Epidemiology of Cryptosporidiosis in North American Travelers to Mexico

Parvathy Nair, Jamal A. Mohamed, Herbert L. DuPont, Jose Flores Figueroa, Lily G. Carlin, Zhi-Dong Jiang, Jaime Belkind-Gerson, Francisco G. Martinez-Sandoval, and Pablo C. Okhuysen*

The University of Texas Health Science Center at Houston Medical School and School of Public Health, Houston, Texas; Baylor College of Medicine, Houston, Texas; Instituto Nacional de Salud Publica, Cuernavaca, Mexico; Universidad Autonoma de Guadalajara, Jalisco, Mexico

Abstract. We studied 1,179 North American travelers who visited Mexico from 2005 to 2007. Travelers’ diarrhea (TD) was reported by 521 (44%) participants. Among subjects with TD, 218 cases were examined for cryptosporidiosis by polymerase chain reaction (PCR) and enzyme-linked immunoassays (ELISA). There were 14 (6%) cases of cryptosporidiosis and 141 cases (64%) of bacterial diarrhea. Compared with bacterial diarrhea, a longer stay in Mexico was a risk factor for cryptosporidiosis. Additionally, Cryptosporidium cases passed greater number of watery stools (P < 0.05), suffered more episodes of diarrhea (P ≤ 0.05), and were more likely to experience tenesmus (P ≤ 0.05) compared with bacterial causes of TD. ELISA detected seven (3%) cases of Cryptosporidium, whereas PCR identified an additional seven cases (6%). Speciation by 18SrRNA sequencing showed that 13 cases were caused by C. parvum and only 1 case was caused by C. hominis. ELISA showed a sensitivity of 50% and specificity of 100% compared with PCR.

INTRODUCTION

Travelers’ diarrhea (TD) affects 20–50% of persons from developed nations who visit developing countries. Although bacterial pathogens as a group are the most common cause of acute diarrhea in travelers, parasites have been associated with persistent and chronic diarrhea. Common causal organisms of parasitic diarrhea in travelers are Cryptosporidium spp., Giardia spp., and Entamoeba spp. Travel acquired parasitic infections are often insidious in onset, and because of long incubation periods, are often diagnosed on return to the original country of departure.

In adults, seropositivity to Cryptosporidium is an indicator of past or recent infection and is also a marker of partial protection against the parasite. The rate of seropositivity in US adults is ~25% in contrast to 64% among the Latin American urban population.

Over the past two decades, the methods for Cryptosporidium detection have advanced from simple acid-fast staining to enzyme-linked immunoassays (ELISA), and immunofluorescent assays (IFA) to molecular techniques based on polymerase chain reaction (PCR) amplification of specific gene loci. Fecal ELISA is a quick, easy, and convenient method to test large numbers of stools specimens that has found wide application in clinical settings. Several studies have documented a high sensitivity for DNA PCR-based methods in detecting Cryptosporidium in fecal samples. Although technically more demanding, the nested PCR based on the 18S rRNA gene followed by direct sequencing offers the added advantage of characterizing the infecting organism at the species level.

Cryptosporidiosis is a common disease in Mexican children, as evidenced by a study done in infants with severe diarrhea, where 41% were found to be infected with Cryptosporidium. In many instances, the infection is asymptomatic, particularly in older children. In a previous study conducted by our group on 127 US travelers to Mexico and 183 Mexican adults with diarrhea, cryptosporidiosis as determined by ELISA was more commonly seen in US travelers than in Mexican residents (3% versus < 1%). Another study found a 7% Cryptosporidium isolation rate among 87 adult travelers to Mexico. Although epidemiologic features of Cryptosporidium in human outbreaks has been well described, there are few studies on the clinical characteristics, epidemiology, and genotypes of Cryptosporidium that affect international travelers.

The aim of our study was to characterize the clinical features and risk factors associated with cryptosporidiosis among US travelers to Mexico. We compared the detection rate of Cryptosporidium with ELISA to the detection rate with PCR followed by direct sequencing.

MATERIALS AND METHODS

Human subjects. Participants were travelers from North America who visited the Mexican cities of Cuernavaca and Guadalajara between June 2005 and January 2007 to learn the Spanish language. The eligibility for participation entailed a minimum age of 16 years after parental consent or being an adult with informed consent, good health, and a stay of at least 5 days in Mexico. Subjects with known pre-existing irritable bowel syndrome, lactose intolerance, or pregnancy or those taking antibiotic prophylaxis for TD were excluded from the study.

Recruitment and management. Students were enrolled within 72 hours of arrival at Mexico. The cohort was observed for the incidence, severity, and etiology of diarrhea while in Mexico. Participants who had soft unformed or watery stools at a frequency of three or more times in a 24-hour period were asked to contact the study personnel and report to the clinic within 72 hours for stool sample collection. Fecal samples from travelers matched for age, sex, and duration of stay were studied as a control group. This study was approved by the University of Texas Committee for the Protection of Human Subjects.

Laboratory procedures. For detection of enteric pathogens, stools were cultured for Shigella spp., Salmonella spp., Providence spp., Plesiomonas spp., Serratia spp., and Campylobacter spp. Enterotoxigenic Escherichia coli was identified by
PCR. The first PCR was performed in a 1:10 reaction volume with QIAamp DNA stool mini kit (Qiagen, Valencia, CA) following the manufacturer’s instructions.

**PCR for cryptosporidiosis.** An aliquot of stools was frozen for PCR studies. DNA extraction from stools (2 mg of frozen stools or 200 μL of liquid stools) was carried out with QIAamp DNA stool mini kit (Qiagen, Valencia, CA) following the manufacturer’s instructions. The small subunit of the *C. parvum* 18S rRNA gene was amplified by a two-step nested PCR protocol. Amplification of a PCR product of 833 bp was determined by HEp2 cell adherence assay or by colony PCR or colony hybridization, whereas enteropathogenic *E. coli* were detected by HEp2 cell adherence assay or by colony PCR. Stool samples were examined for the presence of cryptosporidiosis by a commercially available microplate ELISA kit (Remel ProSpecT, Lenexa, KS) following the manufacturer’s instructions.

**RESULTS.** Among the 1,179 eligible students who traveled to Mexico between June 2005 to January 2007, 521 (44.19%) developed TD (Table 1). There was no difference in the proportion of TD by sex. US travelers with Asian ancestry displayed a lesser predisposition to develop diarrhea in Mexico. The risk for TD was associated to traveler’s age, length of stay, and season of travel. There was a 2% decrease in risk of diarrhea for every 1-year increase in age (odds ratio [OR], 0.98; 95% confidence interval [CI], 0.97–0.99; *P* < 0.001) and a 3% increase in risk for diarrhea with every additional day of stay in Mexico (OR, 1.03; 95% CI, 1.02–1.05; *P* < 0.001). We also noted that travel during months of March to September was associated with an increased frequency of diarrhea compared with travel during October to February (OR, 2.19; 95% CI, 1.55–3.07; *P* < 0.001).

A subset of 218 travelers with TD, in whom *Cryptosporidium* ELISA and fecal PCR for *Cryptosporidium* were done, was analyzed further in this study. Overall, *Cryptosporidium* was detected in 14 (6%) stools examined. ELISA detected seven (3%) cases of cryptosporidiosis. In contrast, an additional seven cases were identified by PCR (*P* = 0.12; Table 2). Bacterial pathogens were isolated from 141 (66%) cases. Enteropathogenic *E. coli* (N = 102; 47%) was the predominant pathogen, followed by enterotoxigenic *E. coli* (N = 62; 28%). Other bacterial pathogens isolated were *Salmonella*

### Table 1

Demographic features of US travelers to Mexico and risk factors for acquiring travelers’ diarrhea

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Healthy (N = 668)</th>
<th>Diarrhea (N = 521)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td><strong>N</strong></td>
<td><strong>Percent</strong></td>
</tr>
<tr>
<td>Females (N = 861)</td>
<td>491</td>
<td>74.6</td>
</tr>
<tr>
<td>Males (N = 318)</td>
<td>167</td>
<td>25.4</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanics (N = 133)</td>
<td>76</td>
<td>11.6</td>
</tr>
<tr>
<td>Non-Hispanics (N = 1046)</td>
<td>582</td>
<td>88.5</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whites (N = 1056)</td>
<td>581</td>
<td>88.3</td>
</tr>
<tr>
<td>African Americans (N = 71)</td>
<td>44</td>
<td>6.7</td>
</tr>
<tr>
<td>Asians (N = 29)</td>
<td>21</td>
<td>3.2</td>
</tr>
<tr>
<td>Others (N = 23)</td>
<td>12</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Season</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>October–February (N = 187)</td>
<td>133</td>
<td>20.2</td>
</tr>
<tr>
<td>March–September (N = 992)</td>
<td>525</td>
<td>79.8</td>
</tr>
<tr>
<td><strong>Length of stay (days)</strong></td>
<td>21.4 ± 9.1*</td>
<td>24.3 ± 9.6*</td>
</tr>
<tr>
<td><strong>Age (years)</strong></td>
<td>32.5 ± 14.3*</td>
<td>29.6 ± 12.8*</td>
</tr>
</tbody>
</table>

* Student t test: means ± SD.
spp. (N = 7; 3%), Campylobacter spp. (N = 2; <1%), and Pleisomonas spp. (N = 1; 0.5%). Multiple bacterial pathogens were identified from 33 (15.1%) of stools examined.

No significant differences were noted in terms of age, race, ethnicity, or sex between bacterial cases and Cryptosporidium diarrhea. Of interest, the proportion of men with cryptosporidiosis was higher in the bacterial subgroup (43% versus 28%; P = 0.23). A longer period of stay in Mexico was significantly associated with an increased risk of TD caused by Cryptosporidium (OR, 1.07; 95% CI, 1.03–1.13; P = 0.008) compared with bacterial diarrhea. Most cases of cryptosporidiosis and bacterial TD occurred between June and August.

The clinical characteristics of the TD cases categorized by cause of diarrhea are depicted in Table 3. Students infected with Cryptosporidium had greater numbers of episodes (P = 0.05) and passed more unformed (P = 0.07) and watery stools (P = 0.02) than TD caused by bacterial agents. The time from day of arrival in Mexico to the onset of diarrhea after arrival in Mexico was similar in both groups. Among cryptosporidiosis cases, abdominal pain (N = 14; 100%) was the most common complaint. Other frequently experienced clinical features were flatulence (N = 12; 86%), urgency (N = 11; 79%), nausea (N = 8; 57%), and tenesmus (N = 7; 50%). Vomiting (N = 2; 14%) and fever (N = 3; 21%) were relatively infrequent symptoms. Presenting symptoms were similar for cases with Cryptosporidium and bacterial infection except for tenesmus (P = 0.05), which was more common in cases of Cryptosporidium.

Results of the DNA sequencing of the 18SrRNA gene showed that 13 of 14 (93%) cases were infected with Cryptosporidium parvum and only one with Cryptosporidium hominis. Using PCR followed by genetic sequencing as the gold standard, the sensitivity of ELISA was 50% and specificity was 100% (Table 3). The positive predictive value of ELISA was 100%, and the negative predictive value was 96.7%. Thirty-one matched controls were studied by ELISA and PCR; none of the control samples were positive by ELISA. Three C. parvum cases were identified among healthy controls by PCR.

**DISCUSSION**

In this prospective study done in US travelers to Mexico, the incidence of cryptosporidiosis was found to be 6.4%, which was similar to rate of cryptosporidiosis in Mexican children and comparable to the previous series of travelers with similar characteristics. Consistent with prior observations, we found that TD was more frequent among subjects who had a longer length of stay, were younger in age, and traveled during the summer season. Our data are consistent with existing literature that describes the above factors as known risk factors for TD.

Cryptosporidiosis manifested with greater numbers of episodes and watery stools compared with bacterial diarrhea. This may be explained by the use of empiric antibiotics to treat travelers with diarrhea. Symptoms experienced included abdominal pain, flatulence, and nausea in addition to diarrhea.

**Table 2**

Comparison of PCR followed by genotyping versus ELISA for Cryptosporidium detection

<table>
<thead>
<tr>
<th>Method</th>
<th>No of samples examined</th>
<th>No of positives detected</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
<th>Positive predictive value (%)</th>
<th>Negative predictive value (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR*</td>
<td>218</td>
<td>14</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>ELISA</td>
<td>218</td>
<td>7</td>
<td>50</td>
<td>100</td>
<td>100</td>
<td>97.6</td>
</tr>
</tbody>
</table>

* PCR followed by genotype sequencing.
† Calculated as [number of true positives/(number of true positives + number of false negatives)].
‡ Calculated as [number of true negatives/(number of true negatives + number of false negatives)].
§ Calculated as [number of true positives/(number of true positives + number of false positives)].
¶ Calculated as [number of true negatives/(number of true negatives + number of false negatives)].

**Table 3**

Epidemiologic and clinical features of bacterial TD compared with Cryptosporidium TD

<table>
<thead>
<tr>
<th>Variable</th>
<th>Bacterial diarrhea (N = 141)</th>
<th>Cryptosporidium* (N = 14)</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical features</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Episodes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single (N = 114)</td>
<td>107</td>
<td>7</td>
<td>0.23</td>
</tr>
<tr>
<td>Multiple (N = 41)</td>
<td>34</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>Total unformed stools/100 days of stay</td>
<td>84.3 (72.2–96.4)†</td>
<td>121.1 (86.2–155.9)†</td>
<td>0.07</td>
</tr>
<tr>
<td>Total watery stools/100 days of stay</td>
<td>40.8 (31.6–50.0)†</td>
<td>76.4 (39.4–113.3)†</td>
<td>0.02</td>
</tr>
<tr>
<td>Onset after arrival in Mexico (days)</td>
<td>10.6 (9.3–11.8)†</td>
<td>9.3 (5.4–13.6)†</td>
<td>0.53</td>
</tr>
<tr>
<td><strong>Symptoms</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain (N = 130)</td>
<td>116</td>
<td>14</td>
<td>100.0</td>
</tr>
<tr>
<td>Flatulence (N = 118)</td>
<td>106</td>
<td>12</td>
<td>85.7</td>
</tr>
<tr>
<td>Nausea (N = 92)</td>
<td>84</td>
<td>8</td>
<td>57.1</td>
</tr>
<tr>
<td>Vomiting (N = 33)</td>
<td>31</td>
<td>2</td>
<td>14.3</td>
</tr>
<tr>
<td>Urgency (N = 116)</td>
<td>105</td>
<td>11</td>
<td>78.6</td>
</tr>
<tr>
<td>Tenesmus (N = 40)</td>
<td>33</td>
<td>7</td>
<td>50.0</td>
</tr>
<tr>
<td>Fever (N = 15)</td>
<td>12</td>
<td>3</td>
<td>7.1</td>
</tr>
</tbody>
</table>

* Includes the cases of cryptosporidiosis only and cryptosporidiosis with bacterial co-infection. Cryptosporidiosis cases in which bacterial enteropathogens were identified were counted once in the cryptosporidiosis group for analysis and were not included in the bacterial infection subgroup.
† Student t test: mean (95% CI).
in frequencies that correspond with observations in other studies. In our study, 10 of the 14 cases of Cryptosporidium diarrhea (71.4%) presented with bacterial co-infection. The common bacterial agents co-infected being enterotoxigenic E. coli and enterohemorrhagic E. coli.

Our findings are also consistent with a previous report on travel-associated cryptosporidiosis in German travelers, which found cryptosporidiosis to be associated with longer length of stay abroad. In our study, all cases of Cryptosporidium occurred in travelers who remained in Mexico for at least 2 weeks (P = 0.02). This likely reflects the longer incubation period needed for Cryptosporidium compared with bacterial causes of diarrhea. However, we also found that the mean time to onset for diarrhea after arrival in Mexico was comparable in both groups. A possible reason could be the high proportion of concomitant bacterial infections among the Cryptosporidium cases. The mean incubation period of Cryptosporidium is ∼9 days and some participants may have acquired the parasite on their last days of the visit. Hence, our study may underestimate the true number of cases of travel related cryptosporidiosis.

The distribution of the infecting species of Cryptosporidium varies according to the type of population studied and the geographic location. Studies have noted that differences in predominant infecting Cryptosporidium species relate to the level of urbanization, season studied, the immune status, and age of subjects considered. Studies in Europe and New Zealand have reported a predominance of the C. parvum species among human infections. In other series, a greater proportion of C. hominis has been reported from Thailand, the United States, and Japan. C. hominis has been frequently detected among children and HIV-positive adults in other Latin American studies. The high proportion of C. parvum compared with C. hominis seen in our study suggests that the source of infection may have been zoonotic in origin, although the possibility of person to person transmission cannot be ruled out. As far as we know, this is the first study on the speciation of infecting Cryptosporidium species acquired by US travelers to Mexico. Our subjects were healthy adult travelers, whereas previous Latin American studies focused on children and HIV-positive men. It is possible that the risk factors and modes of transmission are different among these study populations. There is a need for more extensive molecular studies with a larger number of cases to unravel the relationship between the distribution, epidemiology, and transmission routes of Cryptosporidium in travelers.

Cryptosporidium ELISA showed a higher specificity and sensitivity compared with conventional staining techniques. Because oocyst wall antigens are well conserved among most species in the Cryptosporidium genus, a limitation of the ELISA is its inability to identify the different infecting species. Although previous studies have noted high sensitivity rates for fecal PCR, the detection of Cryptosporidium spp. in environmental samples has a low sensitivity. The presence of bilirubin, bile salts, and other contaminants in fecal samples can inhibit the DNA extraction in PCR reactions, making the detection less accurate. We minimized this by adopting a DNA extraction protocol that remove DNases and facilitates the downstream enzymatic polymerase reaction (QiAamp; Qiagen). We also negated the likelihood of contamination in our study by the use of multiple negative controls during the reactions. The probability of underdetection was also decreased by the use of nested PCR, a method sensitive enough to detect <1 pg of C. parvum DNA in human stool.

Our study confirmed that the infection rates of cryptosporidiosis are underestimated by Cryptosporidium fecal ELISA. ELISA detected only 50% of the positive cases that were identified by PCR followed by genetic sequencing. A possible explanation could be that the parasite burden was lower in PCR-only positive cases, because the threshold for detection by PCR is thought to be ∼10–50 oocysts/g of stool in contrast to the 10–4 parasites needed for ELISA.

Being a highly infectious and ubiquitous parasite that can cause large outbreaks in healthy, immunocompromised persons and the elderly, a quick and reliable diagnosis along with knowledge of the infecting species are of great importance in the management of cryptosporidiosis. The use of molecular tools for the diagnosis of cryptosporidiosis coupled with the knowledge of the parasite’s epidemiology in travelers will promote the understanding of the factors influencing species transmission pathways and host susceptibility factors, which can aid in more targeted and successful interventions for prevention and control of cryptosporidiosis.

Received November 5, 2007. Accepted for publication May 30, 2008.

Acknowledgments: We thank Dorothy Ruelas, RN, Judy Guillen, RN, Margaret DuPont, MS, Jackie Vaca, RN, and the administration and staff of Universidad Internacional en Cuernavaca, Morelos, for assistance with this project.

Financial support: This work was supported by the following sources: NIHHDID R01 AI54948-01 (PCO), to the Center for Clinical and Translational Sciences of the University of Texas Health Science Center at Houston, NIHNRR U1LR024148 (CTSA), of the University of Texas Medical School at Houston, and DK56338, which funds the Texas Gulf Coast Digestive Diseases Center.

Disclosure: The authors report that there are no conflicts of interest related to this work.

Authors’ addresses: Parvathy Nair, Jamal A. Mohamed, Jose Flores Figueroa, and Lily G. Carlin, 6431 Fannin, MSB 7.510, Houston, TX 77030, Herbert L. DuPont and Zhi-Dong Jiang, 1200 Hermann Pressler Dr., Houston, TX 77030. Jaime Belkind-Gerson, Av. Universidad #655, Col. Santa Maria Ahuacacitlan CP 62508, Cuernavaca, Morelos, Mexico. Francisco G. Martinez-Sandoval, Av. Patria 1201, Lomas del Valle, 3ª seccion, Apartado postal 1440, CP 44100, Guadalajara, Jalisco, Mexico. Pablo C. Okhuysen, Division of Infectious Diseases, The University of Texas Medical School, 6431 Fannin Street, MSB 2.112, Houston, TX 77030, Tel: 713-500-6736, Fax: 713-500-5495, E-mail: Pablo.c.okhuysen@uth.tmc.edu.

REFERENCES


