

SURVEILLANCE REPORT

Gonococcal antimicrobial susceptibility surveillance in Europe

Results summary

2018

www.ecdc.europa.eu

ECDC TECHNICAL DOCUMENT

Gonococcal antimicrobial susceptibility surveillance in Europe

Results summary 2018



This report was commissioned by the European Centre for Disease Prevention and Control (ECDC), coordinated by Gianfranco Spiteri and Andrew J. Amato-Gauci, and produced by Public Health England, London, United Kingdom, and Örebro University Hospital, Örebro, Sweden.

Authors

Susanne Jacobsson and Magnus Unemo, Örebro University Hospital, Örebro, Sweden

Michaela Day and Michelle Cole, Public Health England, London, United Kingdom

Acknowledgements

We would like to thank the members of the European STI network for their active participation in Euro-GASP: Austria: Alexander Indra, Sonja Pleininger, Steliana Huhlescu; Belgium: Irith de Baetslier; Croatia: Blaženka Hunjak, Tatjana Nemeth Blažić; Cyprus: Panagiota Maikanti-Charalampous, Despo Pieridou; Czech Republic: Hana Zákoucká, Helena Žemličková; Denmark: Steen Hoffmann; Estonia: Rita Peetso, Jelena Viktorova; France: Ndeindo Ndeikoundam, Beatrice Bercot; Germany: Peter Kohl, Susanne Buder, Klaus Jansen; Greece: Eva Tzelepi, Vasilios Raftopoulos; Hungary: Eszter Balla, Mária Dudás; Iceland: Guðrún Sigmundsdóttir, Guðrún Svanborg Hauksdóttir, Lena Ros Asmundsdottir; Ireland: Aoife Colgan, Sinead Saab, Brendan Crowley; Italy: Anna Carannante, Paola Stefanelli; Latvia: Gatis Pakarna, Violeta Mavcutko; Luxembourg: Monique Perrin, Patrick Hoffmann; Malta: Robert Cassar, Christopher Barbara, Francesca Vella; Netherlands: Alje Van Dam, Ineke Linde; Norway: Dominique Caugant, Hilde Kløvstad; Poland: Slawomir Majewski; Beata Mlynarczyk-Bonikowska; Portugal: Jacinta Azevedo, Maria-José Borrego; Slovak Republic: Peter Pavlik, Peter Truska; Slovenia: Irena Klavs, Samo Jeverica; Spain: Julio Vazquez, Asuncion Diaz, Raquel Abad Torreblanca; Sweden: Inga Velicko, Magnus Unemo; United Kingdom: Gwenda Hughes, Kate Templeton, Neil Irvine, Noshin Sajedi.

Suggested citation: European Centre for Disease Prevention and Control. Gonococcal antimicrobial susceptibility surveillance in Europe – Results summary 2018. Stockholm: ECDC; 2020.

Stockholm, May 2020

ISBN 978-92-9498-464-7 ISSN 2315-0947 doi 10.2900/943147 Catalogue number TQ-AP-20-001-EN-N

© European Centre for Disease Prevention and Control, 2020

Contents

Abbreviations	iv
Executive summary	1
1 Introduction	2
1.1 Background	2
1.2 Objectives	2
2 Methods	3
2.1 Participating laboratories and isolate collection	3
2.2 Antimicrobial susceptibility testing	3
2.3 Data collection and analysis	3
2.4 Statistical analysis	3
3 Results	4
3.1 Epidemiological data	4
3.2 Antimicrobial susceptibility and resistance	6
4 Conclusions	16
References	18
Annex 1. Percentage completeness of epidemiological variables	20
Annex 2. Statistical tables	21

Figures and maps

Figure 1. Percentage of resistant <i>Neisseria gonorrhoeae</i> by antimicrobial and year, Euro-GASP, 2009–2018 Figure 2. Distribution of MIC for ceftriaxone in Euro-GASP, 2009–2018	6
Map 1. Proportion of gonococcal isolates with cefixime resistance by country, EU/EEA, 2018	10
Figure 3. Distribution of MIC for cefixime in Euro-GASP, 2009–2018	10
Figure 4. Percentage of isolates with cefixime resistance by gender and male sexual orientation, Euro-GASP, 200)9–
2018	11
Map 2. Proportion of gonococcal isolates with azithromycin MICs >0.5 mg/L (previously recommended EUCAST	
resistance breakpoint) by country, EU/EEA, 2018	12
Map 3. Proportion of gonococcal isolates above azithromycin ECOFF (>1 mg/L) by country, EU/EEA, 2018	12
Figure 5. Distribution of MIC for azithromycin in Euro-GASP, 2011–2018	13
Figure 6. Percentage of isolates with azithromycin MIC >0.5 mg/L (previously recommended EUCAST resistance	
breakpoint), by gender and male sexual orientation, Euro-GASP, 2009–2018	13
Figure 7. Percentage of isolates with ciprofloxacin resistance by gender and male sexual orientation, Euro-GASP,	,
2009–2018	14
Figure 8. Percentage of known treatments used for patients with no other concurrent STI by gender and	
transmission type for the most frequently used therapies, 2018	15

Tables

Table 1. Patient characteristics reported for Euro-GASP gonococcal isolates, 2009–2018	,
Table 2. Patient age distribution by gender and sexual orientation, 20186	j
Table 3. Resistance to cefixime, ciprofloxacin and azithromycin (using the previously recommended EUCAST	
azithromycin resistance breakpoint), by country, Euro-GASP, 20187	1
Table 3. Resistance to cefixime, ciprofloxacin and azithromycin (using the previously recommended EUCAST	
azithromycin resistance breakpoint), by country, Euro-GASP, 2018 (continued)8	S
Table 4. Initial diagnostic tests used for isolates submitted in 201814	ŀ
Table A 1. Completeness of epidemiological variable reporting, 201820)
Table A 2. Univariate association of cefixime resistance/susceptibility and patient characteristics, Euro-GASP, 2018	
Table A 3. Univariate association of azithromycin MICs >0.5 mg/L (previously recommended EUCAST resistance	
breakpoint) and patient characteristics, Euro-GASP, 201822	2
Table A 4. Univariate association of azithromycin MICs above/below ECOFF (>1 mg/L) and patient characteristics,	
Euro-GASP, 2018	;
Table A 5. Univariate association of ciprofloxacin resistance/susceptibility and patient characteristics, Euro-GASP,	
2017	ŀ

Abbreviations

Antimicrobial resistance
Breakpoint
Confidence interval
Epidemiological cut-off value
European Economic Area
External quality assessment
European Union
European Committee on Antimicrobial Susceptibility Testing
European Gonococcal Antimicrobial Surveillance Programme
Gonococcal
Gonococcal Resistance to Antimicrobials Surveillance Programme
Human immunodeficiency virus
High-level azithromycin resistance
Multidrug resistant
Minimum inhibitory concentration
MIC gradient strip test
Men who have sex with men
Nucleic acid amplification test
Odds ratio
Public Health England
Penicillinase-producing Neisseria gonorrhoeae
Sexually transmitted infection
The European Surveillance System at ECDC
United Kingdom
World Health Organization
Extensively drug resistant

Executive summary

The surveillance of *Neisseria gonorrhoeae* antimicrobial susceptibility in the European Union/European Economic Area (EU/EEA) has been co-ordinated by the European Centre for Disease Prevention and Control (ECDC) since 2009. This surveillance is essential for detecting emerging and increasing antimicrobial resistance and making quality-assured data available to inform treatment guidelines.

During 2018, the European Gonococcal Antimicrobial Surveillance Programme (Euro-GASP) followed an annual decentralised and centralised testing model, requesting participating laboratories to collect gonococcal isolates during the period September–November. Susceptibility testing was performed on all isolates – MIC gradient strip test (mostly Etest) or agar dilution – for the following antimicrobials: ceftriaxone, cefixime, azithromycin, and ciprofloxacin, as well as testing for β -lactamase production for the detection of high-level penicillin resistance. Decentralised testing took place at participating laboratories that met a defined set of quality criteria.

In 2018, 27 EU/EEA Member States participated in Euro-GASP, 19 via decentralised testing. In total, 3 299 isolates were tested, the majority of which (85.3%) were collected from male patients. The age of the patients ranged from under one year to 86 years, with a median age of 30 years. Overall, 28.0% of patients were under 25 years, and males were significantly older than females. The anatomical site of specimen collection was mainly genital (70.4%), followed by rectal (18.6%) and pharyngeal (8.5%). Among cases with information on previous diagnosis of gonorrhoea, 26.9% had previously been diagnosed with the infection. Twenty-two percent of the patients were concurrently diagnosed with *Chlamydia trachomatis* infection. Among cases with known sexual orientation and gender (68.6%), 47.6% were heterosexual men or women, and 52.4% were men who have sex with men (MSM). Among all cases, 15.7% were HIV positive, and 92.4% of those were MSM.

In 2018, three isolates with resistance to ceftriaxone (two MIC=0.25 mg/L, one MIC=0.5 mg/L) were detected, one in Germany and two in Spain. One of the three ceftriaxone-resistant isolates had an azithromycin MIC over the epidemiological cut-off (MIC=16 mg/L) with susceptibility to increased exposure of ciprofloxacin (MIC=0.064 mg/L). The other two isolates had azithromycin MICs below the ECOFF (MIC=0.5 mg/L and 0.25 mg/L), both of which were resistant to ciprofloxacin (MIC≥32 mg/L). The 2018 Euro-GASP results revealed stable cefixime resistance (MIC>0.125 mg/L) at 1.4% compared to 2017 (1.9%), with a stable number of countries reporting any resistant isolates (n=12). There was a significant increase in the number of isolates with azithromycin MICs above 0.5 mg/L (i.e. the previously recommended EUCAST azithromycin resistance breakpoint); 7.5% of the isolates observed in 2016 and 2017 showed azithromycin MICs above 0.5 mg/L, compared to 13.3% in 2018 (p<0.0002). Since January 2019, the EUCAST clinical resistance breakpoint for azithromycin of MIC>0.5 mg/L has been replaced with an ECOFF of MIC>1 mg/L. Using also the EUCAST ECOFF, a significant increase in the proportion of isolates above this ECOFF was observed: from 3.7% in 2017 to 7.6% in 2018 (p<0.0002). In 2018, 24 countries reported isolates with azithromycin MICs >0.5mg/L, compared to 23 countries in 2017, and 21 and 18 countries in 2016 and 2015, respectively. The proportion of isolates showing ciprofloxacin resistance significantly increased from 46.5% in 2017 to 50.3% in 2018 (p<0.01).

The decreasing azithromycin susceptibility combined with the appearance of ceftriaxone resistance is a major concern and threatens the effectiveness of the currently highly effective dual-therapy regimen (ceftriaxone plus azithromycin). Even though the level of resistance to cefixime is stable, cefixime resistance needs to be monitored closely, particularly because gonococcal strains with resistance to both cefixime and ceftriaxone continue to spread internationally. The continuation of quality-assured antimicrobial susceptibility surveillance activities, along with the development of alternative gonococcal regimens, is essential to ensure gonorrhoea remains a treatable infection.

1 Introduction

1.1 Background

The emergence and spread of antimicrobial resistance (AMR) in *Neisseria gonorrhoeae* is a serious threat to the treatment and control of gonorrhoea. The main therapeutic agents currently recommended in Europe [1], extended-spectrum cephalosporins, are the last remaining options for effective empiric first-line antimicrobial monotherapy. Susceptibility to these antimicrobials has decreased in the past [2-6], which is why the current European treatment guideline recommends combination treatment with ceftriaxone plus azithromycin as first-line in an attempt to mitigate the development and/or spread of resistance to these antimicrobials [1]. Surveillance of the susceptibility to these agents is essential in order to ensure effective patient management and monitor current and emerging trends in AMR [3].

Since 2009, the European Gonococcal Antimicrobial Surveillance Programme (Euro-GASP) is coordinated by the European Centre for Disease Prevention and Control (ECDC), supported by an international network led by Public Health England (United Kingdom) and Örebro University Hospital (Sweden). Euro-GASP has identified decreasing susceptibility to extended-spectrum cephalosporins, and treatment failures have been documented [3], prompting the creation of a European response plan to control and manage the threat of multidrug-resistant *N. gonorrhoeae* in the European Union (EU)/European Economic Area (EEA) [4]. This response plan was reviewed and updated in 2019 [7].

1.2 Objectives

The overall aim of Euro-GASP is to strengthen the surveillance of gonococcal antimicrobial susceptibility in EU/EEA Member States in order to provide quality-assured data to inform gonorrhoea treatment guidelines. The objectives are as follows:

- Develop and implement sentinel surveillance of gonococcal susceptibility to a range of therapeutically relevant antimicrobials.
- Improve the timeliness of surveillance to allow more frequent monitoring of developments in gonococcal antimicrobial susceptibility across EU/EEA.
- Link susceptibility data with epidemiological information to better understand the risk factors associated with emerging resistance patterns.
- Implement an external quality assessment (EQA) scheme for antimicrobial susceptibility testing across EU/EEA.
- Provide training in gonococcal culture and antimicrobial susceptibility testing to facilitate enhanced gonococcal antimicrobial susceptibility surveillance, using a standardised methodology across EU/EEA.

This report presents the results from the 2018 gonococcal antimicrobial susceptibility sentinel surveillance.

2 Methods

2.1 Participating laboratories and isolate collection

Twenty-seven participating laboratories from 27 EU/EEA countries collected *N. gonorrhoeae* isolates from consecutive patients. The official collection window was from September to November 2018, except for the United Kingdom (UK), which collected isolates between July and September 2018 to coincide with the national Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP). Twenty-four countries collected isolates outside of the collection window to attempt to reach the minimum 100 isolate target. Eight of these countries collected isolates throughout the whole year. No new countries joined Euro-GASP in 2018.

The Euro-GASP collection criteria and methodology remained the same as in previous years [8]. Eight countries reported more than their target isolate number, and all isolates reported were included in the analysis. Isolates from eight (29.6%) countries were tested centrally at Public Health England, UK, or Örebro University Hospital, Sweden, with the remaining 19 (70.4%) countries performing antimicrobial susceptibility testing in their own laboratories. Twenty-six Euro-GASP laboratories participated in an annual EQA programme [9, 10] to ensure comparability of data. The one laboratory that did not participate was tested centrally. Countries that perform decentralised testing have fulfilled established quality criteria prior to commencing their own testing. Isolates from Luxembourg were not tested centrally, even though the country it was not assessed for decentralised testing, due to low isolate numbers (one isolate in 2018).

2.2 Antimicrobial susceptibility testing

Antimicrobial susceptibility testing was performed using MIC gradient strip tests (MGS; mainly Etest) or an agar dilution method (determination of MIC (mg/L) or breakpoint technique) for ceftriaxone, cefixime, azithromycin, and ciprofloxacin. Production of penicillinase resulting in high-level penicillin resistance was tested using nitrocefin, as previously described [8]. The results were interpreted using breakpoints from the European Committee on Antimicrobial Susceptibility Testing (EUCAST): cefixime/ceftriaxone resistance, MIC >0.125 mg/L; azithromycin epidemiological cut-off value (ECOFF), MIC >1 mg/L; and ciprofloxacin resistance, MIC >0.06 mg/L [11]. Due to the absence of a clinical resistance breakpoint for azithromycin in the 2019 EUCAST guidelines, also the previously recommended EUCAST breakpoint of azithromycin resistance (MIC >0.5 mg/L) was used for comparison to historical data in this report.

Gentamicin and spectinomycin were removed from the routine antimicrobial panel in 2014 as these antimicrobials are not in routine use. These are only tested in 'snapshot' studies every three years, with the next 'snapshot' study due in 2019.

2.3 Data collection and analysis

The following data were collected for each isolate, where available: date specimen obtained, specimen site, gender, age, sexual orientation, previous gonorrhoea diagnosis, other STI diagnosed during the current episode, place of residence, clinical service type, HIV status, probable country of infection, diagnostic test and treatment used. All susceptibility and epidemiological data were uploaded to TESSy by Member States and then approved.

To evaluate the reporting completeness of epidemiological data for each country, the number of nil responses and unknowns entered for each variable were subtracted from the total number of isolates received; this number was used to calculate a percentage completeness value (number of responses/total isolates received x 100). An overall response rate for each country was then calculated by taking the average of the percentage completeness for all 13 epidemiological fields.

2.4 Statistical analysis

Statistical analysis was performed using Stata v15.1. The Z-test was used to determine the difference between epidemiological and AMR data collected in 2018 versus 2017, and a Mann-Whitney test was used to test whether the differences in age distribution were statistically significant. Where datasets contained sufficient numbers, the odds ratios (OR) and 95% confidence intervals (CI) were calculated and Pearson's χ 2 test was used to measure if these odds ratios differed significantly from 1. For small cell numbers, Fisher's exact test was performed. Using a forward stepwise approach, the most significant and strongest associations from the univariate analysis were added to a multivariable logistic regression model sequentially. Statistical significance for all tests was assumed when p<0.05.

3 Results

In 2018, a total of 3 299 isolates from 27 countries were tested. This represents an increase of 51 isolates (1.6%) compared with 2017. The number of isolates tested from each country varied from one (Luxembourg) to 402 (Netherlands).

3.1 Epidemiological data

Overall, reporting completeness was 62.1% compared to 58.2% in 2017 and 61.6% in 2016. The level of completeness was in line with previous years for the majority of variables (lowest completeness: 29.8% for previous gonorrhoea; highest completeness: 99.4% for gender and 98.7% for age) [8]. Treatment and previous gonorrhoea were the only variables where reporting decreased in 2018 (significant decrease for previous gonorrhoea p=0.0002), whereas the completeness of all other variables increased when compared to 2017 (significantly for gender p=0.03; age p=0.01; concurrent STI p<0.0002; place of residence p<0.0002; clinical service type p<0.0002; country of birth p<0.0002; probable country of infection p<0.0002 and HIV status p<0.0002). Further details on reporting completeness for 2018 data can be found in Annex 1.

As in previous years, the majority of gonococci (85.3%) were collected from men (Table 1). Information on sexual orientation was available for 68.6% (n=2264) of cases. The proportion of heterosexual males was significantly lower in 2018 compared to 2017 (p=0.008); at the same time there was an increase in the proportion of men who have sex with men (MSM) (p=0.001). The main anatomical site of specimen collection was similar to previous years, predominantly genital samples (70.4%). There was a significant decrease, however, in the proportion of genital samples compared to 2017 (72.8%, p=0.04); a significant increase was recorded in the proportion of anorectal samples (2017: 14.6%; 2018: 18.6%, p<0.002). Information on previous diagnosis of gonorrhoea was available for 29.8% of cases (n=982) of which 26.9% had had a previous infection, which was significantly more than 2017 (21.8%; p=0.007). Information on other concurrent STIs was available for 36.8% (n=1215) of cases; 22.2% had a concurrent chlamydia infection, 7.4% had another STI, and 70.7% had no concurrent STIs. Of 1 428 cases (43.3%) with known HIV status, 224 (15.7%) were HIV positive. Of these 224 HIV-positive cases, 92.4% were MSM. Probable country of infection was available for 1 318 (40.0%) cases from 17 different countries; overall, only 11.2% of these cases (n=148) were likely acquired in a country outside of the reporting country.

Table 1. Patient characteristics reported for Euro-GASP gonococcal isolates, 2009–2018

	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Total number of isolates	1366	1766	1902	1927	1994	2151	2134	2660	3248	3299
Gender										
Male	1123 (83.7)	1441 (82.4)	1505 (82.4)	1596 (83.7)	1676 (84.7)	1821 (85.1)	1736 (81.8)	2256 (85.1)^	2737 (84.5)	2795 (85.3)
Female	219 (16.3)	308 (17.6)	321 (17.6)	310 (16.3)	302 (15.3)	318 (14.9)	385 (18.2)	395 (14.9)	502 (15.5)	483 (14.7)
Unknown	24	17	76	21	16	11	13	9	9	21
Age (years)										
<25	422 (32.0)	599 (34.4)	572 (31.9)	617 (32.9)	554 (28.4)	605 (28.7)	617 (29.5)	720 (27.5)	898 (28.2)	925 (28.4)
≥25	898 (68.0)	1141 (65.6)	1221 (68.10)	1261 (67.1)	1399 (71.6)	1501 (71.3)	1476 (70.5)	1902 (72.5)	2283 (71.8)	2332 (71.6)
Unknown	46	26	109	49	41	44	41	38	67	42
Sexual orientation & gender										
Females	219 (27.9)	308 (27.3)	321 (27.1)	310 (28)	302 (25.7)	318 (22.7)	385 (26.4)	395 (22.9)	502 (22.6)	483 (21.3)
Heterosexual males	314 (40.1)	426 (37.7)	423 (35.6)	390 (35.2)	376 (32)	485 (34.7)	419 (28.7)	632 (36.7)	663 (29.9)	595 (26.3)
Men who have sex with men	251 (32)	395 (35)	442 (37.3)	408 (36.8)	496 (42.3)	594 (42.5)	657 (45.0)	696 (40.4)^	1055 (47.5)*	1186 (52.4)
Unknown	582	637*	716	819	820	754	673	937	1028	1035
Site of infection										
Genital	1164 (86.5)	1426 (84.7)	1466 (82.1)	1537 (83)	1531 (79)	1549 (76.3)	1517 (72.9)	1943 (75.5)	2166 (72.8)	2155 (70.4)
Pharyngeal	34 (2.5)	62 (3.5)	79 (4.4)	92 (5)	122 (6.3)	154 (7.6)	180 (8.7)	165 (6.4)	254 (8.5)	259 (8.5)
Anorectal	138 (10.3)	191 (11.4)	216 (12.1)	188 (10.2)	255 (13.2)	192 (9.5)	280 (13.5)	366 (14.2)	435 (14.6)	570 (18.6)
Other	9 (0.7)	7 (0.4)	24 (1.3)	35 (1.9)	30 (1.5)	135 (6.6)	103 (5.0)	100 (3.9)	120 (4)	77 (2.5)
Unknown	21	80	117	75	56	121	54	86	273	238
Previous gonorrhoea										
Yes	84 (18.1)	145 (21)	146 (19)	130 (17.2)	142 (17.8)	163 (19.7)	157 (17.5)	171 (17.2)	235 (21.8)	264 (26.9)
No	379 (81.9)	546 (79)	621 (81)	627 (82.8)	654 (82.2)	663 (80.3)	739 (82.5)	824 (82.8)	845 (78.2)	718 (73.1)
Unknown	903	1075	1135	1170	1198	1325	1238	1665	2168	2317
Concurrent STI										
Concurrent chlamydia infection	78 (14.3)	172 (22.1)	194 (22.2)	187 ^{††} (23.4)	183 (21.8)	170 (20)	153 ^{††} (19.0)	203 (23.9)~	243 (23.6) ັ	270 ^{††} (22.2)
Concurrent other STI (not HIV)	35 (6.4)	28 ⁺ (3.6)	43 (4.9)	49 [‡] (6.1)	55 (6.5)	41 [†] (4.8)	48 ^{††} (6.0)	53 (6.2) ^{††}	67 (6.5)	90 ^{††} (7.4)
No concurrent STI	433 (79.3)	579 (74.3)	638 (72.9)	564 (70.6)	603 (71.7)	640 (75.2)	605 (75.1)	593 (69.9)	721 (69.9)	859 (70.7)
Unknown	820	987	1027	1127	1153	1300	1328	1811	2217	2084
HIV status [*]										
Positive	N/D	48 (15.5)	141 (17.6)	104 (13.5)	144 (17.6)	172 (19.3)	132 (15.3)	156 (15.9)	188 (15.4)	224 (15.7)
Negative	N/D	262 (84.5)	661 (82.4)	668 (86.5)	675 (82.4)	720 (80.7)	733 (84.7)	823 (84.1)	1029 (84.6)	1204 (84.3)
Unknown	N/D	556	1100	1155	1175	1259	1269	1681	2031	1871
Probable country of infection										
Same as reporting country	N/D	151 (90.4)	700 (95.0)	790 (92.3)	764 (94.1)	552 (94.0)	800 (92.2)	614 (87.0)	795 (88.6)	1155 (87.6)
Different from reporting country	N/D	16 (9.6)	37 (5.0)	66 (7.7)	48 (5.9)	35 (6.0)	68 (7.8)	92 (13.0)	102 (11.4)	163 (12.4)
Unknown	N/D	1599	1165	1071	1182	1564	1266	1954	2351	1981

Percentages calculated from known values.

Cells shaded in blue indicate a significant difference in proportion compared to previous year (p < 0.05)

* Includes one individual of unknown gender, but with mode of transmission reported as heterosexual.

^{*t*} Includes two individuals with two concurrent STIs

^{*tt*} Includes four individuals with two concurrent STIs

[°]Includes three individuals with two concurrent STIs

⁺ Includes six individuals with chlamydia and an additionally diagnosed STI.

**Includes thirteen individuals with chlamydia and an additionally diagnosed STI.

^ Includes one individual of unknown gender, but with mode of transmission reported as MSM.

* Includes two individuals of unknown gender, but with mode of transmission reported as MSM

~ Includes nine individuals with chlamydia and an additionally diagnosed STI

The age of the patients ranged from <1 year to 86 years, with a median of 30 years. Males (median age 31 years) were significantly older than females (median age 24 years) (Mann-Whitney p<0.001) (Table 2).

Maxiable	NI-L	Age (years)	
variable		Range	Median	<25 years N (%)
All patients	3299	0-86	30	925 (28.0)
Female	482	0-67	24	254 (52.7)
Male*	2795	10-86	31	670 (24.0)
Male heterosexual	590	15-68	29	182 (30.8)
MSM	1177	16-69	31	238 (20.2)

Table	2. Patient ad	ae distribution	by (gender and	l sexual	orientation	2018
labic	Z. Fatient ay	ge alstribution	Dy 1	genuer and	i Schuai	oncation	2010

† Where information was available.

* Including all males, irrespective of sexual orientation.

As in previous years, the majority of patients for whom a clinical service type was known had attended a dedicated STI or sexual health clinic. There was a significant increase in patients from this service type between 2017 (47.9%) and 2018 (59.7%) (p<0.01). This increase is largely attributable to the increase in reporting for this variable in Spain which recorded 189 isolates from STI clinics in 2018 compared to 2017 when only four isolates from STI clinics were reported, with 409 unknowns. There was a significant decrease in the number of patients attending primary care facilities, 3.2% in 2018 vs 9.1% in 2017 and 6.5% in 2016 (p<0.002). This decrease is largely attributable to a change in clinic type in Germany which recorded 100 patients attending primary care facilities in 2017. There was a significant increase in the number of patients who attended 'other' service types in 2018 compared to 2017, with an increase from 3.1% to 4.5% (p=0.03). Attendance at outpatient clinics remained consistent compared to 2017 at 8.5%.

3.2 Antimicrobial susceptibility and resistance

Resistance to cefixime, ciprofloxacin and azithromycin (using the previously recommended EUCAST azithromycin >0.5 mg/L breakpoint) over time is summarised in Figure 1 and Table 3.

Figure 1. Percentage of resistant *Neisseria gonorrhoeae* by antimicrobial and year, Euro-GASP, 2009–2018



Azithromycin data is presented using the historical EUCAST >0.5 mg/L resistance breakpoint in figure one and table three.

	Method of testing	N	Decentralised – MGS	Decentralised – MIC	Centralised – MGS	Decentralised – MGS	Centralised – MGS	Decentralised – MGS	Centralised – MGS	Decentralised – BKP	Decentralised – MGS	Decentralised – MGS	Decentralised – MGS	Centralised - MGS	Decentralised – MGS	Decentralised – MGS	Decentralised – MGS	Centralised – MGS	Decentralised – MGS	Decentralised – MGS	Decentralised – MGS	Centralised – MGS	Centralised – MGS	Decentralised – MGS	Centralised – MGS	Decentralised – MGS
	cin	% 2009- 2018	mar.	and a second		1 mm	1		\sim	/	\sum			A A A	\sim	and the second se	The second		\			\sim	\bigvee	Yw.	Sarahara a	
	Ciprofloxa	%	56.6	44.4	80.0	60.0	49.5	41.2	42.9	51.2	63.3	61.2	56.6	39.3	48.9	60.1	55.0	60.0	0.0	76.0	42.0	55.6	50.7	32.8	35.1	55.5
	U	No.	151	80	8	ε	47	47	ε	86	69	123	47	35	22	119	55	3	0	19	169	70	37	40	27	86
e	ain	% 2009- 2018			~	$\langle \langle \langle \rangle$	7		Ť	/	2		\langle			Z			Ŧ		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	J~~~	\leq		\sim	~~~~
Resistan	Azithromyo	%	14.2	14.4	60.0	20.0	21.1	7.9	0.0	11.3	14.7	13.9	1.2	13.5	17.8	8.0	36.0	0.0	0.0	20.0	10.7	24.6	8.2	17.2	6.5	7.7
	đ	No.	38	26	9	1	20	6	0	19	16	28	1	12	8	16	36	0	0	5	43	31	9	21	5	12
		% 2009- 2018		\leq	~	Ì	<		ŧ	1	\$	Z	- V	52	•	J.				\sim		The second	\sim	V	\sim	λ_{mn}
	Cefixime	%	3.4	2.9	0.0	20.0	1.1	0.0	0.0	0.0	0.0	1.0	6.0	2.2	0.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	1.4	0.0	0.0	0.0
		No.	6	5	0	1	1	0	0	0	0	2	ъ	2	0	0	5	0	0	0	0	0	1	0	0	0
Alumbor of	isolates	2009-2018	. <u></u>	<u> / · · · · · · · · · · · · · · · · · · </u>	\geq		\checkmark	$\sim \sim $	~	•	\sim	، مسلمان			and and		\square		1	\sim		\sim	\sim		Sum	معمومومومو
Number	of	isolates 2018	267	180	10	2	95	114	7	168	109	201	83	89	45	200	100	5	1	25	402	126	73	122	77	155
	Country		Austria	Belgium	Croatia	Cyprus	Czech Republic	Denmark	Estonia	Finland	France	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Slovakia	Slovenia

Table 3. Resistance to cefixime, ciprofloxacin and azithromycin (using the previously recommendedEUCAST azithromycin resistance breakpoint), by country, Euro-GASP, 2018

SURVEILLANCE REPORT

	Number	Number of					Resistan	e				
Country	of	isolates		Cefixime		A	zithromyo	cin	U	Siprofloxa	ain	Method of testing
	isolates 2018	2009-2018	No.	%	% 2009- 2018	No.	%	% 2009- 2018	No.	%	% 2009- 2018	
Spain	189	\bigvee	6	4.8	Jun June	33	17.5	\searrow	96	50.8		Decentralised – MGS
Sweden	200	1	3	1.5	A	17	8.5	くく	120	60.0		Decentralised – MGS
United Kingdom	251	mark	ĸ	1.2		29	11.6	\sim	86	39.0	\sim	Decentralised – MIC/BKP/MGS
Total:	3299	and a second										
Cefixime	3289		46	1.4	A A A A A A A A A A A A A A A A A A A							
Ciprofloxacin	3297								1660	50.3		
Azithromycin	3299					438	13.3					
95% CI				1.0-1.9			12.2- 14.5			46.0- 49.4		

Table 3. Resistance to cefixime, ciprofloxacin and azithromycin (using the previously recommended EUCAST azithromycin resistance breakpoint), by country, Euro-GASP, 2018 (continued)

N/T: not tested; BKP: Breakpoint; MGS: MIC gradient strip test; MIC: MIC by agar dilution

Three isolates displayed ceftriaxone resistance in 2018 compared to zero in 2017 and 2016 (Figure 2). One resistant isolate was detected in Germany, with a ceftriaxone MIC=0.25 mg/L, azithromycin MIC=0.5 mg/L and ciprofloxacin MIC=32 mg/L. Both country of birth and probable country of infection were unknown for this patient. Two resistant isolates were detected in Spain, one was extensively-drug resistant (XDR), with a ceftriaxone MIC=0.25 mg/L, azithromycin MIC=16 mg/L and ciprofloxacin MIC=0.064 mg/L; the other Spanish isolate had a ceftriaxone MIC=0.5 mg/L, azithromycin MIC=0.25 mg/L and ciprofloxacin MIC=32 mg/L. The countries of birth for both patients in Spain were unknown; the probable country of infection was recorded as Spain. The MIC distribution for ceftriaxone in 2018 showed no significant changes compared to 2017.





Cefixime resistance has remained stable at around 2% since 2014 (p=0.09 (Figures 1 and 3, Table 4). There has been a significant increase in the number of isolates with a cefixime MIC ≤ 0.016 mg/L (77.0% in 2018 vs 73.0% in 2017, p<0.002) and a significant decrease in isolates with a cefixime MIC 0.032 mg/L compared to 2017 (11.1% in 2018 vs 14.3% in 2017, p<0.002) (Figure 3). There has been an increase in the number of isolates with a cefixime MIC ≥ 0.5 mg/L, from three in 2017 to five in 2018 – although these numbers are too low to test for statistical significance. Percentages of cefixime-resistant isolates in 2018 by country are shown in Map 1.



Map 1. Proportion of gonococcal isolates with cefixime resistance by country, EU/EEA, 2018

Figure 3. Distribution of MIC for cefixime in Euro-GASP, 2009–2018



Cefixime resistance in isolates from patients by sexual orientation and gender was stable (no significant differences) in 2018 compared to 2017 (Figure 4). Cefixime resistance was significantly higher in isolates from heterosexual males and females compared to MSM (p<0.01, Fisher's exact test). There was a higher proportion of

genital isolates with cefixime resistance compared to other anatomical sites (p=0.02, Fisher's exact test) (Annex 2).





A total of 251 isolates (7.6%) had an MIC of >1 mg/L (EUCAST ECOFF) to azithromycin. Using the previously recommended EUCAST clinical resistance breakpoint of >0.5 mg/L, there was a large increase to 13.3% from the previously stable 7%–8% observed from 2014 to 2017 (p<0.0002) (Figure 1; Table 4). Five isolates displayed 'high-level azithromycin resistance' with MICs of \geq 256 mg/L, compared to seven in 2017 and seven in 2016. These five isolates were comprised of one isolate from Cyprus, one from Ireland, one from Italy, one from the Netherlands and one from the United Kingdom. The United Kingdom is the only country that has identified a 'highlevel azithromycin resistant' isolate in each consecutive year (2016–2018). All five isolates were susceptible to the other antimicrobials tested, except for ciprofloxacin to which three were resistant and one was susceptible to increased exposure (0.06 mg/L). The MIC distribution for azithromycin in 2018 was different to previous years, with a significant decrease in the number of 'highly susceptible' isolates with an MIC ≤ 0.016 mg/L (p< 0.002) and isolates with MIC=0.25 mg/L (p=0.04). Seventy one percent of isolates above the ECOFF had an MIC of 2 mg/L, and 42.7% of isolates previously classified as resistant (>0.5 mg/L) had MICs of 1 mg/L. The modal MIC continued to be 0.25 mg/L in 2018 (Figure 5). In 2018, isolates with an azithromycin MIC >0.5 mg/L (previously recommended EUCAST resistance breakpoint) were highest in male heterosexuals (13.6%), followed by MSM (12.3%), and lowest in females (9.7%) (Figure 6). No significant associations between patient demographics and azithromycin MICs of >0.5 mg/L and >1 mg/L (ECOFF) were identified (Annex 2).

Map 2. Proportion of gonococcal isolates with azithromycin MICs >0.5 mg/L (previously recommended EUCAST resistance breakpoint) by country, EU/EEA, 2018



Map 3. Proportion of gonococcal isolates above azithromycin ECOFF (>1 mg/L) by country, EU/EEA, 2018





Figure 5. Distribution of MIC for azithromycin in Euro-GASP, 2011–2018

* 3 299 isolates were susceptibility tested with azithromycin in 2018; 66 isolates had an MIC≤0.06 mg/L. These isolates were excluded from the MIC distribution analysis as they did not fit into one discrete category.





Overall, ciprofloxacin resistance levels in 2018 (50.3%; 1660/3297) significantly increased (p<0.01) from those observed in 2017 (46.5%) and 2016 (46.5%) (Figure 1). In a change from 2017, resistance was highest among MSM (53.5%) and lowest in females (41.4%). Following multivariable analysis, ciprofloxacin resistance remained associated with isolates from MSM compared to male heterosexuals (OR 1.26, CI 1.03–1.54, p=0.02) and the absence of a concurrent chlamydial infection (OR 1.4, CI 1.07-1.85, p=0.01) (Annex 2).

Figure 7. Percentage of isolates with ciprofloxacin resistance by gender and male sexual orientation, Euro-GASP, 2009–2018



3.3 Diagnostic tests and treatments used

Data on the type of diagnostic test are summarised in Table 5. Culture alone was used in 2016 cases; this was the most common diagnostic test (95.1% of all cases), which is comparable to 2017 (95.9%), 2016 (92.7%) and 2015 (90.2%). To identify *N. gonorrhoeae*, NAAT testing alone was used in 85 cases and microscopy alone in 15 cases.

Table 4. Initial diagnostic tests used for isolates submitted in 2018

	Culi	ture	NA	AT	Micro	scopy
	No.	%	No.	%	No.	%
Primary diagnostic test only	2016	81.2	85	3.4	15	0.6
Primary test plus other diagnostic tests	346*	13.9	318†	12.8	140‡	5.6
Total	2362	95.1	403	16.2	155	6.2

* Includes 50 tests with microscopy, 178 with NAAT and 118 with both microscopy and NAAT

† Includes 178 tests with culture, 22 with microscopy and 118 with culture and microscopy

‡ Includes 50 tests with culture, 22 with NAAT and 118 with culture and NAAT





Antimicrobial treatements

Note: Thirty-eight different combinations/concentrations of antimicrobials were recorded in 2018, only treatments with \geq 2.5% in any gender/ transmission group are shown (differences in concentration of antimicrobials prescribed have been grouped for analysis). Only 859 patients were recorded as having no concurrent STI, of these patients, data for treatment used were available for 80.1% (n=688) patients. The chart presents data for the 688 patients with no concurrent STI and a recorded treatment type.

Data on used type of treatment were known in 1 264 cases, of which 688 were recorded as having no other concurrent STI (Figure 8). As in 2017, the most common treatment was azithromycin alone (52%), followed by ceftriaxone and azithromycin (33.7%). Data on countries reporting treatment type and concurrent STI is presented in Table A1 (Annex 1).

4 Conclusions

Overall, resistance to extended-spectrum cephalosporins has been stable since 2014 (cefixime resistance ranged from 1.4% to 2.1% between 2014 and 2018). Three isolates displayed ceftriaxone resistance in 2018 (0.1%), compared to none in 2017 and 2016. These ceftriaxone-resistant isolates were detected in two different countries, and their antibiograms do not suggest clonality. One of the isolates was extensively drug resistant, with an azithromycin MIC=16 mg/L and ciprofloxacin resistance. Cefixime-resistant isolates were detected in 12 (44.4%) of the 27 countries reporting in 2018. Cefixime resistance continues to be lowest among MSM (0.2%) and highest in male heterosexuals (3.2%) and females (2.5%). Although the continuing low levels of cephalosporin resistance is promising, the detection of three ceftriaxone-resistant isolates is concerning because cephalosporins are the last remaining options for empiric first-line monotherapy. Among patients with no recorded concurrent STI and for whom treatment was reported, 86% were administered ceftriaxone with or without azithromycin, which is the same level as in 2017. The increased use of the recommended dual antimicrobial therapy (ceftriaxone plus azithromycin) or ceftriaxone high-dose monotherapy is promising and is likely to have contributed to the overall low-level of cephalosporin resistance.

The proportion of isolates above the azithromycin ECOFF (>1 mg/L) and above the previously recommended EUCAST azithromycin resistance breakpoint (>0.5 mg/L) significantly increased in 2018 (3.7% to 7.6% ECOFF; 7.5% to 13.3% >0.5 mg/L breakpoint, p<0.0002). This is a large change from the previously stable resistance rate despite the reported use of azithromycin monotherapy remaining the same in 2017 (2.9%) and 2018 (2.8%). It should be noted that the majority of isolates with an azithromycin MIC >1 mg/L (EUCAST ECOFF) are just above the ECOFF (71.3% had an MIC of 2 mg/L), and 42.7% of isolates previously classified as resistant (>0.5 mg/L) had MICs of 1 mg/L. Minor fluctuations in azithromycin MICs are expected because susceptibility testing is sensitive to minor differences in agar media composition, pH and CO_2 levels. However, the increase in azithromycin MICs is of concern. Ciprofloxacin resistance significantly increased (p<0.01) to 50.3% (46.5% in 2017). Neither azithromycin nor ciprofloxacin are recommended for monotherapy unless the isolates are first shown to be susceptible. The detection of an isolate in Spain with an azithromycin MIC >16 mg/L and both ceftriaxone and ciprofloxacin resistance is very concerning. This isolate came from a Spanish resident and the recorded probable country of infection was Spain. These findings deviate from other reported extensively resistant isolates which are largely connected to travel to south-east Asia.

MSM continue to have a lower risk of harbouring AMR isolates [12]; cefixime resistance in 2018 was detected in only 0.2% of MSM, compared to 3.2% in heterosexual males.

Given the increase in azithromycin MICs and the appearance of ceftriaxone resistance, the recently reviewed European response plan to control the threat of multidrug-resistant *N. gonorrhoeae* in Europe [4] should continue to be observed to identify and report treatment failures and ensure that gonorrhoea remains a treatable infection.

Euro-GASP has a major role in meeting the objectives of the response plan which include:

- Strengthening surveillance of gonococcal antimicrobial susceptibility in the EU/EEA Member States by
 providing sufficient epidemiological information to inform national treatment guidelines and public health
 interventions. Overall completeness of variables has increased from 58.2% in 2017 to 62.1% in 2018.
 Improvements in reporting are still required for many variables if statistical analysis of the linked
 susceptibility and patient data is to be robust.
- Ensure that appropriate capacity for culture and susceptibility testing in EU/EEA Member States is available
 or developed further. In addition, training in STI diagnostics and antimicrobial susceptibility testing should
 be provided and experts (and other staff related to the field) are encouraged to participate, where required,
 with the goal to eventually move towards decentralised testing.
- Effectively disseminate results from AMR surveillance in order to increase awareness and inform authorities, professional societies, clinicians and other healthcare workers and persons at risk about the threat of multidrug-resistant (MDR) and XDR *N. gonorrhoeae*. The Euro-GASP AMR surveillance data are freely accessible online via the ECDC surveillance atlas of infectious diseases [13]. Data are updated annually prior to the publication of the annual surveillance report. Data from the project are frequently published in peer-reviewed journals and presented at international conferences.
- Introduce strategies to reduce the burden of gonorrhoea, such as the implementation of appropriate gonorrhoea management, prevention, control. Strategic measures should also include AMR policies/guidelines, including an enhanced focus on high-risk groups, as well as mandatory reporting of gonorrhoea. Recommended therapies to treat gonorrhoea are supported by the Euro-GASP project. It is encouraging to see that the highly effective ceftriaxone, with or without azithromycin, was used in 86% (52% ceftriaxone alone; 34% plus azithromycin) of cases with known treatment and no concurrent STI. The same percentage was recorded in 2017. It is, however, of major concern that some patients continue to be inappropriately treated, for example with ciprofloxacin. This is particularly worrisome if patients harbour resistant strains: four resistant strains from 13 patients were treated with ciprofloxacin.

Even though Euro-GASP detected stable levels of cefixime resistance in 2018, the increase in ciprofloxacin resistance, azithromycin MICs and the detection of three ceftriaxone resistant isolates are of major concern. Treatment failures have been documented [14, 15], along with sustained transmission of HLAziR strains [16] and the international spread of gonococcal strains with resistance to ceftriaxone [15-21]. It is therefore essential to continuously conduct quality-assured antimicrobial surveillance. In this context, adherence to the recently updated and refined response plan is essential. In addition, the development of alternative therapy regimens is urgently needed to ensure that gonorrhoea remains a treatable infection.

References

- 1. Bignell C, Unemo M. 2012 European guideline on the diagnosis and treatment of gonorrhoea in adults. Int J STD AIDS. 2013;24:85-92. Available from: <u>http://www.iusti.org/regions/Europe/pdf/2012/Gonorrhoea 2012.pdf</u>
- 2. Unemo M, Shafer WM. Antimicrobial resistance in *Neisseria gonorrhoeae* in the 21st century: past, evolution, and future. Clin Microbiol Rev. 2014;27:587-613.
- 3. Van de Laar M, Spiteri G. Increasing trends of gonorrhoea and syphilis and the threat of drug-resistant gonorrhoea in Europe. Euro Surveill. 2012;17:pii=20225.
- 4. European Centre for Disease Prevention and Control (ECDC). Response plan to control and manage the threat of multi-drug resistant gonorrhoea in Europe. Stockholm: ECDC; 2012. Available from: http://www.ecdc.europa.eu/en/publications/Publications/1206-ECDC-MDR-gonorrhoea-response-plan.pdf
- 5. Cole MJ, Spiteri G, Jacobsson S, Woodford N, Tripodo F, Amato-Gauci AJ, Unemo M; Euro-GASP network. Overall Low Extended-Spectrum Cephalosporin Resistance but high Azithromycin Resistance in *Neisseria gonorrhoeae* in 24 European Countries, 2015. BMC Infect Dis. 2017 Sep 11;17(1):617.
- 6. Day MJ, Spiteri G, Jacobsson S, Woodford N, Amato-Gauci AJ, Cole MJ, Unemo M; Euro-GASP network. Stably high azithromycin resistance and decreasing ceftriaxone susceptibility in *Neisseria gonorrhoeae* in 25 European countries, 2016. BMC Infect Dis. 2018 Dec 3;18(1):609.
- European Centre for Disease Prevention and Control (ECDC). Response plan to control and manage the threat of multi- and extensively-drug resistant gonorrhoea in Europe. Stockholm: ECDC; 2019. Available from: <u>https://www.ecdc.europa.eu/sites/default/files/documents/Tech-Rep_MXDR_gonorrhoea.pdf</u>
- European Centre for Disease Prevention and Control. Gonococcal antimicrobial susceptibility surveillance in Europe 2017. Stockholm: ECDC. 2017. Available from: <u>https://www.ecdc.europa.eu/sites/portal/files/documents/Euro-GASP%202017.pdf</u>
- 9. European Centre for Disease Prevention and Control (ECDC). Euro-GASP external quality assessment (EQA) scheme for *Neisseria gonorrhoeae* antimicrobial susceptibility testing. Stockholm: ECDC; 2018 Available from: <u>https://www.ecdc.europa.eu/sites/default/files/documents/Euro-GASP-EQA%202018.pdf</u>
- Cole MJ, Quaye N, Jacobsson S, Day M, Fagan E, Ison C, et al. Ten years of external quality assessment (EQA) of *Neisseria gonorrhoeae* antimicrobial susceptibility testing in Europe elucidate high reliability of data. BMC Infect Dis. 2019 Mar 25;19(1):281.
- European Committee on Antimicrobial Susceptibility Testing (EUCAST). Clinical breakpoint tables for bacteria. Available from: <u>http://www.eucast.org/fileadmin/src/media/PDFs/EUCAST_files/Breakpoint_tables/v_9.0_Breakpoint_Tables.</u> pdf
- 12. Cole MJ, Spiteri G, Town K, Unemo M, Hoffmann S, Chisholm SA, et al. Risk factors for antimicrobialresistant *Neisseria gonorrhoeae* in Europe. Sex Transm Dis. 2014;41:723-9.
- 13. European Centre for Disease Prevention and Control. Surveillance atlas of infectious diseases antimicrobial surveillance [internet]. Stockholm: ECDC; 2019 [accessed 31 March 2020]. Available from: https://atlas.ecdc.europa.eu/public/index.aspx?Dataset=27&HealthTopic=4
- 14. Fifer H, Natarajan U, Jones L, Alexander S, Hughes G, Golparian D, Unemo M. Failure of dual antimicrobial therapy in treatment of gonorrhea. N Engl J Med. 2016;374:2504-6.
- 15. Eyre DW, Sanderson ND, Lord E, et al. Gonorrhoea treatment failure caused by a *Neisseria gonorrhoeae* strain with combined ceftriaxone and high-level azithromycin resistance, England, February 2018. Euro Surveill. 2018;23(27):pii=1800323
- 16. Fifer H, Cole M, Hughes G, et al. Sustained transmission of high-level azithromycin resistant *Neisseria gonorrhoeae* in England; an observational study. Lancet Infect Dis. 2018; 18:573-581
- 17. Whiley DM, Jennison A, Pearson J, Lahra MM. Genetic characterization of *Neisseria gonorrhoeae* resistant to both ceftriaxone and azithromycin. Lancet Infect Dis. 2018;18:717-8.
- Lahra MM, Martin I, Demczuk W, Jennison AV, Lee KI, Nakayama SI, et al. Cooperative recognition of internationally disseminated ceftriaxone-resistant Neisseria gonorrhoeae strain. Emerging Infect Dis. 2018;24:735-40.
- 19. Terkelsen D, Tolstrup J, Johnsen CH, Lund O, Larsen HK, Worning P, et al. Multidrug-resistant *Neisseria gonorrhoeae* infection with ceftriaxone resistance and intermediate resistance to azithromycin, Denmark, 2017. Euro Surveill. 2017;22(42):1273.
- Poncin T, Fouere S, Braille A, Camelena F, Agsous M, Bebear C, et al. Multidrug-resistant *Neisseria* gonorrhoeae failing treatment with ceftriaxone and doxycycline in France, November 2017. Euro Surveill. 2018;23(21).

21. Harris SR, Cole MJ, Spiteri G, Sánchez-Busó L, Golparian D, Jacobsson S et al. Euro-GASP study group. Public health surveillance of multidrug-resistant clones of *Neisseria gonorrhoeae* in Europe: a genomic survey. BMC Infect Dis. 2019 Mar 25;19(1):281.

Annex 1. Percentage completeness of epidemiological variables

Table A 1. Completeness of epidemiological variable reporting, 2018

Country	Number of isolates	Gender	Age	Mode of transmission	Site of infection	Diagnostic test	Treatment	Previous gonorrhoea	Concurrent STI	Place of residence	Clinical service type	Country of birth	Probable country of infection	HIV status	Overall Percentage response rate
Austria	267	100.0	100.0	18.7	98.9	100.0	0.0	21.0	9.4	71.9	91.8	15.0	0.0	4.5	48.5
Belgium	180	98.9	95.0	36.1	90.6	0.0	0.0	38.9	0.0	0.0	23.3	31.1	20.6	35.6	36.2
Croatia	10	70.0	70.0	0.0	100.0	100.0	0.0	0.0	30.0	100.0	0.0	100.0	0.0	0.0	43.8
Cyprus	5	100.0	100.0	0.0	100.0	100.0	20.0	0.0	0.0	100.0	100.0	80.0	0.0	0.0	53.8
Czech Republic	95	100.0	100.0	86.3	95.8	100.0	85.3	85.3	80.0	87.4	100.0	95.8	87.4	83.2	91.3
Denmark	114	100.0	100.0	79.8	93.9	100.0	0.0	0.0	0.0	83.3	100.0	0.0	79.8	64.0	61.6
Estonia	7	100.0	100.0	57.1	100.0	100.0	0.0	0.0	100.0	100.0	100.0	0.0	0.0	0.0	58.2
Finland	168	100.0	100.0	91.7	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.6	88.7	0.0	36.8
France	109	100.0	99.1	34.9	99.1	100.0	0.0	0.0	45.9	71.6	100.0	38.5	42.2	56.9	60.6
Germany	201	99.0	98.5	0.0	96.0	100.0	0.0	0.0	0.0	100.0	60.2	0.0	0.0	0.0	42.6
Greece	83	98.8	90.4	88.0	95.2	100.0	89.2	89.2	10.8	84.3	100.0	0.0	86.7	13.3	72.8
Hungary	89	97.8	96.6	0.0	96.6	0.0	0.0	0.0	0.0	0.0	97.8	1.1	1.1	0.0	30.1
Iceland	45	100.0	100.0	66.7	93.3	100.0	0.0	0.0	95.6	88.9	97.8	91.1	0.0	100.0	71.8
Ireland	200	100.0	100.0	96.0	99.0	88.0	87.5	80.0	92.0	98.5	98.5	84.5	18.5	86.5	86.8
Italy	100	97.0	93.0	76.0	98.0	100.0	75.0	72.0	71.0	86.0	100.0	88.0	61.0	69.0	83.5
Latvia	5	100.0	100.0	80.0	100.0	100.0	0.0	100.0	100.0	100.0	100.0	0.0	80.0	0.0	73.8
Luxembourg	1	100.0	100.0	0.0	100.0	100.0	0.0	100.0	0.0	100.0	100.0	0.0	0.0	0.0	53.8
Malta	25	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Netherlands	402	99.3	100.0	99.3	100.0	100.0	100.0	0.0	100.0	99.3	100.0	99.8	0.0	94.5	84.0
Norway	126	100.0	100.0	0.0	97.6	0.0	0.0	0.0	0.0	0.0	54.8	0.0	0.0	0.0	27.1
Poland	73	100.0	100.0	0.0	100.0	100.0	89.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0	45.3
Portugal	122	100.0	100.0	15.6	100.0	100.0	3.3	4.9	9.8	76.2	12.3	12.3	12.3	12.3	43.0
Slovakia	77	100.0	100.0	64.9	100.0	100.0	57.1	97.4	80.5	98.7	100.0	96.1	57.1	81.8	87.2
Slovenia	155	100.0	100.0	89.0	98.1	100.0	64.5	88.4	96.1	97.4	100.0	97.4	89.0	93.5	93.3
Spain	189	100.0	98.4	98.4	100.0	100.0	0.0	3.2	0.5	100.0	100.0	0.0	100.0	0.5	61.6
Sweden	200	100.0	100.0	94.5	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	97.0	0.0	37.8
United Kingdom	251	98.01	98.01	86.85	96.02	88.84	86.85	85.26	36.25	75.3	98.01	70.92	52.59	84.06	81.3
Average completeness	3299	99.4	98.7	63.1	92.8	75.3	38.3	29.8	36.8	66.4	76	47	40	43.3	62.1

Cell shading; green=100%, red=0%, blue=below average

Annex 2. Statistical tables

Table A 2. Univariate association of cefixime resistance/susceptibility and patient characteristics, Euro-GASP, 2018

	Cefixime resistance N (%, 95% CI)	Odds ratio	95% CI	P value
Site of infection (n=3057)				
Genital (2152)	40 (1.9, 1.4-2.5)			
Anorectal (569)	2 (0.4, 0.1-1.3)			0.02*
Pharyngeal (259)	2 (0.8, 0.2-2.8)			0.02
Other (77)	2 (2.6, 0.7-9.0)			
Sexual orientation and gender	(n=2260)			
MSM (1185)	2 (0.2, 0.0-0.6)			
Male heterosexual (595)	19 (3.2, 2.1-4.9)			<0.01*
Female (480)	12 (2.5, 1.4-4.3)			
Previous GC (n=981)				
Yes (263)	2 (0.8, 0.2-2.7)			0.26*
No (718)	14 (2.0, 1.2-3.2)			0.20*
Concurrent chlamydia (n=1213)				
Yes (269)	4 (1.5, 0.6-3.8)			0.08*
No (940)	4 (0.4, 0.2-1.1)			0.00*
HIV status (n=1424)				
Positive (224)	0 (0.0, 0.0-1.7)			0.37*
Negative (1200)	9 (0.8, 0.4-1.4)			0.57
Age (n=3253)				
<25 years (923)	13 (1.4, 0.8-2.3)	1		
≥25 years (2330)	31 (1.3, 0.9-1.9)	0.94	0.49- 1.81	0.86

* Expected value for one cell < 5, so Fisher's exact test performed

Table A 3. Univariate association of azithromycin MICs >0.5 mg/L (previously recommended EUCAST resistance breakpoint) and patient characteristics, Euro-GASP, 2018

	Azithromycin MIC >0.5 mg/L N (%, 95% CI)	Odds ratio	95% CI	P value
Site of infection (n=3061)				
Genital (2155)	275 (12.8, 11.4-14.2)	1		
Anorectal (570)	91 (16.0, 13.2-19.2)	1.3	1.00-1.68	0.05
Pharyngeal (259)	35 (13.5, 9.9-18.2)	1.07	0.73-1.56	0.73
Other (77)	8 (10.4, 5.4-19.2)	0.79	0.38-1.67	0.54
Sexual orientation and ge	ender (n=2264)			
MSM (1186)	146 (12.3, 10.6-14.3)	1		
Male heterosexual (595)	81 (13.6, 11.1-16.6)	1.12	0.84-1.50	0.44
Female (483)	47 (9.7, 7.4-12.7)	0.77	0.54-1.09	0.14
Previous GC (n=982)				
Yes (264)	35 (13.3, 10.3-15.2)	1.07	0.70-1.62	0.76
No (718)	90 (12.5, 9.7-17.9)	1		
Concurrent chlamydia (n=1215)				
Yes (270)	35 (13.0, 9.5-17.5)	1.07	0.72-1.61	0.73
No (945)	115 (12.2, 10.2-14.4)	1		
HIV status (n=1428)				
Positive (224)	24 (10.7, 7.3-15.4)	0.92	0.51-1.26	0.34
Negative (1204)	157 (13.0, 11.3-15.1)	1		
Age (n=3257)				
<25 years (925)	117 (12.7, 10.7-14.9)	0.27	0.74-1.18	0.6
≥25 years (2332)	311 (13.3, 12.0-14.8)	1		

Table A 4. Univariate association of azithromycin MICs above/below ECOFF (>1 mg/L) and patient characteristics, Euro-GASP, 2018

	Azithromycin ECOFF N (%, 95% CI)	Odds ratio	95% CI	P value
Site of infection (n=3061)				
Genital (2155)	163 (7.6, 6.5-8.8)	1		
Anorectal (570)	47 (8.3, 6.3-10.8)	1.1	0.78-1.54	0.59
Pharyngeal (259)	20 (7.7, 5.1-11.6)	1.02	0.63-1.66	0.93
Other (77)	5 (6.5, 2.8-14.3)	0.85	0.34-2.13	0.73
Sexual orientation and gender (n=2264)				
MSM (1186)	86 (7.3, 5.9-8.9)	1		
Male heterosexual (595)	45 (7.6, 5.7-10.0)	1.04	0.72-1.52	0.81
Female (483)	27 (5.6, 3.9-8.0)	0.76	0.48-1.18	0.22
Previous GC (n=982)				
Yes (264)	19 (7.2, 4.7-11.0)	1		
No (718)	52 (7.2, 5.6-9.4)	0.99	0.58-1.71	0.98
Concurrent chlamydia (n=1215)				
Yes (270)	15 (5.6, 3.4-9.0)	0.82	0.46-1.47	0.51
No (945)	63 (6.7, 5.2-8.4)	1		
HIV status (n=1428)				
Positive (224)	8 (3.6, 2.8-6.9)	0.48	0.23-1.01	0.05
Negative (1204)	86 (7.1, 5.8-8.7)	1		
Age (n=3257)				
<25 years (925)	72 (7.8, 6.2-9.7)	1.04	0.78-1.38	0.79
≥25 years (2332)	175 (7.5, 6.5-8.6)	1		

Table A 5. Univariate association of ciprofloxacin resistance/susceptibility and patient characteristics, Euro-GASP, 2017

	Ciprofloxacin resistance N (%, 95% CI)	Odds ratio	95% CI	P value
Site of infection (n=3059)				
Genital (2154)	1036 (48.1, 46.0-50.2)	1		
Anorectal (570)	317 (55.6, 51.1-59.6)	1.35	1.12-1.63	0.001
Pharyngeal (258)	144 (55.8, 49.7-61.7)	1.36	1.05-1.77	0.01
Other (77)	42 (54.55, 43.5-65.2)	1.29	0.82-2.04	0.27
Sexual orientation and gende	er (n=2262)			
MSM (1184)	634 (53.6, 50.7-56.4)	1.26	1.03-1.54	0.02
Male heterosexual (595)	284 (47.7, 43.7-51.7)	1		
Female (483)	200, (41.4, 37.1-45.9)	0.77	0.61-0.99	0.04
Previous GC (n=980)				
Yes (262)	134 (51.2, 45.1-52.5)	1.09	0.82-1.45	0.5
No (718)	351 (48.9, 45.2-52.5)	1		
Concurrent chlamydia (n=1213)				
Yes (270)	115 (42.6, 36.8-48.6)	1		
No (943)	482 (51.1, 47.9-54.2)	1.4	1.07-1.85	0.01
HIV status (n=1426)				
Positive (223)	109 (48.9, 42.4-55.4)	1.02	0.77-1.36	0.03
Negative (1203)	581 (48.3, 45.5-51.1)	1		
Age (n=3255)				
<25 years (925)	431 (46.6, 43.4-49.8)	1		
≥25 years (2330)	1207 (51.8, 49.7-53.8)	1.23	1.06-1.44	0.007

European Centre for Disease Prevention and Control (ECDC)

Gustav III:s Boulevard 40, 16973 Solna, Sweden

Tel. +46 858601000 Fax +46 858601001 www.ecdc.europa.eu

An agency of the European Union www.europa.eu

Subscribe to our publications www.ecdc.europa.eu/en/publications

Contact us publications@ecdc.europa.eu

Follow us on Twitter @ECDC_EU

• Like our Facebook page www.facebook.com/ECDC.EU

