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Bloody Diarrhea and STEC-HUS in Children: Data from the ItalKid-HUS Network

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~~Bloody diarrhea and STEC HUS~~

Conflict of interest disclosure

~~None of the authors have any conflict of interest to disclose~~

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Abbreviations

BD: bloody diarrhea

CI: confidence interval

Eae: intimin

HUS: hemolytic uremic syndrome

ipaH: invasion plasmin antigen H gene

IQR: interquartile range

LPS: lipopolysaccharide

STEC: shigatoxin-producing *Escherichia coli*

Stx: shiga-toxin

TMA: thromboticmicroangiopathy

VTEC :verocytotoxin-producing *Escherichia coli*

Yr: year

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Deidentified individual participant data will not be made available.

Contributors' statement

~~Dr. Ardissino, Dr. Arghittu, Dr. Capone, Dr. Tel, Dr. Testa, Dr. Paglialonga, Dr. Brigotti, Dr. Baldioli, Dr. Pagani, Dr. Ceruti, Dr. Tommasi, Dr. Possenti and Dr. Cresseri conceptualized and designed the study, participated in data collection, drafted the initial manuscript, and reviewed and revised the manuscript.~~

~~Dr. Vignati, Dr. Masia, Dr. Colombo, Dr. Daprai, Dr. Dodaro, Dr. Luini and Dr. Picieco performed laboratory tests and data collection and carried out analysis and revised the manuscript~~

~~Dr. Consonni and Dr. Montini critically reviewed the manuscript for important intellectual content.~~

~~All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.~~

Abstract

Objective: To analyze the results of an enhanced laboratory-surveillance protocol for bloody diarrhea (BD) aimed at identifying children with *Shiga Toxin-Producing Escherichia coli* (STEC) infection early in the course of the disease towards the early identification and management of patients with Hemolytic Uremic Syndrome (HUS).

MethodsStudy design: The study (2010-2019) involved a referral population of 2.3 million children. Stool samples of patients with BD were screened for Shiga Toxin (Stx) genes. Positive patients were rehydrated and monitored for hemoglobinuria until diarrhea resolved or STEC-HUS was diagnosed.

Results: A total of 4767 children were screened; 214(4.5%) were positive for either Stx1(29.0%) or Stx2(45.3%) or both Stx1+2(25.7%); ~~34~~ ~~Thirty four~~ patients (15.9%) developed STEC-HUS (0.71% of BDs). Hemoglobinuria was present in all patients with HUS. Patients with Stx2 alone showed a higher risk of STEC-HUS (23.7% vs. ~~12~~ 12.7%) ~~while and~~ none of the patients with Stx1 alone developed HUS. During the sameperiod of time 95 other patients were diagnosed STEC-HUS but were not captured by the screening program (26 had non-BD and 11 came from areas not covered by the screening program and 58 had not been referred to the screening program although they did meet the inclusion criteria). At HUS presentation, serum creatinine of patients identified by screening was significantly lower compared ~~to~~ ~~with~~ that of the remaining patients (median: 0.9 vs 1.51 mg/dL).

Discussion: Nearly 1% of children with BD developed STEC-HUS and its diagnosis was anticipated by the screening program for Stx. The screening of BD for Stx is recommended and monitoring patients carrying Stx2 with urine dip-stick for hemoglobinuria is suggested to identify the renal complication as early as possible.

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Background

The epidemiology of acute bloody diarrhea (BD) in children is not clearly known both in high and low-middle income countries [1,2]. What is known is that a wide array of pathogens can cause BD in children with varying incidence by geography, season, age, socioeconomic conditions and hosts' immune status [3-9].

In Western countries culture-proven BD is mostly due to *Campylobacter*, *Salmonella*, *Shigella*, *Yersinia* and *Escherichia coli* especially Shiga toxin-producing *Escherichia coli* (STEC) [10-16].

STEC infections can be complicated by the hemolytic uremic syndrome (HUS) [17] that, besides being the most common thrombotic microangiopathy (TMA) in children, is the leading cause of acute kidney injury in children beyond the neonatal age [18]. STEC-HUS is characterized by platelet consumption, mechanical non-immune mediated hemolysis and renal, as well as multi-organ, damage with severe and life-threatening consequences.

Detailed knowledge of the local epidemiology is of paramount importance for identifying new and effective prevention strategies as well as for driving the optimal diagnostic approach. Moreover, the patient's early clinical management can be modified by knowledge of epidemiological data (virulence profiling and risk of complications).

~~The present paper~~We describes the results obtained from the 10 years experience with a centralized screening program of BD for *Shiga Toxin (Stx)* in children that was promoted in a large area with over 12 million general population. The study presents the general epidemiology of *Stx*+BD in children with special regard to HUS development and the impact of the screening program in anticipating the diagnosis and the management of HUS.

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Methods

~~Study setting and design~~

The present analysis includes all tested children (up to age 20 years of age) with BD obtained from 2010 through 2019 within a network of 63 pediatric units in Northern Italy (ItalKid-HUS Network), with a referral pediatric population of 2.3 million. We present all STEC-HUS cases diagnosed during the analyzed period including those not screened prior to the diagnosis of HUS, either because they were not tested (n: 58) due to the rapid course of the disease or because they came from areas not covered by the screening program (n: 11) or because they did not exhibit bloody diarrhea at all (n: 26) (Figure 1).

The network was developed for the identification of STEC infections aimed at the early diagnosis and management of STEC-HUS.

Exclusion criteria were history of chronic diarrhea due to any cause.

Stool specimens (occasionally, fecal or rectal swabs) were obtained either from the emergency department or upon patient's admission and only one sample was recorded for each patient. Samples were delivered at room temperature and accepted 24 hours a day /7 days a week and the results were made available during the subsequent day since sample receipt.

All the patients/parents were informed about the investigations and gave their written consent to the diagnostic procedures. The study received the approval by the Ethical Committee of our Institution.

Objectives and End-points

The present study was carried out on an intention-to-diagnose basis. The study was aimed at anticipating the diagnosis and the management of STEC-HUS while evaluating the prevalence of STEC-infection among children with BD. Primary end-points of the study were the measurement of the proportion of Stx positive patients among children with acute BD, the distribution of Stxs and STEC serotypes involved. Secondary end-point was the comparison of laboratory (serum creatinine,

platelet counts and hemoglobin) at presentation and the outcomes of HUS in patients identified by screening and/or diagnosed with HUS (with or without prodromal BD).

Definitions

BD was defined as: “acute (<10 days) diarrhea with visible blood in at least one bowel movement either seen by health professionals or reported by caregivers”.

STEC-HUS was defined as the concomitant presence of platelet consumption (platelet count <150,000/mm³ or more than 50% acute reduction of platelet count), non-immune mediated (Coombs negative) hemolysis (anemia or undetectable haptoglobin or LDH above upper limit of normal) and renal damage (serum creatinine above upper normal limit for age and ~~gender-sex~~ or proteinuria or hematuria) in a patient with evidences of STEC infection (Stx genes in stool or anti-LPS positivity against the “top 6” serotypes). “Top 6” serotypes are: O157, O26, O103, O111, O145 and O104 [19]. Cases with negative Stx and negative anti-LPS, were further investigated to exclude complement dysregulation. The same was done in cases of atypical course and/or with poor outcome. Positive urine dipstick or urinalysis for hemoglobinuria was defined as \geq +(small) or \geq 20 mg/mL, respectively. Positive urine dipstick or urinalysis for hematuria (presence of RBCs) was defined as \geq + (small) or \geq 5 RBCs/HPF, respectively.”

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Laboratory procedures

The biological samples are centralized at our Center where the test for the detection of STEC-related genes was performed using the Reverse Dot Blot Assay (Genotype EHEC (Arnika)) until 2018 and subsequently a Real-Time PCR (RIDA Gene-Relab).

In detail, 50 μ L of feces or rectal swabs are inoculated on the MacConkey broth and incubated at 37° C for 18-24 hours. DNA from bacteria is extracted (Gentra Puregene blood kit) and quantified (NanoDrop 1000 spectrophotometer). Reverse Dot Blot (Genotype EHEC-Arnika) was used to identify the following genes: *Stx1*, *Stx2*, *eae* and *ipaH*. The target DNA was amplified with 5

'biotinylated primers and hybridized to specific oligonucleotides immobilized on the membrane strips. Hybridization is detected by adding streptavidin-horseradish peroxidase to the membrane hence obtaining a colorimetric reaction.

Since 2018, STEC-related genes were detected by multiplex Real-Time PCR performed by the RIDA Gene-EHEC/EPEC (R-biopharm) screening kit. If the screening was positive for *Stx*, a second multiplex Real-Time PCR was performed using the RIDA Gene E. coli Stool Panel I kit (R-biopharm) to discriminate between *Stx1* and *Stx2* genes. The amplified targets are revealed with probes marked at the ends, respectively, with a quencher on one side and with a fluorescent dye (fluorophore) on the other. In the presence of a target, the probes hybridize with amplicons. The main serotypes of STEC were identified using a Real Time multiplex PCR for the serogroups most frequently associated with human infection: "top 6". The procedures required a maximum of 6 hours for Reverse Dot Blot and 2 hours for Real Time PCR.

Statistical analyses

Data are provided in absolute numbers and percent with 95% confidence intervals or as median and interquartile range (IQR) Correlation between variables was analyzed by means of the Pearson's correlation coefficient. Chi squares test was used to compare categorical variables. The Student's t test was used to compare discrete variables. Statistical significance was set at a P value of < 0.05 (2-tailed). Data analysis was performed using StatView (Abacus Corp., California, USA).

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Results

Bloody diarrhea

A total of 4767 patients with BD have been screened for the presence of *Stx* genes during the past 10 years. Male ~~gender~~ sex was significantly ($p: 0.001$) over-represented (56.9%) compared ~~to~~ with the expected 48.8% of the general population. The median age of screened patients was 3.4 years (IQR

1.5-7.0). BD was more common in younger children with the highest relative frequency in the age group <1 yr. More than 60% of screened patients were in the age range 0-5 years. Additionally, as known and expected, BD was more common during summer with a peak relative frequency in August and the nadir in February.

Shiga Toxin Gene Positivity

Out of the 4767 screened samples of BD, 214 (4.5%) were positive for either *Stx1* (n:62; 29.0%) or *Stx2* (n:97; 45.3%) or both genes (n:55; 25.7%). Moreover, 741 (15.5%) patients with BD were positive to the *intimin (eae)* gene either in association with *Stx* genes (n:124) or without (n: 617); in 85 samples (1.8%) the *invasion plasmin antigen H* gene (*ipaH*) was identified.

The rate of *Stx* gene positivity among children with BD per year ranged from as low as 2.5% in 2010 to 5.6% in 2016 with a positive slope of the regression line suggesting an increasing incidence of STEC infection over time (Figure 2).

During the same period of time, 95 children were also tested because of ongoing HUS associated with either BD (n:69) or non-BD (n:26) thus the total of *Stx* gene positive children identified during the 10 years, raises to 277.

Although the age group more commonly affected by bloody diarrhea is <1 year, this age-group seems relatively less affected by STEC infection compared ~~to~~ with other age groups. From age 1 yr onward, the percentage of *Stx*+ among BDs remains fairly constant across ages ranging from 7% to 9% thus demonstrating that no age is exempt from STEC infection. However, more than 50% of STEC infections were recorded below age 5 (Table 1).

BD is more common in late summer and autumn, and the rate of *Stx* gene positivity among children with BD is higher from July through October. In September the rate of *Stx gene* positivity for BD observed, was well above 10% (almost three-fold the average).

Additionally no difference was observed in the gendersex, age, or seasonal distribution of identified *Stx* genes (1, 2 or 1+2).

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Among *Stx*+ patients captured by the screening program, the most frequently identified serotype was O157 (25.3% of cases), followed by O26 (24.9%), O103 (7.0%), O111 (6.1%), O145 (4.4%), O127 (1.3%) and O104 (0.4%). Non-top6 serotypes accounted for 30.6% of cases positive for *Stx* at the time of screening for BD.

STEC-HUS

Out of the 214 *Stx*+ patients identified through the screening program, only 34 developed HUS (15.9% of *Stx* + and 0.71% of screened BD). Only STEC-infected patients carrying either *Stx2* gene (with or without *Stx1*) developed STEC-HUS. Thus, if the analysis is restricted to the 152 patients carrying *Stx2* gene (either alone or in combination with *Stx1*) the subjects at actual risk of STEC-HUS was 3.2% of BDs (152/4767). The risk of *Stx* gene positive infection to turn into STEC-HUS was significantly different according to the isolated *Stx* gene: 0% for *Stx1*, 23.7% for *Stx2* and 12.7% for *Stx1+2* (p: 0.0001).

Out of 63 patients who were *Stx2*+ that were tested with urine dipsick or urinalysis for hemoglobinuria, all those with HUS, had a positive urine and only 7 positive testes were not associated with HUS. The median number of days between presentation and the detection of hemoglobinuria was 4.8 (IQR: 3.3-6.0) and whenever the urine turned positive for hemoglobinuria the diagnosis of HUS was confirmed by blood tests within the subsequent 24 hours. None of the patients persistently negative for hemoglobinuria developed HUS. Thus, the sensitivity of hemoglobinuria for the development of HUS was 100% (95% CI 95-100%) with a specificity of 85% (95% CI 77-91%); the positive predictive value was 68% (95% CI 55-79), the negative predictive value was 100% (93-100) and the accuracy was 89% with a likelihood ratio of 6.7.

While-Although *Stx* gene positivity (as percent of BDs) does not change with age (ranging from 2.6 to 4.3), the risk of conversion of *Stx*+ into STEC-HUS decreased with age, being as high as 26.4% in children younger than 5 years old (P for trend: 0.10) (Table 1).

With regard to *Stx* genes involved in the 129 patients who developed HUS, *Stx1* alone was found in 0.8% only, ~~while and~~ the most common association was with *Stx2* and *Stx1+2* (details are provided in Table 2). The most frequent STEC serotype identified among children with HUS was O26 (34.1%) ~~while and~~ O157 was detected in 17.8% of cases. The distribution of serotypes was significantly different in patients whose STEC infection who did or did not turn into HUS (Table 2).

The median creatinine level (and IQR) at presentation of STEC-HUS in children who were identified as STEC infected by the screening program prior to the development of the renal complication (n:34) was significantly (p:0.001) lower (0.9 mg/dL; IQR 0.4-1.5) compared ~~to~~ ~~with~~ that of patients diagnosed with ongoing STEC-HUS with BD (n:95; 1.5 mg/dL; IQR 0.9-2.9). As shown in Figure 1, no significant differences were observed in the rate of short-term complications (need for RRT or CNS involvement) between the 2 groups. The overall long-term outcome was more favorable in patients diagnosed with STEC infection prior to HUS development (any adverse long-term outcome: 2.9% vs 15.8%). Moreover, the distribution of *Stx* type and of serotypes were not different in patients whose STEC infection was identified before or following the diagnosis of HUS. Finally, out of 129 children with HUS managed at our Center during the 10 years of activity of the screening program, only one died (0.8%; 95%CI 0.02-4.3).

Discussion

BD is not uncommon in children and, when caused by STEC, it can be complicated by the development of STEC-HUS, with possible life-threatening consequences, including severe acute and chronic renal damage. ~~So far, No~~ specific treatment for STEC-HUS is available and the management of patients is centered on supportive care.

In 2010, we became increasingly aware that control of STEC-HUS required strong preventive measures. Thus, we decided to move our attention from overt HUS to the early (prodromal) phase of the infection when the kidney is not yet symptomatically involved. The target of our intervention was to decrease the incidence of STEC-HUS while ameliorating its course and outcome. This ambitious target was supported by the increasing availability of reliable diagnostic tools as well as by new evidence that well hydrated children exhibited better outcomes (20). The working hypothesis behind the activity of the ItalKid-HUS Network was that the screening of BDs for Stx could lead to the early identification, referral and inpatient management of STEC infected children at high risk for STEC-HUS.

~~Ten years after the beginning of this effort we present our finding.~~ Our efforts did not decrease the incidence of STEC-HUS, which has remained fairly stable in our area (around 5-6 cases/million age-related population). We also observed that the disease often has ~~such~~ a rapid course from the development of BD to STEC-HUS, ~~thus that~~ only 1/3 of STEC-HUS were identified at the stage of BD prior to the development of the TMA (Figure 1). ~~Another critical issue is that,~~ ~~m~~More than 20% of STEC-HUS cases did not have BD or BD was not noticed, so the screening did not capture them. Nevertheless, the program has provided evidence of a positive impact on the disease. First of all, we now have a much better understanding of the local epidemiology of the disease that leads to more detailed individual risk assessment with important clinical implications. For instance, we are now aware that 4.5% of all children with BD are Stx+. Furthermore, we confirmed that Stx 1 is a very rare cause of STEC-HUS ~~while and~~ Stx2 alone is associated with a higher (double) risk than when present in combination with Stx1 as previously hypothesized from both human (21-25) and experimental data (26-27). In addition, although BD is more common in very young children (<1 yr. old), these seem relatively less likely to be Stx+ compared ~~to~~ ~~with~~ other age groups.

Our screening program clearly identified only a portion of BDs occurring in the area and this is among the reasons why a substantial number of HUS cases were not captured before the development of the renal complications. Nevertheless, because of the screening program and the consequent awareness

among pediatricians of BD presenting as a prodromal phase of a subsequent severe disease, the diagnosis of STEC-HUS was significantly anticipated in patients who entered the screening program compared ~~to~~ with unscreened patients as well. For example, the median level of serum creatinine (sCr) at STEC-HUS presentation in the screened patients was 0.9 mg/dL compared with 1.5 mg/dL in unscreened patients. Furthermore, the sCr level during the years immediately prior to the initiation of the screening program of BD for Stx at our Center was 2.0 mg/dL (IQR 1.1-3.3) [20]. In addition, if we analyze some recently published series of STEC-HUS, the sCr of our patients at presentation is significantly lower: in Belgium, Keenswijk ~~W-~~ et al- reported a median value of 2.98 mg/dL in 34 patients [28], in Argentina, Alconcher ~~et al-~~ reported a median sCr at presentation of 2.39 mg/dL in 466 patients [29] and that reported by Balestracci ~~et al-~~ was 2.35 mg/dL in 153 patients [30]. Finally, in a series from France, Netherlands and UK, altogether involving 270 patients, sCr at admission was well above 2 mg/dL (unpublished data kindly provided by Chantal Loirat, Veronique Fremeaux-Bacchi, Nicole van der Kar and Sally Johnson).

Finally, among the major results of anticipating the diagnosis and the management of STEC infections and of STEC-HUS, we observed an important drop of the case-fatality rate from 5.2% [27] to less than 0.8%. However, as shown in Figure 1, early diagnosis did not affect the acute phase of the disease (both in terms of need for RRT and overt CNS involvement) but early diagnosis did reduce the overall long-term sequelae of the disease. Given the relatively small numbers of BD in children, the severity of the possible complications and their rapid development, we believe that all patients with BD should be closely monitored and managed as if any of them could evolve into STEC-HUS until Stx testing excludes the diagnosis. In our setting, close monitoring and appropriate management means stool analysis for Stx, weight restoration (if dehydrated), generous maintenance fluid and urine dip-stick every 12 hours aimed at identifying upcoming TMA (Figure 3).

Only patients carrying Stx2 (alone or in combination with Stx1) (3.2% of BDs) will continue to require the described measures (generous fluid supplementation and urine dip stick every 12 hours) until diarrhea resolves. Almost 15% of this subgroup will develop STEC-HUS. This becomes

particularly relevant during late summer and early fall when the probability that BD is associated with Stx rises well above 10%.

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Figures and Tables

Figure 1: Schematic representation of the results of the ItalKid-HUS Network activity (2010-2019): screened bloody diarrheas for Stx, diagnosed HUS by screening group and related laboratory at HUS diagnosis.

Legend: STEC-HUS: shiga toxin-related hemolytic uremic syndrome, Stx: Shiga Toxin, sCr: serum creatinine, IQR: interquartile range; PTL: platelets count; Hb: hemoglobin; RRT: renal replacement therapy, CNS: central nervous system, CKD: chronic kidney disease, §: IDDM (n: 2) and radial artery thrombosis with consequent finger amputation (n: 1),*: p<0.001 vs other groups.

Figure 2: Changes in the rate of Stx2- and Stx1+2-positive bloody diarrheas over time in the area of the ItalKid-HUS Network (figures include all patients identified positive including patients with ongoing HUS referred to our Center during the analyzed period: screened and unscreened).

Figure 3: Diagnostic management of bloody diarrhea focused on the risk of STEC-HUS used in the ItalKid-HUS Network.

Legends: Stx: Shiga Toxin, uHb: hemoglobinuria; PTL: platelets.

Table 1 – Distribution of bloody diarrhea, of Stx 2 and Stx1+2 positivity and of eHUS by age groups including only patients being tested at the stage of bloody diarrhea (prior to the development of eHUS).

Table 2 – Virulence profile and serotypes in patients infected with STEC and in those who developed STEC-HUS (the table includes all patients: screened and unscreened).

Data Sharing Statement

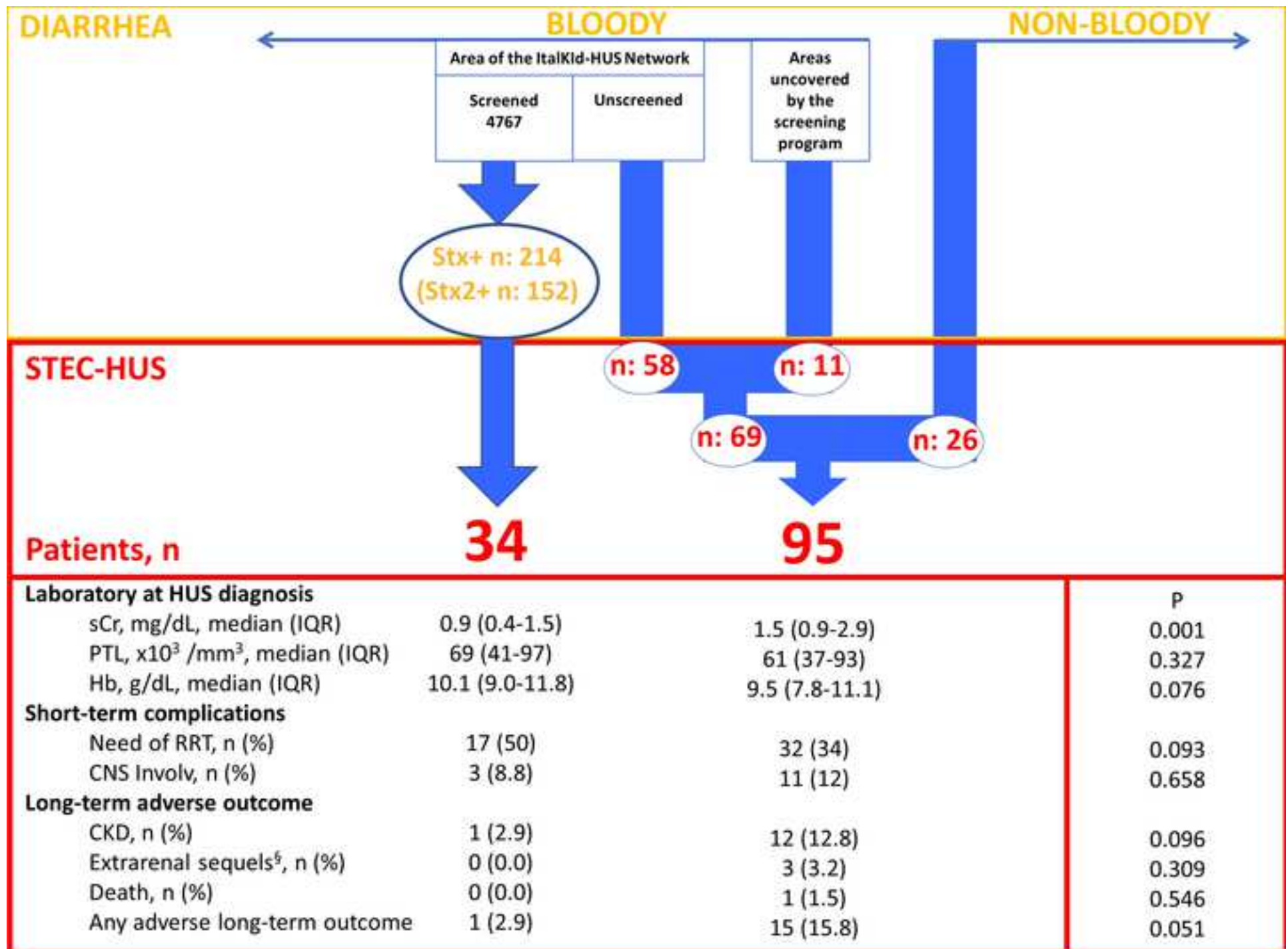
Deidentified individual participant data will not be made available.

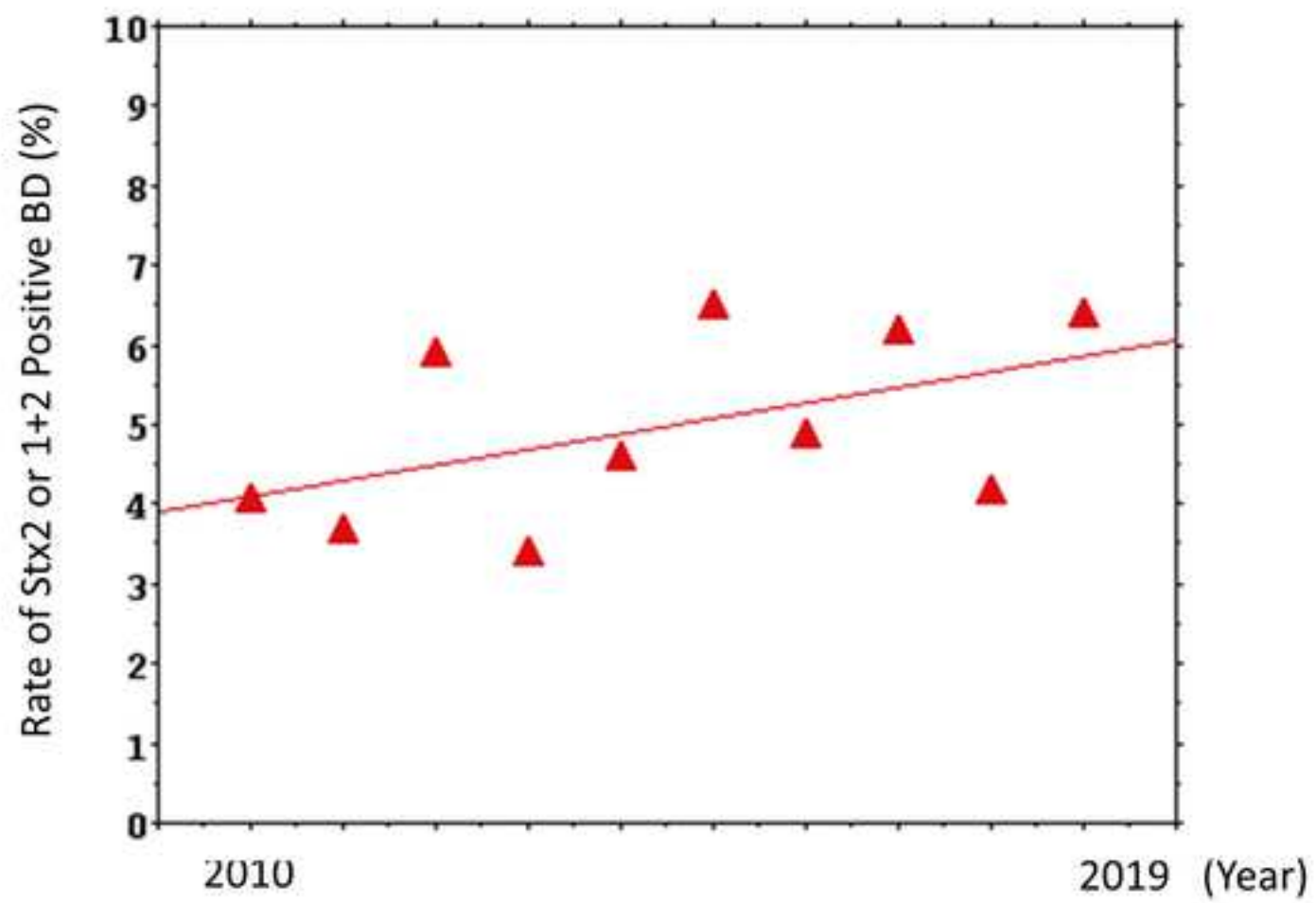
Table 1.

Age group (yr)	Bloody Diarrhea (%)	Stx2 & 1+2 Pos. (% of BD)	STEC-HUS (% of Stx Pos.)
0-5	3078 (64.6)	87 (2.8)	23 (26.4)
5-10	1012 (21.2)	40 (4.0)	8 (20.0)
10-15	491 (10.3)	21 (4.3)	3 (14.3)
15-20	186 (3.9)	4 (2.6)	0 (0.0)
Total	4767 (100)	152 (3.2)	34 (22.4)

Table 2.

	STEC+ w/o HUS (n. 180)	STEC-HUS (n. 129)	Chi-square
Stx, n (%)			
1	61 (33.9)	1 (0.8)	p<0.001
2	72 (40.0)	71 (55.0)	
1+2	47 (26.1)	21 (16.3)	
unknown	NA	36 (27.9)	
Eae+, n (%)	124 (68.9)	78 (60.5)	
Serotype, n (%)			
O157	35 (19.4)	23 (17.8)	p<0.001
O26	15 (8.3)	44 (34.1)	
Other top6	22 (12.2)	22 (17.1)	
Non top6	42 (23.3)	28 (21.7)	
Unknown	66 (36.8)	12 (9.3)	





Appendix

Additional members of the ~~Members of the ItalKid~~-HUS Network

Commented [MM1]: Authors: Individuals already listed as authors have been removed from the Appendix

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