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<td>Author(s)</td>
<td>Kobari, Kazumine; Mitsui, Kazuko; Nakatomi, Masao; Iwanaga, Masaaki; Chin, Kenro</td>
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<tr>
<td>Citation</td>
<td>熱帯医学 Tropical medicine 12(1). p14-21, 1970</td>
</tr>
<tr>
<td>Issue Date</td>
<td>1970-03-20</td>
</tr>
<tr>
<td>URL</td>
<td><a href="http://hdl.handle.net/10069/4066">http://hdl.handle.net/10069/4066</a></td>
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A Long-term Carrier of Shigella sonnei

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(Received for Publication February 6, 1970)

Abstract

It has been known that patients with the bacillary dysentery may continue to excrete the bacilli in convalescence and there are not a few healthy carriers without any manifestation of clinical sign. The duration of excretion of bacilli in both convalescent and healthy carriers is generally within a few weeks. A very small proportion of carriers continues to excrete the bacilli for long time. However, even in cases of which stool cultures have been repeatedly positive for the same type of Shigella, it would be difficult to decide a long-term carrier or reinfection.

The case reported here was designated as carrier of Shigella sonnei six times for about three years and half since he recovered from the bacillary dysentery. The strains isolated from the case belonged to Shigella sonnei I of which Colicin type was 6, and they were sensitive to antibiotics as Chloramphenicol, Tetracycline and Streptomycin. Regarding the present situation that all strains of Shigella isolated in Nagasaki prefecture are highly resistant to these antibiotics, the sensitivity pattern of these strains could be considered as a characteristic marker, so that it could be able to exclude a possibility to have been reinfected.

Some particular investigations as the roentgenographic examinations of the digestive tractus and gallbladder, sigmoidoscopy, rectal biopsy, bile extraction by duodenal intubation etc. were carried out in order to clarify the state of carrier in this case. However, the results were negative so that it could be unable to realize how do the bacilli harbour in the body of the carrier.

Introduction

Patients with the bacillary dysentery may continue to excrete the bacilli after recovery from an acute attack, although this excretion lasts generally for only a week or so. On
the other hand, there are healthy carriers which have not presented any clinical symptom. In the recent, it has been noticed that extremely mild cases have increased which are difficult to be differentiated to the healthy carrier, particularly in cases infected with Shigella sonnei[1]. The period of the excretion of the bacilli in the healthy carriers also is usually limited within two weeks. However, a very small proportion of convalescent and healthy carriers become exceptionally persistent carriers in which the excretion of the bacilli lasts for more than three months, although it may be unable to exclude perfectly a possibility of a reinfection in any case.

A long-term carrier of Shigella sonnei is presented in this paper in which the stool culture was positive for the bacilli during the period of three years and half whenever the rectal swab was examined.

Case

J. T. male, born August 1944, is an employee of the milk manufactory. His residence is in Aino Town near the Nagasaki City. He was infected with Shigella sonnei in the month of March 1965 and hospitalized at the Omura National Hospital as a patient with the bacillary dysentery. He was recovered from an acute and mild illness and discharged after three consecutive negative stool cultures for Shigella sonnei.

In the periodical examination of stool for the food handlers June 1965 he was checked with the positive stool culture for Shigella sonnei and isolated at the same hospital as a carrier of Shigella. He became free from the bacilli after the antibiotic therapy and was discharged.

The periodical stool culture for the food handlers kept him again as the Shigella carrier on 8th June 1966. He was isolated at the Isahaya Health Insurance Hospital and treated with nalidixic acid 150mg three times daily for 6 days. Five days after the treatment, however, the positive stool culture was seen. Then, more three days treatment with 200mg of nalidixic acid three times daily was repeated and discharged after three consecutive negative cultures.

The next episode began on 19th November 1967. The third hospitalization as the Shigella carrier was done after the periodical examination at the same hospital and he was kept for 12 days until the stool cultures became negative consecutively three times. At that time, Colimycin 1,200mg daily was used for 5 days.

In 1968 he was again hospitalized on 28th February at the Isahaya Health Insurance Hospital as the Shigella carrier because of the positive result of the regular stool examination for the food handlers. Colimycin 1,200mg was given for 10 days. Although the stool culture became negative tentatively, the positive results were obtained in May and November of the same year by the culture of rectal swabs.

He was hospitalized at the Hospital of the Institute for Tropical Medicine of Nagasaki University for the precise examination and perfect treatment of the carrier state.

Strains of Shigella isolated from the case

The biochemical and serological behaviour and sensitivity to various antimicrobial agents were examined on the strains which were isolated from the case November 1967, February and November 1968 (S1, S2, S3).

The strains were serologically identified as Shigella sonnei I.
According to the colicine typing, they belonged to type 6.

The biochemical behaviour was as follows:

<table>
<thead>
<tr>
<th>Fermentation of</th>
<th>S1</th>
<th>S2</th>
<th>S3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adonitol</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dulcitol</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sorbitol</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Arabinose</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Xylose</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rhamnose</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Maltose</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Salicin</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inositol</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lactose</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sucrose</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mannitol</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Glucose</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Indole production</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>H2S production</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sodium citrate utilization</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Gelatin liquefaction</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>KNO3 reduction</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Voges-Proskauer</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Methyl red</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Urea decomposition</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

The sensitivity of the strains to various antimicrobial agents was investigated by the dilution method. The result was as follows:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Minimum Inhibitory Concentration (mcg/ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>S1</td>
</tr>
<tr>
<td>Chloramphenicol</td>
<td>3.12</td>
</tr>
<tr>
<td>Tetracycline</td>
<td>1.56</td>
</tr>
<tr>
<td>Streptomycin</td>
<td>6.25</td>
</tr>
<tr>
<td>Kanamycin</td>
<td>6.25</td>
</tr>
<tr>
<td>Colimycin</td>
<td>12.5</td>
</tr>
<tr>
<td>Furadiomycin</td>
<td>6.25</td>
</tr>
<tr>
<td>Aminobenzyl-Penicillin</td>
<td>6.25</td>
</tr>
<tr>
<td>Nalidixic acid</td>
<td>3.12</td>
</tr>
<tr>
<td>Furazolidone</td>
<td>1.56</td>
</tr>
<tr>
<td>Furatrizine*</td>
<td>1.56</td>
</tr>
</tbody>
</table>

*WHO uses the term "Dihydroxymethyl-Furalazine"*
A Long-term Carrier of Shigella sonnei

gies of E. coli, lactose fermentizing and non-
fermentizing, on the same days.

Afterwards, results of culture on the three
types of medium remained negative for
Shigella during the period of the hospitaliza-
tion.

The combined treatment with one gram of
Tetracycline and one gram of Dihydroxy-
methylfuraturazine, divided in four times daily,
started on 22nd November and continued
for one week. The number of colonies of
E. coli on BTB agar and Macdonkey agar
decreased markedly after the treatment, but
did not disappear absolutely.

Since he was discharged on the end of
November 1968, he has come to the Institute
once a week for the continuation of bacterio-
logical examination of rectal swabs. The
isolation of Shigella from his rectal content
has been tried 21 times from 4 December
1968 through 19 May 1969. However, every
culture resulted in negative for Shigella.
In the third week of the hospitalization,
Magnesium sulfate was repeatedly given as
a purgative. The carrier had a few times
loose bowel movement after the administra-
tion of the purgative, but a provocation for
the excretion of Shigella did not succeed.

Results of other examinations

He was a thin but well nourished young
man. Physically he had no complain.
No peculiar finding was recognized by the
ordinary physical examination. Suspected
harbouring bacilli in the gallbladder, the
extraction of bile was tried twice, on 16 May
1968 and 14 November 1968, by the duodenal
tubing. The results of the bacteriological ex-
amination of bile were negative for the
dysentery bacilli. A normal shadow of the
gallbladder was obtained by the cholecysto-
graphy taken on 13 November 1968.

Barium study of the upper gastrointestinal
tract was carried out on 12 November 1968.
The roentgenographic finding of the stomach
and upper intestine indicated no abnormality
except ptosis of the stomach.

The roentgenographic examination of the
colon using barium enema with air contrast
was tried twice, on 4 April 1968 and 19
November 1968. No abnormal figure as
stenosis, dilatation, tumor or ulcer, was found
although the mucous membrane of the sig-
moid and descendens seemed to be slightly
oedematous and the motility was a little
hyperkinetic.

The sigmoidoscopic examination and rectal
biopsy was carried out on 12 March 1968
and 15 November 1968. Both examinations
indicated that the mucous membrane of the
rectum and colon was slightly oedematous
and hyperemic, but neither ulcer nor tumor
was recognized. The histological finding of
the snippet of the mucous membrane of the
rectum showed almost normal appearance
of the intestinal wall except slight cell prol-
feration in the tunica propria.

The serum antibody against the stock
culture of Shigella sonnei and the own ba-
cilli was twice examined by the agglutination
test, but no elevation of titer was found.

Discussion

The problem of the carrier in Shigella in-
fection contains important unsolved ques-
tions; for instances, in what site of the body
do the bacilli survive? is there any essential
difference between patients and carriers?
how is a role of the carrier for the tran-
smission of the disease? how different is
the pathogenicity of the bacilli isolated from
the carrier to that of the patient? etc…
So far, these questions have remained to be
not clarified. Besides, the recent clinical
manifestation of Shigellosis in our country has become so mild that it may be unable to demarcate by a distinct line between patient and carrier.

The fact seems to make more difficult to decide even the definition of the carrier in Shigella infection.

However, if the duration of a carrier state lasts longer than three months, nobody would have an objection to designate the case as a carrier of Shigella.

Since old times it has been known that a small proportion of infected persons with Shigella has become a long-term carrier.

In our country, long-term carriers have recently been reported by some authors. But, anywhere in the endemic area like our country it should be very difficult to exclude a possibility of a reinfection instead of a decision as a carrier state.

The case reported here was proved to have excreted Shigella sonnei I in stool during the period from June 1965 through November 1968, whenever the periodical stool examination was carried out once or twice yearly. In the recent, Shigella sonnei has taken the place of Shigella flexneri which had been predominating in Japan for more than fifty years. Since a few years ago about 90% of the isolated strains of Shigella in the Nagasaki prefecture belong to the group of Sonnei.

The Colicin type of the strains of this case is type 6. It cannot be a particular marker to characterize the strains, because Type 6 and 14 have been the most popular Colicin types in the Nagasaki prefecture.

As far as the drug-sensitivity of the strains of Shigella is concerned, a considerable increase of the highly resistant strains of Shigella, particularly Sonnei, to Chloramphenicol, Tetracycline and Streptomycin has been recognized in the last five years in the Nagasaki prefecture as well as in the whole country. Figure 1 indicates the proportion of the resistant strains of Shigella sonnei among those isolated at the Nagasaki Municipal Hospital from 1958 up to 1967, and the percentage of the resistant strains of Shigella sonnei and flexneri isolated at the Kosei Hospital in Sasebo City during the same period is shown in Figure 2. According to these Figures, all strains of Shigella sonnei (Nagasaki City) and Shigella sonnei and flexneri (Sasebo City) are highly resistant to these three antibiotics. In fact, no sensitive strain of Shigella sonnei has been detected from dysentery cases which were admitted at the isolation hospitals in Nagasaki and Sasebo Cities since 1967. Therefore, the fact that the strains which were isolated from this case November 1967, February and November 1968 are sensitive to the antibiotics should be worth of note.

At the moment when he was attacked with Shigella sonnei, March 1965, about half of the strains of Shigella sonnei in the Nagasaki prefecture were still sensitive to the antibiotics. It is presumed that he was infected with a sensitive strain of Shigella sonnei at that time, and the strain may have survived anywhere in his body without changing its sensitivity pattern to the antibiotics.

The investigations using the roentgenographic examinations of the digestive tractus and gallbladder, sigmoidoscopy, rectal biopsy and duodenal intubation were carried out for the purpose to clarify the state of carrier in this case. However, any positive result was unable to be obtained.

This carrier was detected by the periodical stool examination which is compulsorily once or twice yearly carried out on hotel and restaurant employees and food handlers. Pro-
Fig. 1. Proportion of Resistant Strains of Shigella Sonnei to C. T. S.
Nagasaki Municipal Hospital
by
Kunihiko Aikawa

Number of Strains
14 108 37 47 96 80 291 168 377 188

Fig. 2. Proportion of Resistant Strains of Shigella sonnei and flexneri to C. T. S.
Kosei Hospital (Sasebo City)
by
Shukei Goto

Number of Strains
208 133 281 138 137 99 96 38 319 266
bably he may not have been checked as a carrier unless he was working in the milk manufactory. It can be supposed that there may be not a few long-term carriers which continue an intermittent excretion of the bacilli after recovery from the dysentery. Approximately 0.3% of stool samples which were collected by the periodical examination on hotel and restaurant employees and food handlers were reported to be positive for Shigella. It can be presumed that among those positive cases there may be some long-term carriers.

The question, how do the bacilli survive in the body of the long-term carrier, should be an important task to be solved.

Summary

A long-term carrier of Shigella, male born August 1944, was reported. He was infected with Shigella sonnei March 1965. Afterwards, from June 1965 until November 1968, he was confined six times at the isolation hospital. The strains isolated from the case are Shigella sonnei I, Colicin type 6 and sensitive to Chloramphenicol, Tetracycline and Streptomycin. Their sensitivity pattern was considered as an important marker to exclude a possibility of reinfecion, regarding the fact that all strains of Shigella sonnei isolated in Nagasaki prefecture are highly resistant to these antibiotics.

Some particular examinations were carried out for the purpose to clarify the state of harbouring the bacilli for long time, but failed to know, how do the bacilli survive in the body.

Acknowledgements

The authors would like to appreciate the kind cooperation of Professor Yoshio Aoki, School of Medicine Nagasaki University, for the Colicin typing, Dr Akira Ghoda and his Colleagues, Kitasato Institute, for the test of pathogenicity, Dr Katsuya Murakami, Nagasaki University Hospital, for taking care of the case during the period of hospitalization, and Dr Junko Takahara, Isahaya Health Center, for the administrative management of the carrier.

References

1) Kobari, K. et al : Tropical Medicine 10 (1) : 50-64, 1968
ソーニ菌長期菌者の一例

小 張 一 峰・三 井 一 子・中 富 昌 夫
岩 永 正 明・陳 建 郎

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摘　要

赤痢患者が症状消失後もある期間排菌をつづける者があること、なんらの臨床症状のみられない健康保菌者が近年特に増加していることは、一般に認められている。しかし、保菌期間が年余にわたる長期例の報告は少ないし、またそのような例について、再感染が否かを判断する資料を見当らないのが常である。

ここに報告する例は、1944年8月生の青年で、1965年3月ソーニ菌赤痢に罹患、隔離入院させられただが、抗菌剤治療により順調に治癒退院した。本人は某乳業会社に勤務していたため、毎年食品ならびに接客業者のための定期検便のもとと、その結果、1965年6月から1968年11月までの約3年半の期間に、6回にわたって、ソーニ菌が便中に証明された。

菌はShigella sonnei I、コリシン型6、クロラムフェニコール・テトラサイクリン・ストレプトマイシン感受性であった。長崎地区における赤痢菌にソーニ菌の薬剤感受性は最近の5年間に著しく増減し、1962年以降の分離されるソーニ菌を主体とする赤痢菌は著しくC.T.Sに高度の耐性を示すもののみとなった。この例は、当時約半数は感受性があったソーニ菌に感染、その後が3年有余にわたって体内に生残していたと推定される。

赤痢菌がこのように長期保菌される場合、腸内のいづれかの個所に生残しているのか、あるいは因態をチフス菌者のように細胞に隠れているのか、を知るために、各症X線検査、十二指腸ソノデによる腸汁採取、直腸検査、直腸生検などを行なったが、菌の存在場所を確認することはできなかった。

患者の自家菌ならびに保存ソーニ菌に対する血中抗体の上昇は認められなかった。

この菌の原性については、北里研究所日田博士が行なったウサギ小腸ループを用いる実験によれば、一般の赤痢菌と同様に、ループ内接種後薬剤を混じた薬液の貯留によりループの著明な腫脹がみられている。