High Frequency of Reactive Joint Symptoms After an Outbreak of Salmonella enteritidis

HENNING LOCHT, KÅRE MØLBAK, and KAREN A. KROGFELT

ABSTRACT. Objective. To study reactive symptoms following an outbreak of Salmonella enteritidis that occurred after a dinner party held January 15, 1999, in Copenhagen, Denmark. An epidemiological study pointed toward a dish of minced raw salmon, in which one of the constituents was unboiled eggs as the likely cause of the outbreak. Remnants of this dish were not available for bacteriological examination.

Method. All 94 guests and kitchen staff members were mailed a questionnaire about gastrointestinal, joint, and eye symptoms. Nonrespondents were contacted by telephone. Thirty-five individuals delivered blood samples for serological analysis mean 90 days (range 60–186) after the exposure.

Results. Answers were obtained from all participants and 91 were regarded as Salmonella exposed. Male/female ratio was 40/51, mean age 49 years. Fifty-two reported diarrhea (57%), 49 abdominal pain (54%), 33 fever (36%), and 12 vomiting (13%). Eight (9%) delivered stool samples, and all were positive for S. enteritidis. Seventeen fulfilled predefined criteria of reactive arthritis/arthralgia (ReA), and of these 13 had had enterocolitis. Joint pain from knees and ankles was most frequently reported. The mean duration of diarrhea among the patients reporting joint symptoms was 7.5 days, while in the group of patients with enterocolitis without joint symptoms it was 4.1 days (p = 0.00047). Three participants, all from the ReA group, reported ocular redness and irritation compatible with conjunctivitis. Although there was a trend to higher IgG anti-Salmonella antibody levels among the patients with ReA the difference was not significant.

Conclusion. Reactive joint symptoms after food-borne Salmonella infection may be more frequent than previously thought. The duration of diarrhea is strongly correlated with the occurrence of joint symptoms. (J Rheumatol 2002;29:767–71)

Key Indexing Terms: REACTIVE ARTHRITIS SALMONELLA ENTERITIDIS INFECTION EPIDEMIC

Reactive joint symptoms ranging from transient arthralgia to overt exudative synovitis, sometimes associated with extraarticular phenomena, may occur as a complication after a urogenital or gastrointestinal (GI) infection caused by Chlamydia, Salmonella, Yersinia, Shigella, or Campylobacter. Individuals possessing the HLA-B27 MHC class I antigen are considered to be at increased risk of developing reactive arthritis (ReA).1

The incidence of zoonotic Salmonella infections has increased in recent years in a number of industrialized countries. In Denmark, the number of registered cases peaked in 1997, with over 5000 cases within a population of 5 million. Thus Salmonella is recognized as a leading cause of bacterial food-borne infectious gastroenteritis. However, the extent to which Salmonella infections are followed by reactive symptoms such as ReA is not well established.

When calculating the risk of ReA following Salmonella food poisoning it is pivotal to know the exact size of the exposed population. In larger outbreaks this has often proved difficult to achieve and studies may be biased toward those with severe disease, leaving out patients with only mild transient ReA or enterocolitis or with no enteric symptoms at all. It is well known from studies and clinical practice that cases of ReA appear in which no triggering agent can be identified. We were able to trace all exposed individuals who were involved in a localized outbreak of S. enteritidis and inquire about GI, eye, and joint symptoms. Blood samples from 35 participants were analyzed for antibodies against Salmonella with ELISA and compared to the Widal agglutination technique.

MATERIALS AND METHODS
An outbreak of gastroenteritis due to S. enteritidis phage type 6 occurred January 15, 1999, in Copenhagen, Denmark. It took place at the annual New Year celebration event held by the Copenhagen Medical Association, and the guests were largely medical doctors and their spouses.

As soon as the epidemic became apparent an investigation was undertaken to identify its extent and source. This investigation was conducted at the end of January by the Danish Zoonosis Center in Copenhagen.
Serotyping of these paratyphi strains expressing Salmonella strains expressing specific antigens for either lipopolysaccharide (O-antigen) or flagella (H-antigens) from performing essentially as described. Briefly, microtiter plates (Nunc, Denmark with antisera produced by Statens Serum Institut. The Widal agglutination test was as described by a case of enterocolitis was defined as having at least 2 of diarrhea, abdominal pain, nausea, vomiting, or fever following the exposure. The development of pain in a previously asymptomatic joint or onset of cervical or lumbar back pain within 4 weeks of the exposure was regarded as ReA (which in this regard covers the spectrum from reactive arthralgia to overt arthritis) when other obvious causes, for example trauma or wrong movements, could be ruled out. Individuals with current rheumatological problems at the time of the outbreak were excluded.

**Widal agglutination test.** The Widal agglutination test was as described by Widal and Faarp. Two-fold dilutions of patient sera were incubated with suspensions of O- and H- antigens from Salmonella strains expressing specific antigens for either lipopolysaccharide (O-antigen) or flagella (H-antigen) and checked for agglutination after 24 hours. Salmonella strains used for preparing antigens for determinations of antibodies against Salmonella serotypes were: S. enteritidis (9,12,g,m), S. typhimurium (1,4,5,12:i:-), S. typhi (9,12:i:- and 9,12:o), S. paratyphi A (1,2,12:a:-), S. paratyphi B (4,5,12:i:- and 4,5,12:o), S. paratyphi C (5,5,12:i:-). Serotyping of these Salmonella strains was performed by the National Salmonella Reference Center in Denmark with antisera produced by Statens Serum Institut. The Widal reaction was read as positive when the agglutination titer was ≥ 50.

**ELISA for anti-Salmonella antibodies.** The ELISA procedure was performed essentially as described. Briefly, microtiter plates (Nunc, Roskilde, Denmark) were coated with 1 µg/ml of pooled phenol/water extracted lipopolysaccharide (LPS) from S. typhimurium and S. enteritidis (Sigma, St. Louis, MO, USA) in phosphate buffered saline (PBS) (0.1 mol/l, pH 7.5) overnight at 4°C. Plates were blocked overnight with 1% bovine serum albumin in PBS (pH 7.5) at 4°C. Serum samples collected a mean 90 days (range 60–186 days) after the exposure were diluted 1:1000 in PBS and incubated 2 h at room temperature. The plates were washed 3 times in PBS containing 0.05% Tween 20. Then alkaline phosphatase conjugated goat F(ab)2 anti-human IgG, IgA, and IgM (Sigma) diluted 1:300, 1:100, 1:50, respectively, in PBS were separately incubated 1:300, 1:100, 1:50, respectively, in PBS were incubated overnight at 4°C. Plates were washed 3 times in PBS-Tween and freshly prepared p-nitrophenylphosphate (Sigma) in diethanolamine buffer was added and incubated 30 min at room temperature. The optical densities were read at 405 nm and the results expressed in arbitrary units calculated from a standard curve. Fifty-six sera from blood donors served as controls in the IgG, IgA, and IgM anti-Salmonella ELISA. The cutoff level was mean + 3 SD.

**RESULTS**

Sixty-eight individuals returned the questionnaire within the following 2 mo. The 26 nonrespondents were all contacted by telephone and encouraged to return the questionnaire or to give their answers directly by phone. We thus obtained an overall response rate of 100%.

Three staff members denied having eaten from the minced salmon dish and were regarded as nonexposed (they had not presented any symptoms of either GI infection or ReA) and were excluded from further calculations.

The study population thus consisted of 91 (83 guests, 8 staff). Forty were men (44%), mean age 51 yrs (range 26–67), and 51 were women (56%), mean age 48 yrs (range 20–66). Thirty-five delivered blood samples for serological analysis.

**Enterocolitis.** Fifty-two participants (57%) reported diarrhea, of which 47 provided information about the length of diarrhea illness; 49 (54%) had abdominal pain, 36 (40%) nausea, 33 (36%) fever, and 12 (13%) had vomiting. The time relations between onset of diarrhea and exposure are shown in Figure 1.

Eight participants delivered stool cultures (9%); all had had diarrhea. They were found to be positive for Salmonella and 4 were further typed as S. enteritidis phage type 6. The remaining 4 isolates were not available for phage typing.

**Joint symptoms.** Twenty-one individuals reported joint symptoms or pain from the upper or lower spine. Four were ruled out as having ReA because of late onset, i.e., more than 4 weeks after the exposure or because they reported worsening of previous joint pain.

The ReA group thus consisted of 17 (19%), with a male to female ratio of 8 (47%) vs 9 (53%). Mean age for men was 48 yrs (range 26–57) and for women 53 yrs (range 42–66). Two participants commented that they previously had had ReA, in one as a complication of Campylobacter jejuni infection.

The most frequently reported pain was in knee and ankle joints, and the mean number of affected joints per person was 2.4. Two individuals reported onset of low back pain as the only manifestation (Figure 2).

Of the 52 patients with GI symptoms, 13 (25%) developed ReA, compared with 4 (10%) of 39 without GI symptoms (risk ratio 2.4, p = 0.13).

All 4 patients without GI symptoms claimed to have had both tender and swollen joints, but their symptoms lasted less than one month. Five of the 13 with GI symptoms had tender and swollen peripheral joints and 2 had only low back or cervical neck pain. In 4 the symptoms lasted up to one month, in 3 symptoms lasted 1–3 months, and 6 had symptoms longer than 3 months.
The frequencies of individual GI symptoms for ReA compared to enterocolitis patients were nausea 77% vs 58%, vomiting 38% vs 16%, abdominal pain 85% vs 87%, diarrhea 100% vs 87%, and fever 69% vs 53%. It follows that the 13 ReA patients with GI symptoms, although not statistically significant, generally had more severe GI disease than those with enterocolitis only.

When duration of diarrhea was compared between the ReA patients and those who had only enterocolitis, it showed that the ReA population had a mean duration of diarrhea of 7.5 days, while the duration for enterocolitis patients was 4.1 days. Eleven individuals had prolonged diarrhea of at least 7 days’ duration, and 8 (73%) of these experienced ReA compared with 5 (14%) of 36 patients with diarrhea of less than 7 days (risk ratio 5.2, p < 0.001) (Figure 3).

Seven of the cases were classified as mild, 5 moderate, and 5 as severe joint complaints.

Eye symptoms. Three participants, all from the ReA group, reported irritation and redness of the eyes.

Serology. Among the 35 persons who delivered blood samples a mean 90 days (range 60–186) after the exposure, 10 came from the ReA group and 20 from the enterocolitis group. Five sera were from participants who did not experience any symptoms.

Nineteen sera were positive for IgG anti-Salmonella antibodies, 5 for IgA, and one for IgM. When measured by Widal agglutination, 8 sera were positive, all of low titers between 1:50 and 1:400. Six of the Widal positive sera were also positive by ELISA (data not shown).

There was a trend toward higher levels of IgG anti-Salmonella antibodies in the group with ReA symptoms; however, this was not significantly different from the non-ReA group (Figure 4).

DISCUSSION
Spontaneous outbreaks of bacterial enterocolitis are experiments of nature that allow us to study clinical and laboratory
variables among a group of individuals exposed simultaneously to the same bacterial pathogen. The common epidemiological method in these situations is to distribute survey questionnaires to all affected persons, and a prerequisite for obtaining reliable data is of course a high response rate. One problem in this type of research is a bias toward including only those individuals with overt GI or articular symptoms. Individuals with minor symptoms may be less motivated to respond to the questionnaires or may simply pass unnoticed by the investigators.

In this study over 70% returned the questionnaire, but we reached 100% by contacting nonrespondents by telephone. As the majority were medical doctors familiar with the clinical issues under investigation, most gave detailed answers with a precise description of their symptoms.

The frequency of ReA in this study was 19%, which is a higher percentage than estimated in other reports of Salmonella outbreaks published recently9-15. This is most likely because the ReA incidence here is based upon self-reported symptoms and not examination by medical professionals, who may exclude more discrete articular manifestations like arthralgia and cervical and lumbar pain in the absence of objective clinical findings. As well, most rheumatological examinations were often carried out several weeks or months after the outbreaks, which may rule out cases with only minor transient joint symptoms.

In this study one-third of the ReA group (6 out of 17) had symptoms lasting longer than 3 months and 5 of these patients scored their arthritic problems as severe (i.e., causing the patient to stay home from work because of arthritic pain).

The distribution of joint pain was not different from that seen in other studies9,11,14,15. Knee and ankle joints were most frequently affected, but pain from finger joints, wrist, elbow, and axial skeleton almost reached the same numbers.

We previously described an outbreak of Salmonella enteritidis11 that in many aspects was identical to this one, with one major exception: the fraction of participants who fell ill with enterocolitis was nearly 100% in the former, whereas in this outbreak it was 57%. The severity of diarrhea was probably also different, in that 14% were hospitalized (16 out of 108 with enterocolitis) in the previous study, but only one person stayed one night in hospital in the present outbreak. Whether this was due to the virulence of the strain, to the bacterial load ingested, or to differences in host defense in the 2 populations is unclear.

In spite of this the attack rate of ReA was practically the same (15% vs 19%) in the 2 outbreaks. This raises the question, to what extent do people who escape overt GI symptoms develop joint symptoms? Of the 17 patients with ReA, 4 denied having had any signs of enterocolitis. Among those, 2 were classified as mild, one as moderate, and one as severe; however, all 4 claimed that their joint symptoms had resolved within one month. A similar figure of 24% of ReA patients without diarrhea was found by Mattila, et al13, and it is known that some patients apparently experience no symptoms preceding arthritis16-19. The duration of diarrhea was strongly correlated to the development of articular symptoms, an association confirmed by others9,10,14,16,20, but this was not found in a recent large outbreak in Finland19.

The ReA group tended to show higher values of IgG anti-Salmonella antibodies, but the results were difficult to interpret mainly because the intervals from the time of exposure to the time samples were drawn varied considerably. It has been shown that increased antibody levels tend to persist longer among patients with ReA compared to those with uncomplicated enterocolitis21. In salmonellosis a response in all immunoglobin classes is seen, in contrast to Yersinia triggered ReA, where IgA antibodies and particularly those of the secretory IgA class and the IgA2 subclass persist22.

We compared the results obtained from analyzing sera with the Widal test and an ELISA technique and found, like others8,23, that ELISA is by far the most sensitive method to detect anti-Salmonella antibodies. Only 8 sera were weakly positive.
positive in the Widal assay, whereas 19 were positive for IgG anti-Salmonella by ELISA.

Three participants, all from the ReA group, reported eye symptoms compatible with conjunctivitis, thus bringing the number with possible Reiter's syndrome (urethritis not included) down to 3%.

This study of a Salmonella outbreak illustrates that a significant proportion of exposed individuals can develop reactive joint symptoms regardless of the presence of GI complaints. The duration of diarrhea has a strong effect on the risk of ReA; but overall the joint symptoms were mostly mild and transient.

ACKNOWLEDGMENT

The authors thank B. Cederholm, MD, Department of Microbiology, Lund University, Lund, Sweden, for performing the anti-Salmonella ELISA.

REFERENCES