Notifications of Shigella in men (17 years or over): Guidance on investigation, control, and surveillance.

Version 1.5 **09 December 2024**

Key changes

Version	Date	Changes
Version 1.5	9 December 2024	• Sentence included that ongoing monitoring of *Shigella* in gbMSM will be undertaken at Sexual Health Programme 's gbMSM sexual health working group. • Minor edits to section on use of antibiotics, which links out to modified updated advice on treatment of cases in gbMSM in the community. The modified advice has removed the recommendation for the use of azithromycin in milder cases of laboratory confirmed shigellosis due to increasing antimicrobial resistance, seen in up to 80% of cases.
Version1.4	19th May 2024	• Enhanced surveillance of sexual exposures has been stood down. • Sexual Orientation (males 17+ years only) is to be gathered as a priority and entered to CIDR.
Version 1.3	20th December 2023	• New advice to treat probable and confirmed *Shigella* cases in gbMSM in the community with antibiotics to reduce transmission, given current clusters, has been included. • Enhanced surveillance of sexual exposures (sex between men) has been introduced, and the processes for inclusion in CIDR have been outlined. • The option of the Public Health team managing the case without referral has been removed, now providing advice to refer to General Practice or Sexual Health Services • Criteria for microbiological clearance for shigella cases **who are in risk groups at high risk for transmission of intestinal infections** have been updated as follows: one negative stool at least 48 hours after first normal stool or 48 hours after completing antibiotics, whichever is later. • Clarification that screening of sexual and household contacts of cases with *S. flexneri, S. boydii, S. dysenteriae,* **who are in risk groups at high risk for transmission of intestinal infections,** means one test

This guidance document is based on a previous internal document originally agreed by Gastrozoonotic/Vectorborne and HIV/STI Special Interest Subgroups of the Public Health Medicine Communicable Disease Group, December 2017. It was developed and updated as part of the work of the HP-National Incident Management Team on drug resistant *Shigella* in gbMSM (2023-2024).

1.0 Introduction

Clusters of *Shigella* in gay bisexual and other men who have sex with men (gbMSM), many of which are multi-drug resistant, have been recognised in recent years. In Ireland in 2023, a national multi-sectoral response team was convened to respond to increases in clusters seen in this population in Ireland and abroad. This group has worked in partnership with Gay Health Network and MPOWER at HIV Ireland to raise awareness of the situation, what to do if symptoms develop, and of individual actions that persons can take to reduce the likelihood of infection. Ongoing review of drug resistant *Shigella* in gbMSM is now undertaken on a quarterly basis by the gbMSM sexual health working group, convened by the Sexual Health Programme.

In recent years shigellosis cases, many with multidrug-resistant *Shigella sonnei* infections, have been reported to the European Centre for Disease Prevention and Control (ECDC). Cases are linked to several national and international distinct microbiological clusters, with chains of transmission largely, but not exclusively, in gbMSM.

This guidance document is for use by Public Health teams, to enable a systematic coordinated response to be taken to the surveillance, investigation, and control of adult male cases.

2.0 Investigation and Control

On notification of a shigella case (probable or confirmed) in an adult male (17 years or older), the public health team will:

- Check that patient has been informed of diagnosis by healthcare provider.
- For notifications from Sexual Health Services, liaise with personnel at that clinic regarding the necessary public health actions.
- If notification was not from a Sexual Health Service, contact patient and establish facts. If history indicates that the infection is most likely acquired from food or drink, such as cases of infection acquired abroad in areas with endemic transmission (although not necessarily), follow up and institute control measures as per routine practice. Information on food, water and other potential exposures can be collected on the Shigella Enhanced Surveillance form for local investigative purposes. Exclusion is required for cases in higher risk groups, see Appendix A.
- If there is no obvious or likely food or drink source for any **male** case (17+ years), provide an opportunity for him to discuss possible sources of this infection. If it is established that the infection was likely to have been **sexually acquired (sex between men)**, the Public Health team will offer patient the opportunity to:
    - discuss further with own doctor.

  - be referred to Sexual health services.

- If the Patient opts to discuss further with own doctor, the Public Health Team will request consent from patient to contact that doctor. On conclusion of the call, the Public Health team will contact the patient's doctor to provide an update on the situation, the current clusters and outbreak response, and request that he/she provides health advice re:
  - Routine STI screening (chlamydia, gonorrhoea, syphilis, hepatitis B and HIV)
  - Vaccination against hepatitis A and hepatitis B (free in STI clinics), and HPV vaccination for those up to 45 years of age.
  - Use of antibiotics, see treatment guidance here.
  - If in risk group at high risk of transmission of intestinal infections (see Appendix A), patient will be excluded from work until one negative stool at least 48 hours after first normal stool, or 48 hours after completing antibiotics, whichever is later.
  - Patient needs to inform their partner about the infection. If their partner has symptoms of shigella infection, they should seek immediate medical attention
  - Sexual and household contacts of cases with *S. flexneri, S. boydii, S. dysenteriae* who are in risk groups (see Appendix A) should be tested once.
  - Sexual partner(s) are recommended to have routine tests for all STIs, including advice on importance of partner notification.
  - Provide links to additional materials such as http://www.man2man.ie/shigella.html
  - Provide advice for patients on infection prevention and control measures to prevent spread:
    - Wash hands after using toilet and before preparing or eating food.
    - Avoid anal sex, oral-anal sex (rimming), and any sexual act involving faeces (e.g. scat play) whilst symptomatic and for at least seven days after symptoms stop. Advise that *Shigella* can be shed in stools for up to six weeks.
    - Avoid use of pools/spas/hot tubs and sharing towels for at least seven days after symptoms stop

The Public Health team will liaise with the laboratory to ensure that the isolate is sent to the National Salmonella, Shigella and Listeria Reference Laboratory (NSSLRL) (for further details see here).

3.0 Surveillance – probable and confirmed cases.

- Once notification is received, an event of shigellosis should be created on CIDR by Public Health
- For all cases, the national shigella enhanced surveillance form (ESF) should be completed.
  - This form includes information on demographic characteristics, sexual orientation, clinical status (hospitalisation and HIV status), risk group, illness in contacts, as well as travel history. To inform local public health assessment and management, details on food, drink and other potential exposures are collected on this form but are not currently collated nationally on CIDR.

- Upon completion of the generic Shigella ESF, the following key enhanced variables are to be completed on CIDR as a priority for all adult male cases of shigellosis:
    - Sexual Orientation (adult males only): Heterosexual, gbMSM, Other, Unknown – please select an option even when adult male cases are not gbMSM.
    - Suspected mode of transmission: Person-to-person (MSM), Person-to-person (Non-MSM), Laboratory acquired, Foodborne, Waterborne, Other, Unknown

Appendix A

Risk groups at high risk of transmission of intestinal infections.

1. **High- risk food handlers**, e.g. those whose work involves touching unwrapped foods that will not undergo further heat treatment.
2. **Healthcare, preschool, nursery, or other staff** who have direct contact, or contact through serving food, with highly susceptible patients or people in whom an intestinal infection would have particularly serious consequences (for example, the immunosuppressed).
3. **Children under 5 years of age attending nurseries, play groups, or other similar groups** (who have not yet fully developed toilet hygiene).
4. **Older children and adults who are unable to implement good standards of personal hygiene** (particularly toilet hygiene).