.3	-96.2	-94.7
PSE_568	-83.9	-82.8	-87.2	-81.8
PSE_PA01	-83.7	-86.2	-82.8	-89.5
PSE_6749	-88.9	-90.3	-87.1	-88.9
PS_1054	-58.3	-90.7	-83.2	-84.3
PSE_1586	-80.3	-92.0	-89.4	-88.8
EKIN_502	-85.8	-94.8	-91.6	-86.5
EC_073	-93.0	-94.6	-96.2	-96.2
EC_042	-92.1	-91.3	-92.1	-93.4
MDR_A	-87.4	-96.0	-89.2	-82.4
MDR_B	-75.3	-95.0	-95.8	-94.3
MRSA_508	-59.5	-58	-73.7	-83.3
MRSA_520	-44.5	-57.7	-73.2	-78.8
MRSA_531	-81.6	-91.2	-88	-93.7
MSSA_10788	-5.0 ^	-30.9	-36.3	-34.6
MSSA_F77	-67.8	-79.6	-96.4	-92.0
EFM_513	-66.3	-69.3	-68.2	-72.2

^ p value = 0.15. Shading denotes reductions of at least 80% in biofilm seeding compared to the positive control