

# Cooperative Recognition of Internationally Disseminated Ceftriaxone-Resistant *Neisseria gonorrhoeae* Strain

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Ceftriaxone remains a first-line treatment for patients infected by *Neisseria gonorrhoeae* in most settings. We investigated the possible spread of a ceftriaxone-resistant FC428 *N. gonorrhoeae* clone in Japan after recent isolation of similar strains in Denmark (GK124) and Canada (47707). We report 2 instances of the FC428 clone in Australia in heterosexual men traveling from Asia. Our bioinformatic analyses included core single-nucleotide variation phylogeny and in silico molecular typing; phylogenetic analysis showed close genetic relatedness among all 5 isolates. Results showed multilocus sequence type 1903; *N. gonorrhoeae* sequence typing for antimicrobial resistance (NG-STAR) 233; and harboring of mosaic *penA* allele encoding alterations A311V and T483S (*penA*-60.001), associated with ceftriaxone resistance. Our results provide further evidence of international transmission of ceftriaxone-resistant *N. gonorrhoeae*. We recommend increasing awareness of international spread of this drug-resistant strain, strengthening surveillance to include identifying treatment failures and contacts, and strengthening international sharing of data.

Ceftriaxone is among the last remaining recommended therapies for treating *Neisseria gonorrhoeae* infections and is used in many countries around the world as part of a dual therapy with azithromycin. Cephalosporin resistance in *N. gonorrhoeae* has been associated with modifications of the *penA* gene, which encodes penicillin-binding protein 2 (PBP2), a target for  $\beta$ -lactam antimicrobial drugs (1). During 2009–2015, several ceftriaxone-resistant (MIC 0.5–4 mg/L) *N. gonorrhoeae* strains were reported: in 2009, H041 in Japan (2); in 2010, F89 in France (3); in 2011, F89 in Spain (4); in 2013, A8806 in Australia (5); in 2014, GU140106 in Japan (6); and in 2015, FC428 and FC460 in Japan (7). However, until 2017, all of these strains were considered to have occurred sporadically because, except for limited transmission of F89 among persons in France and Spain during 2010–2011, there had been no reports of sustained transmission of these strains identified nationally or internationally. In 2017, this changed, substantiated by independent reports from Canada (8) and Denmark (9) of gonococcal isolates that had substantive similarity to the previously described FC428 strain in Japan.

The first reported case of the FC428 ceftriaxone-resistant *N. gonorrhoeae* strain was in Japan during January 2015 in a heterosexual man in his twenties who had urethritis (7). The FC428 isolate was resistant to ceftriaxone (MIC 0.5 mg/L), cefixime (MIC 1 mg/L), and ciprofloxacin (MIC >32 mg/L); susceptible to spectinomycin (MIC 8 mg/L) and azithromycin (MIC 0.25 mg/L); and, unlike all previously described ceftriaxone-resistant strains, a penicillinase-producing *N. gonorrhoeae* (PPNG; MIC  $\geq$ 32 mg/L) bacterium. The patient was treated successfully with a single dose of spectinomycin 2 g intramuscularly (IM); however, a second isolate with an identical susceptibility profile (FC460) was subsequently cultured from the same patient 3 months later, suggesting reinfection by a separate contact.

In Canada, during January 2017, a gonococcal isolate (47707) (8) of similar susceptibility to the first reported case

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(including ceftriaxone-resistant MIC 1 mg/L and PPNG; Table 1 [10]) was isolated from a sample collected from a 23-year-old woman. This patient had no history of travel, but her male partner, who had been treated empirically and had no culture results available, reported sexual contact during travel in China and Thailand during the fall of 2016. She was successfully treated with combination therapy of a single dose each of cefixime (800 mg orally) and azithromycin (1 g orally) and an additional dose 13 days later of azithromycin (2 g orally). The strain from Denmark (GK124) was also isolated in January 2017, had a similar susceptibility profile to FC428, and was obtained from a heterosexual man in his twenties who had reported unprotected sexual contact with women from Denmark, China, and Australia (9). The patient was successfully treated with single doses of ceftriaxone (0.5 g IM) and azithromycin (2 g orally). Here, we report additional FC-428–like cases among persons in Australia, providing further evidence of the sustained international transmission of a ceftriaxone-resistant *N. gonorrhoeae* strain.

## Methods

We confirmed *N. gonorrhoeae* isolates by using matrix-assisted laser desorption/ionization time-of-flight mass spectrometry (Bruker Daltonics, Melbourne, Victoria, Australia; bioMérieux, Brisbane, Queensland, Australia). We determined antimicrobial susceptibilities of *N. gonorrhoeae* to ceftriaxone, penicillin, tetracycline, azithromycin, gentamicin, and ciprofloxacin by using Etest (bioMérieux) and spectinomycin by using the agar dilution method (11). We interpreted MIC on the basis of interpretive

criteria from the Clinical and Laboratory and Standards Institute (12): penicillin resistance (MIC  $\geq 2.0$  mg/L); tetracycline resistance (MIC  $\geq 2.0$  mg/L); ciprofloxacin resistance (MIC  $\geq 1.0$  mg/L); and spectinomycin resistance (MIC  $\geq 128.0$  mg/L). Because the Clinical and Laboratory Standards Institute does not have an azithromycin breakpoint, and ceftriaxone breakpoints only state susceptibility ( $\leq 0.25$  mg/L), we used the European Committee on Antimicrobial Susceptibility Testing (13) breakpoints for ceftriaxone resistance (MIC  $> 0.12$  mg/L) and azithromycin resistance (MIC  $> 0.5$  mg/L).  $\beta$ -lactamase production was analyzed by using nitrocefin (Thermo-Fisher Scientific, Melbourne, Victoria, Australia). We subcultured isolates on GC agar base with Vitox Supplement (Thermo-Fisher Scientific) and incubated for 24 h at 35°C in a 5% CO<sub>2</sub> atmosphere with or without antimicrobial drugs and stored in Tryptone (Thermo-Fisher Scientific) soya broth with 10% glycerol at –80°C.

## Genomic Analyses

We put each isolate from Japan and Australia through DNA extraction, library preparation, and sequencing (Illumina, San Diego, CA, USA). From the strains from Japan, FC428 and FC460, we extracted DNA samples with the DNeasy Blood & Tissue Kit (QIAGEN, Tokyo, Japan). We created multiplexed libraries with Nextera XT DNA sample prep kit (Illumina) and generated paired-end 300-bp indexed reads on the Illumina MiSeq platform (Illumina) yielding 6,121,575 reads/genome and genome coverage of 845× for FC428 and 1,272,909 reads/genome and genome coverage of 845× for FC460.

**Table 1.** Phenotypic and molecular characterization of ceftriaxone-resistant *Neisseria gonorrhoeae*\*

Isolate ID	Year	Country (ref)	MIC, mg/L										$\beta$ -lac, PPNG		MLST	<i>porB</i>	<i>tbpB</i>	NG-MAST	<i>penA</i>	NG-STAR
			CEF	CFM	SPX	TET	CIP	AZM	GEN	PCN	+	–								
FC428	2015	Japan (7)	0.5	1	8	0.5	>32	0.25	8	$\geq 32$	+	1903	1053	21	3435	60.001	233			
FC460	2015	Japan (7)	0.5	1	8	0.5	>32	0.25	8	$\geq 32$	+	1903	1053	21	3435	60.001	233			
GK124	2017	DEN (9)	0.5	1	8	NA	>32	0.5	NA	>256	NA	1903	1053	33	1614	NA	NA			
47707	2017	Canada (8)	1	2	16	4	32	0.5	8	$\geq 256$	+	1903	1053	33	1614	60.001	233			
A7846	2017	AUS (This study)	0.5	NA	8	2	>32	0.25	4	$\geq 32$	+	1903	1053	33	1614	60.001	233			
A7536	2017	AUS (This study)	0.5	NA	8	4	>32	0.25	4	$\geq 32$	+	1903	9300	21	15925	60.001	233			
F89	2010	France (3,10)	1	2	16	4	>32	1	8	1	–	1901	908	110	1407	42.001	16			
A8806	2013	AUS (5,10)	0.5	2	16	4	>32	1	4	2	–	7363	1059	10	4015	64.001	227			
H041	2009	Japan (2)	2	4	16	2	>32	0.5	4	4	–	7363	2594	10	4220	37.001	226			

\*AUS, Australia; AZM, azithromycin;  $\beta$ -lac,  $\beta$ -lactamase; CEF, ceftriaxone; CFM, cefixime; CIP, ciprofloxacin; DEN, Denmark; GEN, gentamicin; MLST, multilocus sequence type; NG-MAST, *Neisseria gonorrhoeae* multi-antigen sequence type; NG-STAR, *Neisseria gonorrhoeae* sequence type for antimicrobial resistance; NA, not available; PCN, penicillin; PPNG, penicillinase-producing *N. gonorrhoeae*; ref, reference; SPX, spectinomycin; TET, tetracycline; +, positive; –, negative.

To analyze the strains from Australia, A7536 and A7846, we extracted DNA on the QIASymphony SP (QIAGEN) by using the DSP DNA Mini Kit (QIAGEN). We prepared the libraries according to manufacturer instructions for the Nextera XT library preparation kit (Illumina) and sequenced on the NextSeq 500 (Illumina) by using the NextSeq 500 Mid Output V2 kit (Illumina). Sequencing generated 6,763,774 reads and genome coverage of 361× for A7536 and 3,672,072 reads and genome coverage of 202× for A7846.

We then provided sequencing data to the Canadian National Microbiology Laboratory, where bioinformatic analyses were performed as previously described (14). Quality reads were assembled by using SPAdes (15) (<http://bioinf.spbau.ru/spades>) and annotated with Prokka (16) (<https://github.com/tseemann/prokka>), and produced an average of 86 contigs per isolate, an average contig length of 26,276 nt, and an average N50 length of 68,884 nt. Quality metrics for whole-genome sequencing (WGS) are shown in online Technical Appendix Table 1 (<https://wwwnc.cdc.gov/EID/article/24/4/17-1873-Techapp1.pdf>). A core single-nucleotide variation (SNV) phylogeny was created by mapping reads to FA1090 (GenBank accession no. NC\_002946.2) by using a custom Galaxy SNVPhyl workflow (17). Repetitive and highly recombinant regions with >2 SNVs per 500 nt were removed from the analysis. The percentage of valid and included positions in the core genome was 97.6%; 567 sites were used to generate the phylogeny. We used a meta-alignment of informative core SNV positions to create a maximum-likelihood phylogenetic tree for A7536, A7846, FC428, FC460, and 47707 (Figure). The H041, F89, and A8806 ceftriaxone-resistant strains (available in the World Health Organization [WHO] reference panel as WHO-X,

WHO-Y, and WHO-Z, respectively) (10) were included for comparison. WGS read data for A7536, A7846, FC428, and FC460 are available under BioProject PRJNA416507, and previously reported 47707 was submitted under BioProject PRJNA415047 (8).

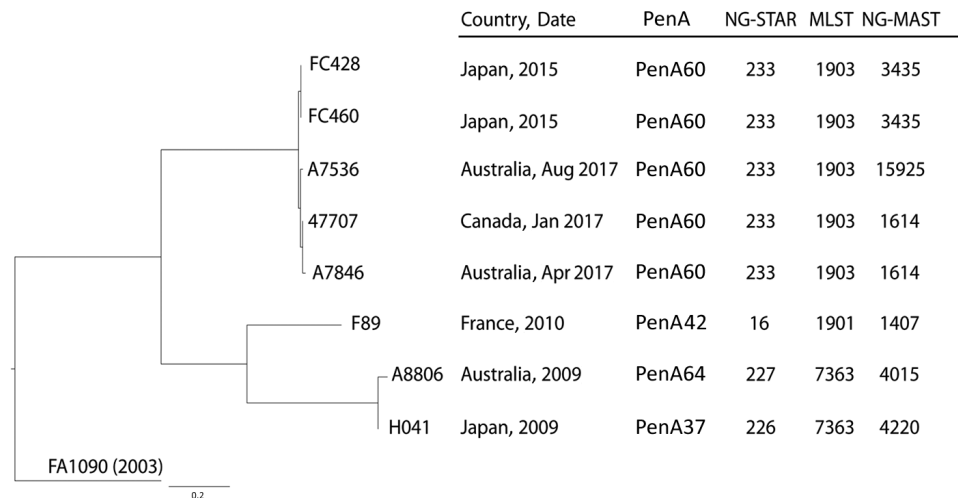
We implemented *N. gonorrhoeae* multiantigen sequence typing (NG-MAST) (18), multilocus sequence typing (MLST) (19), and *N. gonorrhoeae* sequence typing for antimicrobial resistance (NG-STAR) (20) by using gene sequences extracted in silico from WGS data. We submitted the sequences to the NG-MAST (<http://www.ng-mast.net/>), *Neisseria* MLST (<http://pubmlst.org/neisseria/>), and NG-STAR (<https://ngstar.canada.ca>) databases to determine respective sequence types. Sequence data for the GK124 strain (9) were not available for these analyses; however, a summary of the documented susceptibility and MLST and NG-MAST data is provided (Table 1).

## Results

### Case Histories and Isolate Details

The first documented case-patient in Australia was a man in his forties who was visiting from the Philippines. He went to a sexual health clinic in Adelaide in April 2017 reporting urethral discharge and dysuria. He reported recent heterosexual contact with multiple female sex workers in Cambodia and the Philippines; it was unclear where the infection was acquired. An *N. gonorrhoeae* isolate (A7846) of similar susceptibility to FC428 (showing the characteristic ceftriaxone resistance and PPNG; Table 1) was cultured. The patient was treated with a 1-time dose combination therapy of ceftriaxone (500 mg IM) and azithromycin

**Figure.** Core single-nucleotide variation (SNV) phylogenetic tree of ceftriaxone-resistant *Neisseria gonorrhoeae* isolates. The maximum-likelihood phylogenetic tree is rooted on the reference genome of *N. gonorrhoeae* FA1090 (GenBank accession no. NC\_002946.2). Isolates are indicated by country and year. Strains F89, A8806, and H041 (World Health Organization [WHO] reference panel WHO-Y, WHO-Z, and WHO-X, respectively) are previously reported ceftriaxone-resistant reference strains (10). Scale bar indicates estimated evolutionary divergence between isolates on the basis of average genetic distance between strains (estimated number of substitutions in the sample/total number of high-quality SNVs). MLST, multilocus sequence type; NG-MAST, *Neisseria gonorrhoeae* multiantigen sequence type; NG-STAR, *Neisseria gonorrhoeae* sequence type for antimicrobial resistance; PenA, penicillin-binding protein 2.







The cases of *N. gonorrhoeae* described here and the circumstances under which these analyses took place are also a timely reminder of the need for international collaboration in addressing the overall *N. gonorrhoeae* problem and highlight the benefits of rapid access to genomic data by using electronic communications. In fact, in the absence of WGS data, it would have been very difficult to identify the links between these isolates. Not only have we been able to use these tools to readily identify the problem but we also arguably achieved identification in a sufficiently timely manner as to enable countries to put in place interventions that can limit further the spread of this strain, including intensifying follow-up and contact tracing.

Differences in extraction and sequencing procedures among the 3 countries could introduce variations in DNA concentrations that might affect the quality of the sequencing, such as number of reads and depth of coverage. This limitation was minimized because downstream processing of the data, such as assembly and reference mapping software algorithms, standardizes input data before detailed analyses of the genomes are conducted. Laboratory and epidemiologic findings are critical for surveillance that closely tracks the dissemination and emergence of epidemic antimicrobial-resistant strains and for rapid recognition and implementation of control measures to limit the expansion of clones through sexual networks. We recommend that health departments in all countries be made aware of this spreading resistant strain and strengthen *N. gonorrhoeae* antimicrobial-resistance monitoring, including treatment failure identification, adequate follow-up and contact tracing of cases, and STI prevention programs.

In conclusion, international collaboration based on WGS typing methods revealed the dissemination of a ceftriaxone-resistant *N. gonorrhoeae* in Japan, Canada, and Australia. Sustained transmission spanning 2 years suggests unidentified cases are likely present in other locations. These findings warrant the intensification of surveillance strategies and establishment of collaborations with other countries to monitor spread and inform national and global policies and actions.

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## EID Podcast: Antimicrobial Drug Resistance and Gonorrhea

*Neisseria gonorrhoeae*, the causative pathogen of gonorrhea, has been designated an urgent antimicrobial drug resistance threat by the Centers for Disease Control and Prevention. Since the introduction of antimicrobial drugs in the first half of the 20th century, *N. gonorrhoeae* has successively developed resistance to each antimicrobial agent recommended for gonorrhea treatment. In the United States, the prevalence of resistance in *N. gonorrhoeae* often varies by sex of partner and by geographic region. Prevalence is often greater in isolates from gay, bisexual, and other men who have sex with men than those from men who have sex only with women, and prevalence is often highest in the West and lowest in the South. Resistant strains, in particular penicillinase-producing *N. gonorrhoeae*, fluoroquinolone-resistant *N. gonorrhoeae*, and gonococcal strains with reduced cephalosporin susceptibility, seemed to emerge initially in the West (Hawaii and the West Coast) before spreading eastward across the country. These geographic patterns seem to support the idea that importation of resistant strains from other regions of the world, such as eastern Asia, is a primary factor of the emergence of resistant gonococci in the United States. Whereas antimicrobial drug prescribing patterns have been clearly associated with the emergence of resistance in other bacterial pathogens, the degree to which domestic antimicrobial use and subsequent selection pressure contributes to the emergence of gonococcal antimicrobial resistance in the United States is unclear. Using an ecologic approach, we sought to investigate the potential geographic and temporal association between antimicrobial drug susceptibility among US *N. gonorrhoeae* isolates and domestic outpatient antimicrobial drug prescribing rates in the United States during 2005–2013.



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# EMERGING INFECTIOUS DISEASES