

# Incidence, clinical implications and impact on public health of infections with *Shigella* spp. and entero-invasive *Escherichia coli* (EIEC): results of a multicenter cross-sectional study in the Netherlands during 2016–2017

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## Research article

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## Abstract

Background Shigella spp. and enteroinvasive *E. coli* (EIEC) use the same invasive mechanism to cause diarrheal diseases. Public health regulations apply only to Shigella spp. infections, but are hampered by the lack of simple methods to distinguish them from EIEC. In the last decades, molecular methods for detecting Shigella spp. and EIEC were implemented in medical microbiological laboratories (MMLs). However, shigellosis cases identified with molecular techniques alone are not notifiable in most countries. Our study investigates the impact of EIEC versus Shigella spp. infections and molecular diagnosed shigellosis versus culture confirmed shigellosis for re-examination of the rationale for the current public health regulations.

Methods In this multicenter cross-sectional study, fecal samples of patients suspected for gastro-enteritis, referred to fifteen MMLs in the Netherlands, were screened by PCR for Shigella spp. or EIEC. Samples were also cultured to discriminate between the two pathogens. We compared, risk factors, symptoms, severity of disease, secondary infections and socio-economic consequences for (i) culture-confirmed Shigella spp. versus culture-confirmed EIEC cases (ii) culture positive versus PCR positive only shigellosis cases.

Results In 2016-2017, 777 PCR positive fecal samples with patient data were included, 254 of these were culture-confirmed shigellosis cases and 32 were culture-confirmed EIEC cases. EIEC cases were more likely to report ingestion of contaminated food or water and were less likely to be men who have sex with men (MSM). Both pathogens were shown to cause serious disease although differences in specific symptoms were observed. Additionally, culture-negative but PCR positive cases were more likely report travel or ingestion of contaminated food or water and were less likely to be MSM than culture-positive cases. Culture-negative cases were more likely to suffer from multiple symptoms. No differences in degree of secondary infections were observed between both Shigella spp. and EIEC, and culture-negative and culture-positive cases.

Conclusions No convincing evidence was found to support the current guidelines. Therefore, culture and molecular detection methods for Shigella spp. and EIEC should be considered equivalent for case definition and public health regulations regarding shigellosis. Differences were found regarding risks factors, indicating that different prevention strategies may be required.

## Background

*Shigella spp.* are one of the leading causes for diarrheal mortality and morbidity, predominantly in resource-restricted areas (1). In resource-rich areas imported and domestically acquired shigellosis poses a substantial burden on public health due to the use of healthcare facilities, requirement for disease control measures, and a high number of disability adjusted life years (1-4).

Enteroinvasive *Escherichia coli* (EIEC) is a pathotype of *E. coli* that causes diarrhea, using the same invasive mechanisms as *Shigella spp.* (5, 6). *Shigella spp.* and EIEC result from the convergent evolution of ancestral *E. coli* which independently acquired the large invasion virulence plasmid (pINV) on multiple occasions (7). Genetically, *Shigella spp.* and EIEC share virulence genes. Furthermore, they are related to such an extent that they should be classified as one species together with other *E. coli* pathotypes and commensals, however the current designation of two genera is maintained (8, 9).

As a result of their shared characteristics differentiating EIEC from *Shigella spp.* in the routine medical microbiology laboratory (MML) is difficult. Molecular detection is based on the presence of virulence genes in all *Shigella spp.* and EIEC, such as the *ipaH*-gene (10). Moreover, differentiating cultured isolates based on physiological and biochemical properties is complicated, as EIEC can display either an *E. coli*-like profile or a more inactive *Shigella*-like profile, and all profiles in-between (11). Nevertheless, culturing is performed for several reasons. First, culturing for antimicrobial susceptibility testing is pivotal, as *Shigella spp.* are on the global priority list for antibiotic-resistant bacteria (12). Second, to distinguish *Shigella spp.* from EIEC, culture-dependent identification methods are required, as molecular methods cannot be used for this purpose (5, 11). This distinction is only important because EIEC infections are not notifiable in most countries while shigellosis is. Furthermore, in the Netherlands, as in many other countries, confirmed case definitions for shigellosis in control regulations specifically require the isolation of *Shigella spp.* (13-16).

Despite these advantages of culturing, culture methods for *Shigella spp.* are known to have limited sensitivity (17, 18). Isolation of EIEC from fecal samples is even more challenging, as selective agar plates are based on biochemical properties such as fermentation of lactose and decarboxylation of lysine that EIEC shares with some other *Enterobacteriaceae* present in the gut (19).

The similarity between *Shigella spp.* and EIEC makes regulations, which require the notification of *Shigella spp.* but not EIEC, difficult to apply in practice by both laboratories and physicians. Apart from some studies that describe the infectious potential of EIEC and their ability to cause food related outbreaks, limited research has been performed on this subject (20-24). Therefore, little is known of the severity and sequela of EIEC with respect to the incidence and impact on individual patients or public health.

Additionally, public health authorities struggle with the control of shigellosis cases identified with molecular techniques alone, because the impact of these cases for patients and public health is also not well defined (25, 26). Two studies have looked at differences in case demographics, risk factors, and disease outcomes of shigellosis in culture-positive cases versus culture-negative cases (25, 27). However, in both studies the proportion of EIEC infections amongst the culture-negative cases was unknown, and in one of the studies the data was biased because laboratory testing was unevenly distributed between laboratories that used either culture methods or molecular methods (25, 27).

To obtain a more complete insight into the implications of infections with *Shigella spp.* and EIEC and the challenges regarding their detection, distinction and control measures, a multicenter cross-sectional observational

study was performed in the Netherlands 'the Invasive Bacteria *E. coli-Shigella* Study' (IBESS). We compared results with regard to incidence, clinical implications and impact on public health for (i), infections with EIEC or *Shigella spp.* and (ii), culture confirmed shigellosis versus molecular detected shigellosis. With this study, more evidence is obtained for improvements of the guidelines for control of shigellosis.

## Methods

### Study design and inclusion criteria

During 2016 and 2017, fifteen medical microbiological laboratories (MMLs) and their respective public health services (PHS) participated in this study. Fecal samples from patients suspected for gastro-enteritis that were referred to one of the participating MMLs for regular diagnostics, in which *Shigella spp.* or EIEC was detected with molecular methods, were included. After inclusion, the DNA eluate of the fecal sample and, if available, a cultured isolate were sent to the study group. A molecular algorithm based on the ratio of Ct-values of the *ipaH* gene and the *Shigella wzx* genes was used to serotype directly from fecal samples (28). In addition, all obtained isolates were identified and serotyped with classical methods as previously described (28) (Figure 1). Furthermore, clinical and epidemiological data were collected from all included patients (Figure 1).

### Data collection

Data was collected from patients using two approaches. For fecal samples of which a *Shigella spp.* was isolated, which are notifiable under current regulations, PHS performed source tracing according to the guidelines. Patients were informed about the study and requested to give consent for their participation in this study after completion of the regular survey regarding source tracing for shigellosis. After consent, an infectious disease nurse from the study group contacted them by telephone. They were informed again about the study and, after their further consent, subjected to a single survey to collect additional clinical and epidemiological data. In contrast, for fecal samples of which *Shigella spp.* or EIEC was detected with molecular methods only or from which an EIEC isolate was cultured, an infectious disease nurse from the study group contacted the physicians of the patients first to request their permission for contacting the patients. After their consent, the patient was contacted by the infectious disease nurse for collection of data as described above.

### Incidence

Incidence of *Shigella spp.* for the years 2016 and 2017 was calculated using the numbers of national shigellosis notifications as numerator and residents in the Netherlands on 1 January 2017 as denominator. A multiplier of 53 was applied, as for one notified shigellosis case, 53 cases have been estimated to be missed in the Netherlands due to under-reporting and under-diagnosing (29).

The proportion of *Shigella spp.* isolates included in this study from total notified shigellosis cases was determined, and was used to calculate the incidence of EIEC by extrapolating the proportion to the EIEC isolates included in this study to a national level. However, the multiplier that was modelled to calculate the community incidence for shigellosis is not suitable to use for EIEC cases. In the algorithm of Haagsma *et al.*, the sensitivity of the laboratory analysis and the percentage of bloody diarrhea are important factors used to correct for under-reporting and under-diagnosing (29). However, these factors are known to vary among different enteral pathogens. From an earlier study, it is known that only 5 out of 16 MMLs performed culture of EIEC in the Netherlands. This proportion was multiplied with the laboratory analysis sensitivity of 0.63 as proposed for shigellosis by Haagsma *et al.*, resulting in a sensitivity of 0.20 for laboratory analysis of EIEC (29). This factor was used in the calculation of a specific multiplier for the community incidence of EIEC infections, together with the fraction of patients with EIEC infections that reported bloody diarrhea in the study described here, which was 0.16. The country specific parameters for the Netherlands as reported earlier were maintained (29).

## Data and analysis

The following patient variables were collected: risk factors for infection, clinical symptoms, presence and number of related patients indicative for the degree of secondary infections, and socio-economic consequences. The patients themselves provided variables in a telephone interview. In an effort to assess the degree of secondary infections, they were specifically asked if they knew of other people who fell ill before or after their own onset of symptoms to exclude common sources of infection. All reported underlying diseases and medication use reported by patients were stratified into categories and considered as factors. Clinical symptoms were self-reported not measured or verified by a physician. To assess the severity of the disease for individual patients, the total number of reported symptoms by each individual patient was added up. Additionally, two severity scales, the de Wit scale and the modified Vesikari-scale (MVS), were applied in which higher scores indicated more severe course of disease (30, 31). Co-infections with other enteric pathogens were reported by the participating MMLs if detected by molecular methods, culture or microscopy. The study group determined identity of the obtained isolates and bacterial load in fecal samples was estimated by cycle-threshold (Ct) values of the *ipaH* gene following from the molecular algorithm that was used for the direct *Shigella* serotyping in fecal samples. Bacterial load and species designations were only considered in the comparison of culture-positive to culture-negative shigellosis cases because it is known that culture rates increase with an increase in bacterial load (decrease in Ct-value) and that *S. sonnei* is easier to detect by culture than *S. flexneri* (17, 32).

As data was actively retrieved, missing values were scarce, and included as missing in the statistical analysis. Comparisons were made for patients with *Shigella* spp. to patients with EIEC to assess support for the current guidelines in which culture confirmed infections with *Shigella* spp. are notifiable, while infections with EIEC are not. Additionally, culture-positive cases were compared with culture-negative shigellosis cases, to assess support for the current case definition of shigellosis, in which only culture-confirmed cases are notifiable. To examine if large dissimilarities exist for infections with different *Shigella* spp., infections with cultured *S. flexneri* and *S. sonnei* were also compared.

For the comparison of culture-positive with culture-negative cases, only infections with *S. flexneri* and *S. sonnei* were analyzed. *S. boydii* and *S. dysenteriae* were excluded because of low case numbers ( $n < 5$ ). Molecular *Shigella* serotyping by real-time PCR in culture-negative samples was based on the *ipaH* gene, the *S. sonnei* *wzx* gene, and the *S. flexneri* *wzx<sub>1-5</sub>* or *wzx<sub>6</sub>* gene as described before (28). As the *ipaH* gene is present in multiple copies, in contrast to the *wzx* genes, their Ct-values should represent these ratios to confirm the direct identification of *S. sonnei* and *S. flexneri* by molecular methods. Infections were defined as culture-positive if *S. flexneri* or *S. sonnei* was isolated from the fecal sample.

Differences in risks factors between groups were calculated with univariate and multivariate analyses using logistic regression. All variables with  $p < 0.20$  in the univariate analysis were included in the multivariate model, where the least significant variables were one-by-one eliminated until all remaining variables reached significance ( $p$  value  $< 0.05$ ). Analyses were performed using SAS® software version 9.4 (SAS Institute Inc., Cary, NC, USA), odds ratios with their 95% confidence intervals were calculated using the beta and standard error (SE) values from the logistic regression models.

Differences in symptoms, severity of disease, degree of secondary infections and socio-economic consequences were calculated using multivariate analyses with the following confounders: sex, age, MSM contact, co-infections, effect of underlying diseases or medication use, and Ct values as measure for bacterial load. In the multivariate analyses for the comparison of culture-positive infections and culture-negative infections, the confounder "species" was added, because *S. flexneri* showed lower culture rates (38%) than *S. sonnei* (63%). These analyses were performed using R. version 3.4.3. (33) and significance was defined as  $p < 0.05$ .

## Results

In our study, 1199 PCR positive fecal samples were included over the course of two years (Figure 2). From the fecal samples, 414 isolates were cultured and initially identified as 232 *S. sonnei*, 100 *S. flexneri*, 64 EIEC, 10 provisional *Shigella*, 3 *S. boydii*, for the remaining 5 isolates a distinction between *S. flexneri* and EIEC could not be made. *Shigella* were called provisional if the serotype could not be determined, or if the established serotype did not match with the phenotype. In total, 777 (65%) patients provided clinical and epidemiological data. Samples of these patients were included for the comparisons described below (Figure 2). In total, 290 of the 777 patients had a culture-positive infection. The data of patients from whom a *S. sonnei*, *S. flexneri*, *S. boydii* or provisional *Shigella* ( $n = 255$ ) isolate was obtained were used in the comparison to patients of whom an EIEC isolate ( $n=33$ ) was cultured (Figure 2). For comparison of culture positive cases to culture negative cases, only data from patients of which *S. sonnei* or *S. flexneri* was cultured ( $n = 245$ ) were compared to patients of which *S. sonnei* or *S. flexneri* was molecularly detected ( $n = 167$ ) (Figure 2). One *S. flexneri* and one EIEC isolate were excluded from all analyses because they were cultured from the same fecal sample.

Assessment of the sensitivity and specificity of the molecular *S. flexneri* and *S. sonnei* serotyping directly from fecal samples resulted in a sensitivity of 77% and 75%, and a specificity of 98% and 99% respectively.

## Incidence

During 2016 and 2017, 873 cases of shigellosis were notified to the health authorities, resulting in an average of 436.5 cases each year. The total number of residents in the Netherlands on 1 January 2017 was 17,081,507, resulting in an estimated incidence 135 shigellosis cases per 100,000 residents per year in the Netherlands during 2016 and 2017. Almost forty percent (39.5%) of all notified shigellosis cases were included in this study. We assumed the same ratio of EIEC cases having been included in our study and multiplied their number by 2.53 to estimate the national EIEC incidence rates. As 64 EIEC isolates were cultured, this resulted in 160 EIEC cases in 2 years, i.e., 80 per year. From the estimation for specific EIEC community incidence followed that a multiplier of 265 should be applied, see Additional File 1 for calculations. This resulted in  $80 \times 265 = 21,200$  cases in the Dutch population, translated to a community incidence for EIEC of 124 cases per 100,000 residents per year in the Netherlands during 2016 and 2017.

## Risks factors

Our results showed that patients with EIEC infections were more likely to report ingestion of suspected contaminated food or water (OR: 3.04 (1.44-6.42)) and less likely to report MSM contact (OR: 0.21 (0.05-0.98)) as source for infection compared to patients with *Shigella* spp. (Table 1).

As expected, Ct-values were approximately three Ct lower for the culture-positive shigellosis cases (OR: 0.88 (0.84-0.93)) than for culture-negative cases. Additionally, the proportion of *S. flexneri* in culture-positive infections was lower than the proportion in culture-negative infections (OR: 0.32 (0.19-0.54)). Furthermore, assessment of risk factors revealed that culture-positive cases travelled less (OR: 0.40 (0.20-0.78)) and were more likely to report MSM contact (OR: 3.22 (1.70-6.09)) or an unknown infection source (OR: 1.85 (1.17-2.92)) than culture-negative cases. In addition, culture-positive cases were less likely to report ingestion of suspected contaminated food or water as infection source than culture-negative cases (OR: 0.38 (0.24-0.61)) (Table 1).

Table 1 Risk factors of infections with EIEC and *Shigella*, and culture-positive and culture-negative shigellosis

actors	EIEC <sup>a, b</sup> (n=32)	Shigella spp. <sup>a</sup> (n=254)	Univariate OR (95% CI)	Multivariate OR (95% CI)	Culture +/ PCR + <sup>a, b</sup> (n=244)	Culture - / PCR + (n=167)	Univariate OR (95% CI)	Multivariate OR (95% CI)
f patient (female)	44%	46%	0.91 (0.43-1.91)		46%	53%	0.76 (0.50-1.16)	
f patient (mean ± sd)	36.0 ± 20.4	38.9 ± 18.5	0.99 (0.97-1.01)		38.7 ± 18.8	41.1 ± 19.3	0.99 (0.98-1.00)	
† in multi-person hold	78%	74%	1.37 (0.57-3.33)		75%	80%	0.89 (0.58-1.35)	
Infection with other c pathogen	28%	13%	<b>2.72 (1.15-6.38)</b>		12%	11%	1.04 (0.54-1.99)	
rial load (Ct-value, ± sd)					22.9 ± 4.6	25.3 ± 4.8	<b>0.90 (0.86-0.94)</b>	<b>0.88 (0.84-0.93)</b>
es ( <i>S. flexneri</i> )					31%	55%	<b>0.36 (0.23-0.55)</b>	<b>0.32 (0.19-0.54)</b>
underlying disease/use of medication								
higher infection risk	3%	20%	<b>0.18 (0.03-0.91)</b>		21%	17%	1.31 (0.82-2.08)	
> severe course	13%	7%	1.90 (0.69-5.20)		7%	6%	1.28 (0.65-2.55)	
higher infection risk + severe course	9%	10%	1.04 (0.35-3.07)		9%	11%	0.82 (0.46-1.46)	
town effect	13%	6%	2.25 (0.81-6.24)		7%	11%	0.71 (0.39-1.31)	
l history	88%	60%	<b>4.62 (1.57-13.57)</b>		57%	83%	<b>0.26 (0.16-0.43)</b>	<b>0.40 (0.20-0.78)</b>
ns:								
n America	13%	4%	<b>3.07 (1.04-9.04)</b>		3%	5%	0.65 (0.25-1.69)	
entral America	13%	6%	1.73 (0.62-4.79)		5%	5%	0.95 (0.41-2.19)	
	34%	17%	1.77 (0.85-3.67)		12%	26%	<b>0.45 (0.26-0.77)</b>	
a	25%	28%	0.79 (0.36-1.71)		30%	44%	0.65 (0.41-1.01)	
pe	3%	6%	0.49 (0.09-2.78)		5%	2%	2.53 (0.84-7.68)	
e of infection (suspected by patient):								
aminated food/water	53%	26%	<b>3.04 (1.44-6.42)</b>	<b>3.04 (1.44-6.42)</b>	27%	64%	<b>0.33 (0.23-0.48)</b>	<b>0.38 (0.24-0.61)</b>
I contact	3%	22%	<b>0.21 (0.05-0.98)</b>	<b>0.21 (0.05-0.98)</b>	24%	7%	<b>2.84 (1.65-4.90)</b>	<b>3.22 (1.70-6.09)</b>
town	38%	45%	1.25 (0.58-2.71)	1.25 (0.58-2.71)	42%	20%	<b>1.70 (1.14-2.54)</b>	<b>1.85 (1.17-2.92)</b>
ion occupation	9%	4%	1.64 (0.83-3.25)		3%	8%	0.62 (0.38-1.03)	

OR = odds ratio, CI= 95% confidence interval, sd = standard deviation. <sup>a</sup>one *S. flexneri* and one EIEC isolate were excluded from analysis, because they c double-infection. <sup>b</sup>EIEC and culture + /PCR + were considered as cases, *Shigella spp.* and culture -/ PCR + as controls. Bold values indicate significant re values < 0.05.

## Symptoms, severity of disease and socio-economic consequences

Patients with EIEC infections reported suffering for longer from diarrhea than patients with *Shigella spp.* infection. In addition, the maximum vomiting frequency was higher for patients with EIEC infections (Table 2). Although patients with EIEC were symptomatic longer, they exhibited fewer symptoms and scoring lower on the de Wit scale than patients with *Shigella spp.* In contrast, no significant difference in severity was calculated using the MVS scale (Table 2). For socio-economic consequences, patients with EIEC infections were more likely to visit a general practitioner (GP) and to have a shorter stay when hospitalized than patients with a *Shigella spp.* infection (Table 3).

Table 2. Symptoms and severity of infections with EIEC and *Shigella*, and culture-positive and culture-negative shigellosis

Symptoms and severity	EIEC <sup>a, b</sup> (n=32)	<i>Shigella</i> <i>spp.</i> <sup>a</sup> (n=254)	Univariate model, p-value	Multivariate model, p-value	Culture +/ PCR + <sup>a, b</sup> (n=244)	Culture - / PCR + (n=167)	Univariate model, p-value	Multivariate model, p-value
Blood in stool (% present)	16	39	<b>0.005</b>	0.051	39	38	0.901	0.679
Mucus in stool (%) (present)	47	58	0.222	0.290	58	54	0.508	0.688
Abdominal pain (%) (present)	59	74	0.082	0.108	75	71	0.330	0.945
Abdominal cramps (%) (present)	72	82	0.194	0.115	82	83	0.662	0.310
Nausea (% present)	56	44	0.209	0.568	45	54	0.066	<b>0.041</b>
Headache (% present)	22	33	0.187	0.052	32	40	0.108	0.086
Fever (% present)	47	60	0.164	0.248	59	56	0.582	0.420
When fever, duration in lays	3 (2.5- 4.5) median (IQR)	2 (1-4)	0.334	0.165	2 (1-4)	2 (1-4)	0.802	0.698
When fever, maximum temperature (mean ± sd)	40.0 ± 0.7	39.4 ± 0.9	0.063	0.413	39.4 ± 0.9	39.2 ± 0.8	0.084	0.179
Diarrhea (% present)	97	97	0.907	0.776	98	99	0.349	0.303
When diarrhea, duration n days	14 (7- 19.5) median (IQR)	10 (6-14)	<b>&lt;0.001</b>	<b>&lt;0.001</b>	9.5 (6-14)	14 (8-24)	<b>&lt;0.001</b>	<b>0.001</b>
When diarrhea, frequency n 24H (median (IQR))	8 (6-14)	9 (6-15)	0.855	0.796	10 (6-15)	10 (6-16)	0.486	0.185
Vomiting (% present)	28	28	0.979	0.809	29	37	0.073	<b>0.026</b>
When vomiting, duration n days	2 (1-3) median (IQR)	1 (1-3)	0.508	0.929	1 (1-3)	2 (1-3)	<b>0.033</b>	0.167
When vomiting, frequency n 24H	3 (2-8)	2 (1-4)	0.166	<b>0.001</b>	2 (1-4)	3 (1-5.8)	0.525	<b>0.027</b>
Total number of symptoms median (IQR)	4 (3.0- 5.3)	5 (4-6)	<b>0.006</b>	<b>0.006</b>	5 (4-6)	5 (4-6)	0.519	0.104
Severity scores:								
de Wit et al. mean ± sd)	6.4 ±2.6	7.5 ± 2.7	<b>0.033</b>	<b>0.045</b>	7.5 ± 2.7	7.7 ± 2.7	0.380	0.132
Modified vesikari (mean ± sd)	7.4 ± 3.3	7.3 ± 2.8	0.852	0.943	7.3 ± 2.8	7.9 ± 2.8	<b>0.028</b>	<b>0.007</b>

Sd = standard deviation, IQR = interquartile range. <sup>a</sup>one *S. flexneri* and one EIEC isolate were excluded from analysis, because they caused a double-infection. Bold values indicate significant results with p-values < 0.05.

Culture-negative cases were more likely to report nausea, longer duration of diarrhea, vomiting and higher frequencies of vomiting than culture-positive cases (Table 2). Moreover, the MVS score of culture-negative cases was significantly higher than that of culture-positive cases, while the de Wit scores showed no significant difference (Table 2). In addition, culture-negative cases were more likely to report longer absence from work compared to culture-positive cases (Table 3).

Table 3. Socio-economic consequences of infections with EIEC and *Shigella*, and culture-positive and culture-negative shigellosis

Consequences	EIEC <sup>a</sup> <sup>b</sup> (n=32)	<i>Shigella</i> <i>spp.</i> <sup>a</sup> (n=254)	Univariate model, p- value	Multivariate model, p- value	Culture +/ PCR + <sup>a, b</sup> (n=244)	Culture - / PCR + (n=167)	Univariate model, p- value	Multivariate model, p- value
Bedrest (% present)	88	81	0.357	0.186	82	79	0.528	0.514
Leave of absence (% present)	56	53	0.709	0.703	53	47	0.220	0.737
When absence patient, duration in days (median (IQR))	5 (3.0-7.8)	4 (3-7)	0.882	0.401	4 (3-7)	7 (3-10)	<b>0.038</b>	<b>0.005</b>
When absence caretaker, duration in days (median (IQR))	0 (0-0)	0 (0-0)	0.554	0.185	0 (0-0)	0 (0-0)	0.389	0.171
Use of care facilities								
GP (% visited)	100	91	<b>0.015</b>	<b>0.037</b>	91	93	0.299	0.851
When GP visited, number of visits median (IQR)	1.5 (1-2)	1 (1-2)	0.623	0.399	1 (1-2)	1 (1-2)	0.595	0.909
GP outside office hours (% visited)	9	9	0.989	0.537	9	10	0.694	0.757
Specialists (% visited)	16	13	0.732	0.830	13	16	0.388	0.965
When specialist visited, number of visits (median (IQR))	1 (1-2)	1 (1-1)	0.797	0.799	1 (1-1)	1 (1-2)	0.122	0.553
Emergency room (% visited)	9	10	0.933	0.781	10	5	0.072	0.074
Hospitalization (% hospitalized)	3	9	0.180	0.270	9	5	0.163	0.443
When hospitalized, duration n days (median (IQR))	1.5 (0.8-2.3)	3 (2-4)	0.179	<b>0.027</b>	3 (1.5-3.5)	3.5 (1-4.8)	0.244	0.648

IQR = interquartile range. <sup>a</sup>one *S. flexneri* and one EIEC isolate were excluded from analysis, because they caused a double-infection. Bold values indicate significant results with p-values < 0.05.

## Secondary infections

Because there was a lack of specific data about relationships between cases, the presence and number of self-reported related patients was used as a proxy for the degree of secondary infections. No significant differences in

presence and number of self-reported related patients were found when comparing EIEC cases with shigellosis cases or when comparing culture-positive cases to culture-negative cases (Table 4).

Table 4. Degree secondary infections of infections with EIEC and *Shigella*, and culture-positive and culture-negative shigellosis

Secondary infections	EIEC <sup>a</sup> , <sup>b</sup> (n=32)	<i>Shigella</i> <i>spp.</i> <sup>a</sup> (n=254)	Univariate model, p- value	Multivariate model, p- value	Culture +/ PCR + <sup>a, b</sup> (n=244)	Culture - / PCR + (n=167)	Univariate model, p- value	Multivariate model, p- value
Related patients (%) present)	47	39	0.393	0.785	40	39	0.865	0.930
When related patients, total number (median IQR)	1 (1-2)	1 (1-2)	0.239	0.354	1 (1-2)	1 (1-3)	0.326	0.977

IQR = interquartile range. <sup>a</sup>one *S. flexneri* and one EIEC isolate were excluded from analysis, because they caused a double-infection. Bold values indicate significant results with p-values < 0.05

### Comparison of infections with cultured *S. flexneri* and *S. sonnei*

First, patients with *S. sonnei* were more likely to report (85%) abdominal cramps compared to *S. flexneri* (75%, p = 0.047). Second, no differences in total number of symptoms or disease severity were found. Third, patients with *S. sonnei* were more likely to self-report the presence of related patients (45%) than patients with *S. flexneri* (28%, p = 0.028), although the self-reported number of related patients did not differ. Fourth, for the socio-economic consequences, there were multiple differences: patients with *S. flexneri* were more likely to report longer absence from work (median 5 (3-9) days), multiple visits to their GP (average 2.1 visits), visits to specialists (21%) and hospitalization (17%) compared to patients with *S. sonnei* that reported a median of 4 (2-7), p = 0.001) days of absence, an average of 1.6 GP visits (p = 0.049), 10% specialist visits (p = 0.015), and 5% hospitalization (p < 0.001).

## Discussion

This multicenter cross-sectional study was initiated to obtain more insight into the clinical implications and impact on public health of *Shigella spp.* and EIEC infections, by assessing differences in incidence, risk factors, symptoms, severity of disease, degree of secondary infections and the socio-economic consequences. Additionally, the clinical and public health relevance of detection of shigellosis with molecular methods only was investigated by comparing culture-positive shigellosis cases to culture-negative PCR positive shigellosis cases.

The comparison of infections with *Shigella spp.* and EIEC showed some differences, for which several hypotheses can be considered. Patients with EIEC infections were less likely to report MSM contact than patients with *Shigella*

*spp.* Indeed, to our knowledge an EIEC outbreak among MSM has never been described. The higher infectious dose of EIEC could explain these lower transmission rates through the sexual route. Although, the claim of the higher infectious dose for EIEC is based on only one study from the 1970s, in which only two EIEC isolates were tested for pathogenicity at low dosages (22). Despite the fact that patients with EIEC were symptomatic for longer periods, patients with *Shigella spp.* showed more symptoms simultaneously and a higher severity score on the de Wit scale. However, scores on the MVS scale were comparable. These discrepancies between the two disease severity scales were probably caused by the symptoms blood in stool and fever. Blood in stool and fever above 37.5°C is double weighted in the de Wit scale, while in the MVS scale, blood in stool is not a factor and fever is double weighted only when temperature is above 38.4°C. The differences regarding symptoms and disease provided no convincing evidence for a more severe course for one pathogen over the other. Patients with EIEC infections in our study were more likely to visit their GP. However, this is probably an artefact being a consequence of the healthcare system in the Netherlands, where only physicians can request laboratory confirmation, thus all patients diagnosed with an EIEC infection had visited their GP by definition. In contrast, PHS can also request laboratory confirmation of patients with shigellosis for cases that are identified during contact tracing (14). This explains why not every patient with *Shigella spp.* visited their GP while patients diagnosed with EIEC did. Furthermore, similar percentages of patients infected with *Shigella spp.* and EIEC reported hospitalization, but patients infected with *Shigella spp.* were more likely to be admitted for longer periods. This may indicate a more severe disease course.

In our study, no biological evidence was found to support the current difference in approach for infections with *Shigella spp.* and EIEC, indicating that the disease control measures for EIEC should be the same as for *Shigella spp.* for several reasons. First, a reliable separation of these bacteria by MMLs is technically challenging and probably unachievable, as it is increasingly realized that they should be classified as one species as proposed by multiple research groups (8, 34). Second, this study also associates EIEC infections with serious infections although minor differences in symptoms were observed compared to shigellosis. The pathogenic behavior of EIEC is also reflected in its involvement in multiple food-related outbreaks (20-24).

Although in some literature it is stated that *S. sonnei* causes milder forms of shigellosis than the other species of *Shigella* (35), in our study, as well as in other studies, no differences were found in disease severity when comparing *S. sonnei* and *S. flexneri* infections (36).

The limited sensitivity of culture from fecal samples should be further investigated. Causes for this phenomenon could be a low bacterial load, time between onset of symptoms and submission of the sample, and time between submission of the sample and diagnostic procedures. Nevertheless, the proportion of infections from which

bacteria could be cultured in our study is comparable to other studies and is representative of the situation in the Netherlands and other areas (17, 37) (de Boer *et al.*, manuscript in preparation).

The current case definition for shigellosis was formulated when molecular methods were not implemented in routine diagnostics. Since their implementation, molecular methods have improved diagnostic capabilities, especially for organisms that are challenging to culture such as *Shigella spp.* and EIEC. However, because evidence about the meaning of PCR positive results was lacking, these methods are not yet incorporated into the case definition of shigellosis. Our study demonstrates that molecularly detected cases of shigellosis are comparable to culture confirmed shigellosis cases. There is no biological basis supporting the current case definition of shigellosis in which only culture confirmed cases are notifiable. Additionally, case control studies have demonstrated that the molecular detection of the *ipaH* gene in fecal samples was associated with cases rather than controls, and others showed that the sequence composition and quantity of *Shigella spp.* in culture-negative cases was comparable to culture-positive shigellosis cases (24, 32, 37-39). Finally, guidelines from the European Union (EU), United States of America (USA) and Australia recently amended case definitions for shigellosis, and define molecular detected infections as probable cases, which in Australia should be notified, while in the EU and the USA individual countries or states should define their own notification criteria (13, 15, 16).

One of the strengths of this study is the inclusion of samples and patient data representative for the whole of the Netherlands, as a result of the collaboration with MMLs and PHS. A second strength is that the clinical outcomes and impact on public health of infections with EIEC were investigated; these have not often been described before (24). A third strength is that the value of molecular detection of *Shigella spp.* versus culture was investigated in detail.

Limitations of this study are that the representation of species is based on the Dutch situation and therefore no *S. dysenteriae* isolates, and only a few *S. boydii* isolates were included in the comparison of outcomes of *Shigella spp.* and EIEC. Second, not all notified shigellosis cases were included, because not all laboratories in the Netherlands participated in the study, although participating laboratories had a reasonable national geographic distribution. Third, the study design introduces a bias towards more severe infections and certain demographics such as age and frailty, because only infections for which laboratory confirmation was requested were included. Fourth, no data was collected on date of onset of symptoms impeding correction for the comparison of symptomatic periods. Fifth, the number of self-reported related patients was used to estimate secondary infection rate. Although patients were asked to mention if they were aware of any other people that fell ill before or after

them, common sources cannot be excluded with certainty using this method. Last, the clinical and epidemiological circumstances were not a result of objective measurements, but were dependent on the judgement and memory of the patients.

## Conclusion

This study provides evidence to reconsider incorporating molecular detection methods as well as infections with EIEC in the case definition and guidelines for disease control measures regarding shigellosis. As our study showed differences in risk factors between *Shigella spp.* infections and EIEC infections and between culture-positive and culture-negative shigellosis cases, the application of different prevention strategies deserves attention.

## Abbreviations

Ct	Cycle threshold
DNA	deoxyribonucleic acid
EIEC	entero-invasive Escherichia coli
EU	European Union
GP	general practitioner
IQR	inter-quartile range
METC	medisch-ethische toetsing commissie (medical ethics review board)
MMLs	medical microbiological laboratories
MSM	men who have sex with men
MVS	Modified Vesikari-scale
OR	odds ratio
PCR	polymerase chain reaction
PHS	Public Health Services
p-value	probability-value
Spp.	species

## Declarations

### Ethics approval and consent to participate

Patients were informed about the study and, after their consent, subjected to a single survey to collect clinical and epidemiological data. One of the parents or guardians was asked to participate in the survey in case of minors. The medical ethics review board (METC) in Utrecht, the Netherlands, stated that this study was not subject to "medical research with human subjects" laws (protocol number 15-414/C). Data collection of patients took place in 2016

and 2017 and complied with the Dutch Personal Data Protection Act. Data handling complied with the EU General Data Protection Regulation, which was operative from May 2018. The IBESS-study was registered as observational study under number 23481 in the Dutch Trial Register.

### **Consent for publication**

Not applicable.

### **Availability of data and material**

The data are not publicly available due to containment of information that could compromise research participants' privacy.

### **Competing interests**

The authors declare that they have no competing interests.

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### **Authors' contributions**

MB, AF, FR, MK, and JR conceived the project. MB, EW, AF, FR, RB, DN, MP, JR, IF and MK designed the project with input of the IBESS working group. MB, EW, MS, DN, EZ and IF performed the analyses. MB, FR, MS, JR, IF and MK interpreted results. MB wrote the manuscript. All authors read, reviewed and approved the final manuscript.

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- and all adjacent public health services.

## Additional Material

Additional File 1.xlsx - Calculation of EIEC multiplier

In this file the calculation of the multipliers for the estimation of the Dutch community incidence for shigellosis and infections with EIEC were depicted, using equations as described by Haagsma *et al.* 2013.

## References

1. Collaborators G. Estimates of the global, regional, and national morbidity, mortality, and aetiologies of lower respiratory tract infections in 195 countries: a systematic analysis for the Global Burden of Disease Study 2015. *Lancet Infect Dis.* 2017;17(11):1133-61.
2. Khalil IA, Troeger C, Blacker BF, Rao PC, Brown A, Atherly DE, et al. Morbidity and mortality due to shigella and enterotoxigenic Escherichia coli diarrhoea: the Global Burden of Disease Study 1990-2016. *Lancet Infect Dis.* 2018.
3. RIVM. State of Infectious Diseases in the Netherlands, 2013. Bilthoven: National Institute for Public Health and the Environment; 2014.
4. Pijnacker R, Friesema IHM, Franz E, Van Pelt W. Trends van shigellosemeldingen in Nederland, 1988-2015. *Infectieziekten Bulletin.* 2017;28 (4):121-8.
5. Lan R, Alles MC, Donohoe K, Martinez MB, Reeves PR. Molecular evolutionary relationships of enteroinvasive *Escherichia coli* and *Shigella spp.* *Infect Immun.* 2004;72(9):5080-8.
6. Kaper JB, Nataro JP, Mobley HL. Pathogenic *Escherichia coli*. *Nat Rev Microbiol.* 2004;2(2):123-40.
7. Hale TL. Genetic basis of virulence in *Shigella species*. *Microbiol Rev.* 1991;55(2):206-24.

8. Pettengill EA, Pettengill JB, Binet R. Phylogenetic analyses of *Shigella* and enteroinvasive *Escherichia coli* for the identification of molecular epidemiological markers: whole-genome comparative analysis does not support distinct genera designation. *Front Microbiol.* 2015;6:1573.
9. Brenner DJ. Family I. *Enterobacteriaceae* Rahn 1937, Nom. fam. cons. Opin. 15, Jud. Com. 1958, 73; Ewing, Farmer, and Brenner 1980, 674; Judicial Commission 1981, 104. In: Krieg NR, editor. *Bergey's Manual of Systematic Bacteriology*. 1984. p. 408-20.
10. Hartman AB, Venkatesan M, Oaks EV, Buysse JM. Sequence and molecular characterization of a multicopy invasion plasmid antigen gene, *ipaH*, of *Shigella flexneri*. *J Bacteriol.* 1990;172(4):1905-15.
11. van den Beld MJ, Reubaert FA. Differentiation between *Shigella*, enteroinvasive *Escherichia coli* (EIEC) and noninvasive *Escherichia coli*. *Eur J Clin Microbiol Infect Dis.* 2012;31(6):899-904.
12. WHO. Global priority list of antibiotic-resistant bacteria to guide research, discovery, and development of new antibiotics. 2017.
13. EU. Comission Implementing Decision (EU) 2018/945 of 22 June 2018 on the communicable diseases and related special health issues to be covered by epidemiological surveillance as well as relevant case definitions 2018 [updated 6 July 2018].
14. RIVM. LCI Richtlijn shigellose 2017 [Available from: <https://lci.rivm.nl/richtlijnen/shigellose>.
15. CDC. Shigellosis (*Shigella spp.*) 2017 Case Definition 2017 [Available from: <https://www.cdc.gov/nndss/conditions/shigellosis/case-definition/2017/>.
16. CDNA. Shigellosis Surveillance Case Definition 2018 [Available from: [http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-nndss-casedefs-cd\\_shigel.htm](http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-surveil-nndss-casedefs-cd_shigel.htm).
17. Van Lint P, De Witte E, Ursi JP, Van Herendael B, Van Schaeren J. A screening algorithm for diagnosing bacterial gastroenteritis by real-time PCR in combination with guided culture. *Diagn Microbiol Infect Dis.* 2016;85(2):255-9.
18. de Boer RF, Ott A, Kesztyus B, Kooistra-Smid AM. Improved detection of five major gastrointestinal pathogens by use of a molecular screening approach. *J Clin Microbiol.* 2010;48(11):4140-6.
19. Silva RM, Toledo MR, Trabulsi LR. Biochemical and cultural characteristics of invasive *Escherichia coli*. *J Clin Microbiol.* 1980;11(5):441-4.
20. Escher M, Scavia G, Morabito S, Tozzoli R, Maugliani A, Cantoni S, et al. A severe foodborne outbreak of diarrhoea linked to a canteen in Italy caused by enteroinvasive *Escherichia coli*, an uncommon agent. *Epidemiol Infect.* 2014;142(12):2559-66.
21. Herzig CTA, Fleischauer AT, Lackey B, Lee N, Lawson T, Moore ZS, et al. Notes from the Field: Enteroinvasive *Escherichia coli* Outbreak Associated with a Potluck Party - North Carolina, June-July 2018. *MMWR Morb Mortal Wkly Rep.* 2019;68(7):183-4.
22. DuPont HL, Formal SB, Hornick RB, Snyder MJ, Libonati JP, Sheahan DG, et al. Pathogenesis of *Escherichia coli* diarrhea. *N Engl J Med.* 1971;285(1):1-9.
23. Newitt S, MacGregor V, Robbins V, Bayliss L, Chattaway MA, Dallman T, et al. Two Linked Enteroinvasive *Escherichia coli* Outbreaks, Nottingham, UK, June 2014. *Emerg Infect Dis.* 2016;22(7):1178-84.
24. Platts-Mills JA, Babji S, Bodhidatta L, Gratz J, Haque R, Hatt A, et al. Pathogen-specific burdens of community diarrhoea in developing countries: a multisite birth cohort study (MAL-ED). *Lancet Glob Health.* 2015;3(9):e564-75.

25. Tai AY, Easton M, Encena J, Rotty J, Valcanis M, Howden BP, et al. A review of the public health management of shigellosis in Australia in the era of culture-independent diagnostic testing. *Aust N Z J Public Health*. 2016;40(6):588-91.
26. Lede IO K-DM, van den Kerkhof JHTC, Notermans DW. Gebrek aan uniformiteit bij meldingen van Shigatoxinproducerende *Escherichia coli* en *Shigella* aan en door GGDen. *Infect Bull*. 2012;23:116-8.
27. Quinn E, Najjar Z, Huhtinen E, Jegasothy E, Gupta L. Culture-positive shigellosis cases are epidemiologically different to culture-negative/PCR-positive cases. *Aust N Z J Public Health*. 2019;43(1):41-5.
28. van den Beld MJC, de Boer RF, Reubaet FAG, Rossen JWA, Zhou K, Kuiling S, et al. Evaluation of a culture dependent algorithm and a molecular algorithm for identification of *Shigella spp.*, *Escherichia coli*, and enteroinvasive *E. coli* (EIEC). *J Clin Microbiol*. 2018;56:e00510-18.
29. Haagsma JA, Geenen PL, Ethelberg S, Fetsch A, Hansdotter F, Jansen A, et al. Community incidence of pathogen-specific gastroenteritis: reconstructing the surveillance pyramid for seven pathogens in seven European Union member states. *Epidemiol Infect*. 2013;141(8):1625-39.
30. de Wit MA, Kortbeek LM, Koopmans MP, de Jager CJ, Wannet WJ, Bartelds AI, et al. A comparison of gastroenteritis in a general practice-based study and a community-based study. *Epidemiol Infect*. 2001;127(3):389-97.
31. Freedman SB, Eltorky M, Gorelick M, Pediatric Emergency Research Canada Gastroenteritis Study G. Evaluation of a gastroenteritis severity score for use in outpatient settings. *Pediatrics*. 2010;125(6):e1278-85.
32. Bruijnestijn van Coppenraet LE, Dullaert-de Boer M, Ruijs GJ, van der Reijden WA, van der Zanden AG, Weel JF, et al. Case-control comparison of bacterial and protozoan microorganisms associated with gastroenteritis: application of molecular detection. *Clin Microbiol Infect*. 2015;21(6):592 e9-19.
33. R\_core\_team. R: A language and environment for statistical computing. R Foundation for Statistical Computing 2018 [Available from: <https://www.R-project.org/>].
34. Brenner DJ. Characterization and clinical identification of *Enterobacteriaceae* by DNA hybridization. *Prog Clin Pathol*. 1978;7:71-117.
35. Scheutz FaS, N.A. *Genus I. Escherichia Castellani and Chalmers*. In: Garrity GM, editor. Bergey's Manual of Systematic Bacteriology. 2 The *Proteobacteria*. 2nd ed. New York: Springer Science; 2005. p. 616.
36. Khan WA, Griffiths JK, Bennish ML. Gastrointestinal and extra-intestinal manifestations of childhood shigellosis in a region where all four species of *Shigella* are endemic. *PLoS One*. 2013;8(5):e64097.
37. Liu J, Platts-Mills JA, Juma J, Kabir F, Nkeze J, Okoi C, et al. Use of quantitative molecular diagnostic methods to identify causes of diarrhoea in children: a reanalysis of the GEMS case-control study. *Lancet*. 2016;388(10051):1291-301.
38. Lindsay B, Saha D, Sanogo D, Das SK, Omore R, Farag TH, et al. Association Between Shigella Infection and Diarrhea Varies Based on Location and Age of Children. *Am J Trop Med Hyg*. 2015;93(5):918-24.
39. Liu J, Almeida M, Kabir F, Shakoor S, Qureshi S, Zaidi A, et al. Direct Detection of Shigella in Stool Specimens by Use of a Metagenomic Approach. *J Clin Microbiol*. 2018;56(2).

## Figures

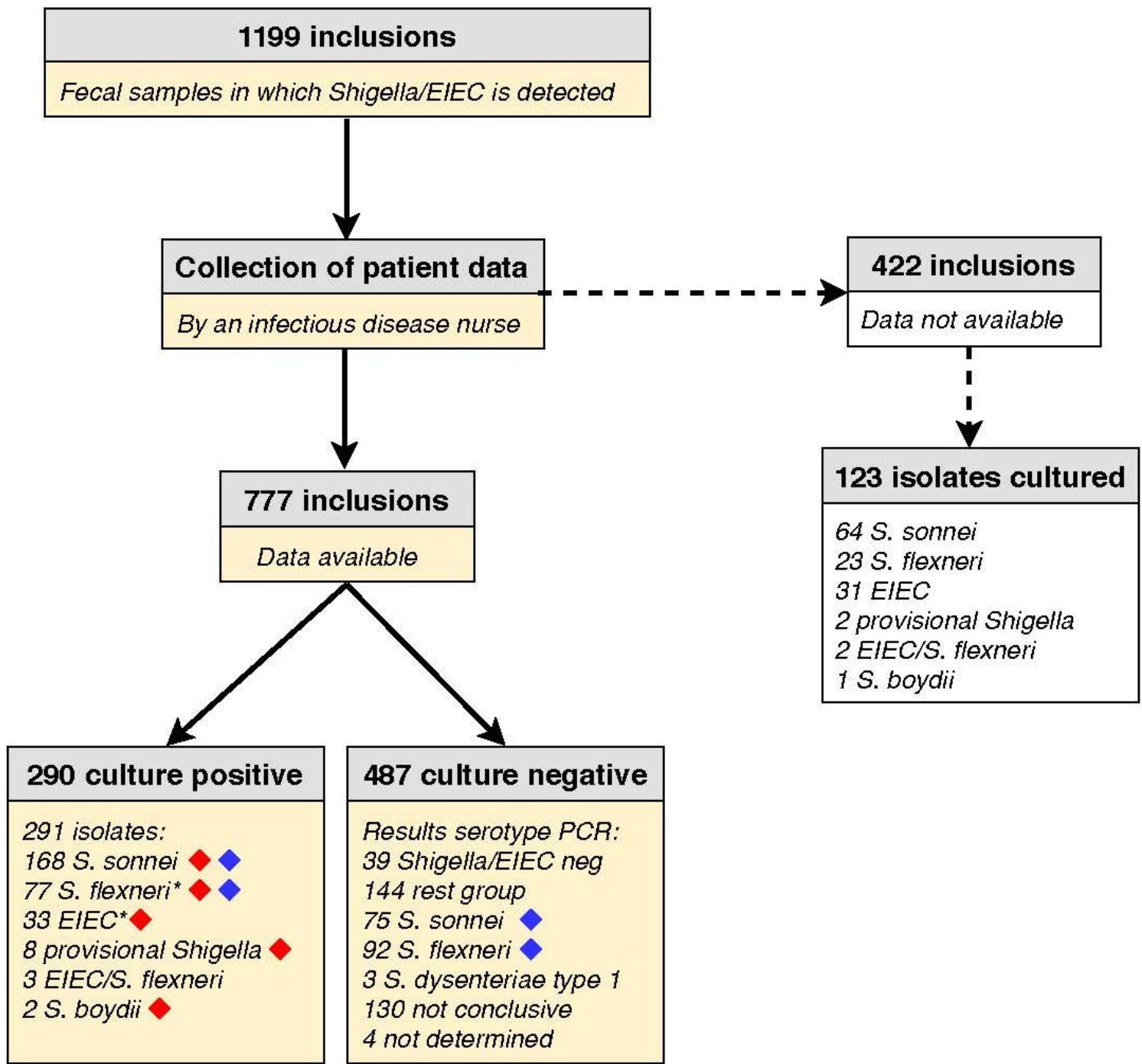
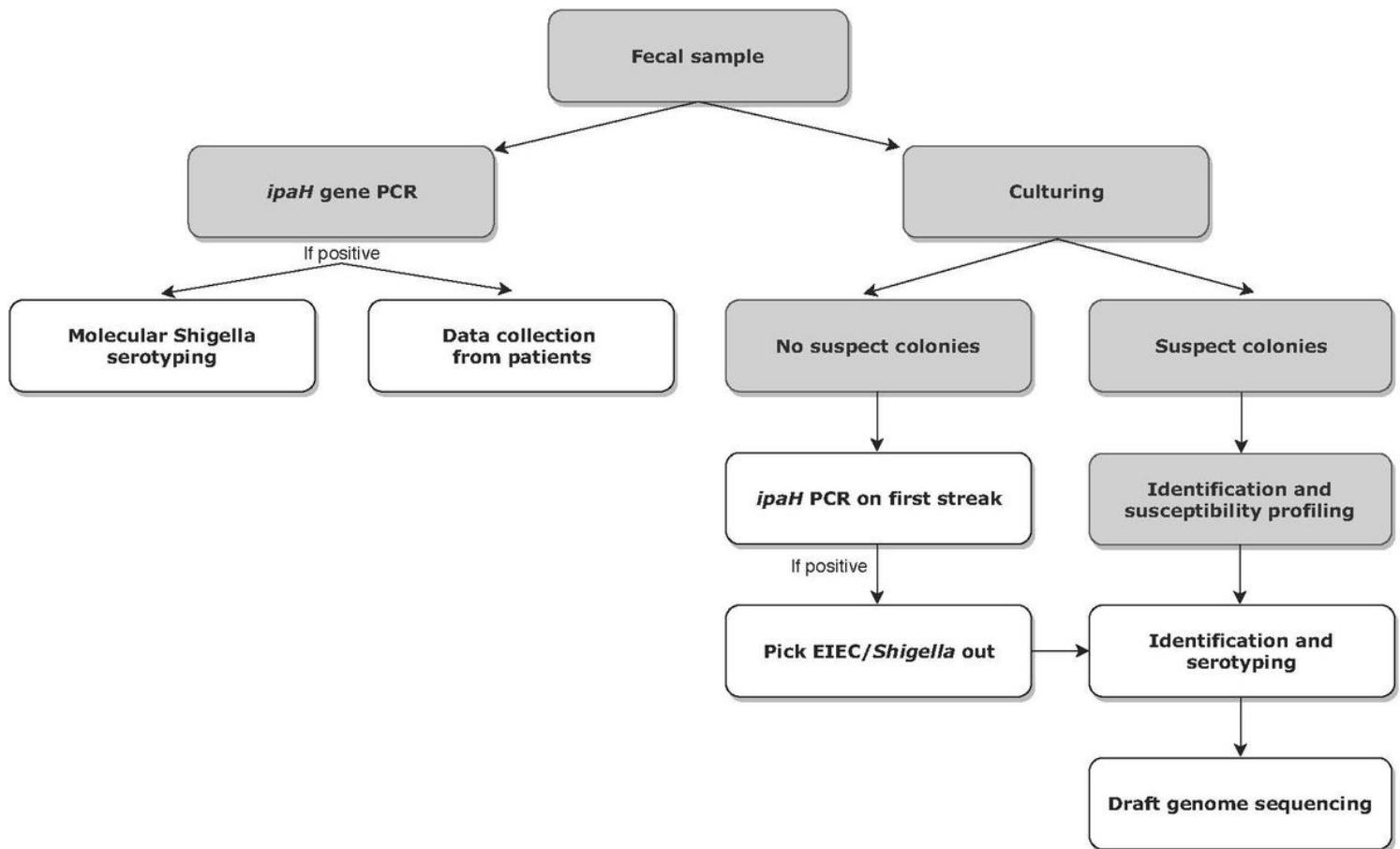


Figure 1

Overview of the design of the IBESS-study Grey boxes = activities performed by participating laboratories. White boxes = activities performed by the IBESS-study group.



**Figure 2**

Flowchart of inclusions in the study Yellow boxes = data used in this study. White boxes = data not used in this study. Red diamonds = Data of patients from whom these isolates were obtained were used in the comparison of *Shigella* spp. with EIEC. Blue diamonds = Data of patients from whom an *S. sonnei* or *S. flexneri* isolate was obtained or detected in the fecal samples were used in the comparison of culture-positive cases with culture-negative cases. \*one *S. flexneri* and one EIEC isolate were excluded from analysis, because they caused a double-infection.

## Supplementary Files

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- [AdditionalFile1.xlsx](#)