# Supplementary Appendix

This appendix has been provided by the authors to give readers additional information about their work.

Supplement to: Bhatt AS, Freeman SS, Herrera AF, et al. Sequence-based discovery of *Bradyrhizobium enterica* in cord colitis syndrome. N Engl J Med 2013;369:517-28. DOI: 10.1056/NEJMoa1211115

## Supplementary appendix

## Supplement to: *Sequence-based discovery of Bradyrhizobium enterica in cord colitis syndrome*

#### Table of contents



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## **I. PathSeq results and genome assembly methods**

PathSeq classification of sequencing reads from colon-biopsy samples 5b, 5c, 11b and 11d revealed a large number of unclassifiable sequences (Table S1).

Sequencing reads from short fragment sequencing libraries (insert size 150 – 400bp) were pooled from temporally separated biopsies from each separate patient (5b + 5c and 11b + 11d) as well as all four patients  $(5b + 5c + 11b + 11d)$ . All paired-end sequences were treated as single-end reads and were run through the PathSeq algorithm for computational subtraction of human reads after quality filtering. All non-human reads from these samples and pair-mates of these non-human reads were also included in the assembly, regardless of the quality score of the pair-mate. Two separate computational assembly methods, Velvet<sup>1</sup> and ALLPATHS<sup>2,3</sup>, were employed, as previously described. ALLPATHS was developed as a tool for genome assembly using dual inputs of short fragment sequencing libraries and large fragment (jumping) libraries. In order to use ALLPATHS for assembly, reads were first assembled into a temporary genome. All paired-end reads were aligned using the Burrows-Wheeler alignment algorithm to this temporary genome and insert size was inferred based on alignment of reads pairs.<sup>4,5</sup> Paired-end reads were then split into "shorter" and "longer" fragment pools and were taken forward for formal ALLPATHS assembly. Both assembly methods assembled a total contig length (of contigs > 2.5kb) of greater than 7.5Mb when applied to the pooled set of reads from all four sequenced samples. The ALLPATHS assembly generated a longer set of contigs for sequences obtained from a single patient (patient 11) and was thus taken forward for further analysis. The results of the final assembly using nonhuman sequences from colon-biopsy samples 11b and 11d are presented in Table S2. Thus, the ALLPATHS assembly of sequences from patient 11, which consisted of a set of 99 contigs was taken forward as the draft genome.

Each contig of greater than 2.5kb was analyzed for percent GC content and read coverage. Contigs were analyzed by  $BLASTN<sup>6</sup>$  against the NCBI nt database and were defined by the top hit (that with the lowest E value; Figure S1).

## Each contig was plotted as a function of % GC and read coverage (Figure S2)

The BLASTN results of each individual contig were evaluated by our genome annotation team (ASB, SSF, CSP, SY, DG, AE, BW). The contig corresponding to the SEN virus was determined to be unlikely inserted into the novel organism's genome and was removed from the draft genome. The vast majority of the remaining contigs mapped to members of the family Bradyrhizobaceae and all other contigs mapping to other bacterial families were maintained in the draft genome due to similar coverage and GC content. As there are gaps in the draft genome, there remains the possibility that a small subset of these contigs is not a part of the true *B. enterica* genome. Future efforts to isolate, culture and complete the genome of this organism will be revealing in this regard, and will also illuminate the question of whether this organism has a circular or linear genome and whether it has a single chromosome or multiple chromosomes.

Contigs were taken forward for further assembly and from the 99 contigs, 90 scaffolds or supercontigs were generated (by end joining of contigs). One of these supercontigs (3,621bp) corresponded to the SEN virus and was excluded from further analysis.

============ Scaffold Stats ========================= Scaffolds 90 Max Scaffold 533,022 Mean Scaffold 84,997 Scaffold N50 155,300 Total Scaffold Length 7,649,768

SEN virus supercontig length 3,621 Total Scaffold number (minus SEN virus supercontig) 89 Total Scaffold Length (minus SEN virus supercontig) 7,646,147 ==

As the *B. enterica* genome was assembled from a complex human tissue sample, the genome has been submitted as a "multispecies" sample to the NCBI, as it was not derived from a isolated, purified culture or a true metagenomic sample. The strain has been designated DFCI-1 (Dana-Farber Cancer Institute-1) for the institution and location of care of cord colitis syndrome-affected patients.

## **II. Comparative genomic analysis and Circos plot construction**

In order to perform comparative genome analysis of *B. enterica*, genome annotation was carried out by PRODIGAL (as previously described and cited in the main manuscript). Gene annotations are available on NCBI.

The most closely related species in a phylogenetic analysis reported in the main text was *Bradyrhizobium japonicum* (strain USDA 110). In order to determine the homology between genes in *B. enterica* and *B. japonicum*, each PRODIGAL-predicted gene was compared to the *B. japonicum* amino acid sequence by peptide BLAST.<sup>6</sup> The full sequence of the top hit was extracted and the full-length genes were then aligned using the Needleman-Wunsch global alignment algorithm.<sup>8</sup> The percentage identity was then calculated for each gene. This value was plotted at the location of the gene on the circular genome plot in the main manuscript.<sup>9</sup> A histogram of global sequence identity by individual gene is provided (Figure S3).

*B. enterica* genes for which no homologous *B. japonicum* gene was found or for which the global amino acid sequence identity was less than 5% were identified and are plotted in the circular genome plot in the main manuscript. A list of the genes that are specific to *B. enterica* compared to *B. japonicum* is provided (Table S3). Note that the PRODIGAL algorithm is a highly specific method that conservatively assigns gene annotations, resulting in a significant number of hypothetical gene "calls".

## **III. Contamination analysis**

Several limitations are introduced by the execution of a single center study that may increase the likelihood of contamination including (1) common paraffin baths used for the generation of FFPE samples, (2) a common nosocomial microbiome, (3) FFPE block handling by a single laboratory, (4) preparation of libraries using very limited DNA in a single laboratory location.

The experimental method employed in this single-center study was designed to minimize the likelihood that the results obtained were due to a contaminant as follows: (1) FFPE colon biopsy samples from normal controls and post-stem cell transplantation GVHD controls processed at the same institution were included and did not demonstrate appreciable *B. enterica* by PCR. (2) Additional frozen colon cancer controls were also included in this analysis and did not demonstrate appreciable *B. enterica* by PCR. (3) DNA extraction for the samples that were sequenced was started on the same day but was completed on successive days. (4) Two different type of barcodes generated at different facilities were used to generate sequencing libraries. (5) Samples 5b+5c and 11b+11d were sequenced at two different sequencing facilities. (6) Buffers and ultrapure water used in the extraction of DNA and generation of the libraries were subjected to targeted PCR to investigate for *B. enterica* in the stock solutions used (Figure S4). (7) DNA extraction and sequencing library construction was carried out in a dedicated "clean area" away from lab areas where organisms are cultured. (8) As samples were very limited, the reserved "top scrolls" from two of the samples (samples 9d and 9e) were subjected to DNA extraction several months after the original extraction and *B. enterica* was present in both scrolls that were studied (Figure S4)*.* (9) Single nucleotide polymorphism analysis was limited by the reported intrinsic low polymorphism rate of organisms such as *Bradyrhizobium japonicum* USDA 110<sup>10,11</sup> and relatively low coverage of *B. enterica* for samples 5b+5c. Despite this, it appeared that there were at least five to 11 SNPs at an allelic fraction of at least 40% between *B. enterica* reads from patient 5 vs. patient 11. Additional intrinsic difficulties in evaluation for SNPs include the lack of a completed genome and the high GC content of the organism, which can lead to more frequent sequencing errors.

(10) All FFPE samples prepared for sequencing in our laboratory within four months of the cord colitis syndrome samples were analyzed by PathSeq for the presence of *B.*  enterica.Samples sequenced at the Broad sequencing facility with the Broad barcode set were found to have the following total number of *B. enterica* reads. Note that the bone marrow and spleen samples were sequenced on the same flow-cell as samples 11b and 11d. There is a known small amount of barcode contamination between the 96 barcodes used at the Broad sequencing facility and the number of reads that correspond to *B. enterica* in the bone marrow and spleen samples are therefore felt to represent crosscontamination from the cord colitis syndrome libraries. Note that bone marrow and spleen RNA samples also had *B. enterica* reads. Mapping of these reads onto the draft *B. enterica* genome was visualized in IGV 2.0.<sup>12</sup> May reads were found to map to intergenic regions of *B. enterica* suggesting that these reads correspond to contamination from the

cord colitis syndrome libraries and not RNA sequence present in the bone marrow and spleen samples, themselves.

Sample descriptions and names are followed by the number of total reads from the samples that map to *B. enterica* by Burrows Wheeler alignment of raw reads against the *B. enterica* draft genome*.* 4,5 Samples included in the analysis below have at least 20 million high quality sequencing reads per sample. No samples studied in the four months before or after cord colitis syndrome sample sequencing had more reads mapping to *B. enterica* than the aforementioned bone marrow and spleen samples (raw *B.* enterica read count noted below). Note that this method has much lower specificity for the identification of *B. enterica* reads than the PathSeq method, which competitively classifies reads against a large database of known microbes.

Below are the file names of the samples sequenced at the Broad on the same lane as samples 5b and 5c followed by the number of raw reads that map to *B. enterica*:

Bone marrow aspirate (frozen DNA) 1512 Bone marrow aspirate (frozen RNA) 1904 Spleen (frozen DNA) 3141 Spleen (frozen RNA) 2118

Below are the de-identified file names of human FFPE tissue specimens sequenced at the same facility as samples 11b and 11d followed by the number of raw reads that map to *B. enterica*:

CC-M-066\_unmapped.sam 4 CC-M-067\_unmapped.sam 8 CC-M-068\_unmapped.sam 52 CC-M-069\_unmapped.sam 13 CC-M-070\_unmapped.sam 3 CC-M-071\_unmapped.sam 48 CC-M-072\_unmapped.sam 4 CC-M-073\_unmapped.sam 2 CC-M-074\_unmapped.sam

 CC-M-075\_unmapped.sam CC-M-076\_unmapped.sam CC-M-077\_unmapped.sam 

# **IV. Viral reads in sequenced cord colitis syndrome samples**

Samples 5b, 5c, 11b and 11d were carried through PathSeq analysis, as described in the main text of the manuscript. Manually reviewed hits are presented in Table S4. A detailed list of all viral hits is also presented (Figure S5).

# **V. PCR conditions**

PCR was performed using 10 mM forward and reverse primers, 0.2 ng of input DNA and the AccuPrime Taq DNA polymerase system (Invitrogen, Grand Island, NY, USA) per manufacturer's directions in a total volume of 10 ml with the following cycle protocol: 95**°**C for 2 minutes, followed by 35 cycles of: 95**°**C for 30 seconds, 62.1**°**C for 30 seconds, 68**°**C for 40 seconds, and finally an extension at 68**°** C for 5 minutes. PCR was carried out on an Eppendorf AG Mastercycler Pro (Hauppauge, NY, USA).

## **VI. Fluorescence** *in situ* **hybridization methods**

FISH was carried out according to Swidsinski's method as follows.<sup>13,14</sup> Following sectioning and mounting of 5um FFPE tissue samples to glass slides, the paraffin embedded tissue was fixed to the slides by incubation at 50°C for 30 minutes. The slides were then deparaffinized by successive incubation in xylene baths (four incubations of five minutes each) followed by four washes in 100% ethanol for five minutes each. The slides were then incubated at 50°C for 25 minutes. A cold PAP pen was used to encircle the samples followed by incubation with 1mg/mL lysozyme (diluted in water) for 15 minutes. Oligonucleotide FISH probes were selected using probeBase (http://www.microbial-ecology.net/probebase/) and were custom synthesized by IDT. Details on oligonucleotide probes are available at probeBase.<sup>15</sup> Two probes were ordered, specific to a eubacterial 16S RNA sequence (EUB338, 5'-/Cy5/-GCT GCC TCC CGT AGG AGT-3') and specific to a Bradyrhizobium 16S RNA sequence (Brady, 5'-/Cy3/- CTG CCG CTG ACA TAT TGC TA-3'). The Brady target sequence was present in the *B. enterica* genomic sequence. Probes were diluted in water to a stock concentration of 50ng/mL and 0.5uL of probe was added to 50uL of hybridization buffer containing 1% formamide (0.88M NaCl, 20mM Tris HCl, pH 7.4, 0.05% SDS). The sample was incubated with the probe solution for 45 minutes at 50°C in a humid, pre-warmed chamber and in the dark. The slides were washed in a prewarmed wash buffer (900mM NaCl, 100mM Tris HCl, pH 7.4, 0.03% SDS) for five minutes. The slides were then washed with ddH<sub>2</sub>O and dried in a 50°C oven for five minutes. The slides were stained with 1ug/mL DAPI (450mM NaCl, 20mM Tris HCl, pH 7.4) and incubated for 5minutes in the dark. The samples were washed with  $ddH<sub>2</sub>O$  and dried at 50 $^{\circ}$ C for five minutes.

A competition assay as a negative control to test for specificity of the Brady probe was performed as follows. Prior to hybridization of the labeled probes, samples were incubated with a 100-fold molar excess of unlabeled Brady probe in hybridization buffer at 50°C for 45 minutes. This buffer was removed and fresh hybridization buffer containing both labeled probes as well as the unlabeled Brady probe at a 100-fold molar excess was applied to the sample. The sample was incubated at 50°C for 45 minutes. Thereafter, the same wash and DAPI staining steps were followed as noted above. Results of the competition assay, demonstrating high specificity of the Brady probe, are displayed in Figure S6.

Prior to visualization, AquaMount aqueous mounting medium (Cardinal Health, Dublin, Ohio) was applied to the sample and the sample was covered with a cover slip.

FISH and hematoxylin and eosin stained tissues were visualized and images captured using a Nikon Eclipse Ni microscope, DS-Qi1 monochrome camera for fluorescence or a DS-Fi2 color camera, and the NIS Elements BR imaging and software station. Exposure times were fixed and consistent for each individual fluor across all imaged samples. Images were pseudocolored and overlayed using the NIS Elements BR software station and cropped for figure generation using Adobe Photoshop CS5.

# **VII. Quantitation of** *Bradyrhizobium enterica* **in sequenced samples before and after antibiotics therapy**

The relative abundance of *B. enterica* before and after antibiotic therapy was calculated in the four samples that were sequenced. The number of *B. enterica* reads was corrected for the total number of human reads. This "relative abundance" was compared in the prevs. post-antibiotic therapy samples (5b and 11b were pre-antibiotics, 5c and 11d were post-antibiotics). A 6.4-fold reduction in *B. enterica* relative abundance was seen in patient 5 with the initiation of antibiotics. A 2.5-fold reduction in *B. enterica* relative abundance was seen in patient 11 with the initiation of antibiotics (Table S5).

# **VIII. Detection of** *Bradyrhizobium enterica* **in upper GI biopsies of cord colitis syndrome-affected patients and in post-HSCT colitis samples from Massachusetts General Hospital (MGH)**

In the original report of cord colitis syndrome, Herrera et al noted the presence of granulomas in selected upper GI biopsies of cord colitis syndrome-affected patients. Given this finding, we tested the hypothesis that *Bradyrhizobium enterica* may be the inciting organism of this host response by obtaining upper GI biopsies from patients of the original cord colitis syndrome-cohort. Four upper GI biopsies (stomach and duodenum) were obtained from three affected patients from the original cohort (two samples from patient 5, one sample from patient 6 and one sample from patient 11). FFPE blocks were retrieved for each of these samples, the first 20um was shaved off and discarded and the subsequent 40um section was subjected to DNA extraction as described in the main text. DNA was quantified using the Q-bit system. 1uL of DNA from each sample was subjected to PCR using the *B. enterica* primer set and PCR conditions indicated in section V of the supplementary appendix. A nontemplate control and positive control (0.2ng of the bar-coded sequencing library for patient 5b) were also subjected to PCR simultaneously.

Results of this experiment are presented in Figure S7 and demonstrate the presence of *B. enterica* in all of the upper GI biopsy samples tested. This suggests that *B. enterica* colonizes not only the lower gastrointestinal tract but also the upper gastrointestinal tract in affected patients.

In order to determine if *B. enterica* was an institution-specific potential pathogen, samples from MGH were obtained for sequencing-based analysis. The following samples were obtained: endoscopic colon, duodenum and stomach biopsies were obtained from four post-HSCT colitis patients and an ileum sample from a control patient with Crohn's disease. All samples were subjected to DNA extraction and PathSeq analysis, as previously described in this manuscript. Pathological review of all patients who had undergone UCB-SCT and had colonic biopsies for evaluation of diarrhea revealed six patients with biopsies that could be consistent with cord colitis syndrome. Of those six patients, three were felt to be lower probability. Upon clinical review, one of the three higher probability cases was felt to have some features that were suggestive of a diagnosis of cord colitis syndrome, although there were some atypical features.

The single potential cord colitis syndrome patient was a 35 year-old female who underwent double umbilical cord transplantation at MGH for FLT3-positive AML Her initial transplant course was complicated by engraftment syndrome requiring glucocorticoid treatment, febrile neutropenia treated with cefepime, vancomycin, and micafungin, *Streptococcus mitis* bacteremia treated with ceftriaxone, HHV-6 viremia treated with foscarnet, and elevated liver function tests. On day 33, the patient was readmitted to MGH with worsening liver function tests and a week of watery diarrhea. Flexible sigmoidoscopy and a liver biopsy were performed. Pathology showed normal colonic mucosa in the sigmoid colon and extensive hepatic iron deposition with ceroid-

laden macrophages and pericentral sinusoidal dilation consistent with recent injury. There was a non-caseating granuloma seen on the liver biopsy. The patient received one dose of vancomycin, cefepime, and metronidazole. The diarrhea was self-limited and the elevated liver function tests resolved with discontinuation of fluconazole. On day 48, the patient presented to a local hospital with recurrent watery diarrhea associated with abdominal cramping and a 4.5 kg weight loss. The patient underwent esophagogastroduodenoscopy (EGD) and colonoscopy, which showed ulcerated mucosa and on pathology demonstrated findings that were not typical for cord colitis syndrome (Subtle increased crypt epithelial cell apoptosis and ulceration with mixed inflammation). A colon biopsy from this time point was available for molecular investigation using PCR-based methods. The patient was treated with ciprofloxacin and metronidazole for 25 days with improvement in her symptoms. On day 92, the patient was started on sorafenib as part of a clinical research trial. On day 98, the patient again developed voluminous diarrhea, nausea, 5kg weight loss, and low-grade fevers, and was re-admitted to the hospital on day 103. She was started on empiric glucocorticoids and cefepime. EGD and colonoscopy were performed; duodenal, gastric and colonic biopsies showed patchy granulomatous inflammation, but no significant increase in gland or crypt epithelial cell apoptosis, and minimal active inflammation. The colonic biopsy showed no architectural distortion to suggest chronic mucosal injury. The presence of granulomas would be consistent with cord colitis syndrome, but the absence of increased apoptosis, architectural distortion, and neutrophilic cryptitis would argue against this diagnosis. Biopsies from the stomach and duodenum were available from this time point for molecular investigation; the colonic specimen was not available for molecular investigation.

AFB, GMS, PAS/d, Giemsa, and Brown-Hopps stains were negative for any organisms. Additionally, immunohistochemical stains for CMV, adenovirus, HSV, and VZV were negative. Glucocorticoids were tapered and the patient was switched to ciprofloxacin and metronidazole to complete a 14-day course with improvement in her diarrhea. Shortly after discontinuing ciprofloxacin and metronidazole, the patient again developed watery, large volume diarrhea, nausea, and poor appetite on day 129 for which she was re-treated with ciprofloxacin and metronidazole. Again, she responded well with decreased diarrhea and weight gain. However, the patient developed recurrent diarrhea and nausea while being treated with antibacterial agents. On day 160, the metronidazole was stopped with the goal of decreasing nausea. On day 176, she developed a fever and because of her persistent upper GI symptoms and diarrhea was restarted on both ciprofloxacin and metronidazole. On day 183, she again underwent EGD and colonoscopy that showed a subtle increase in crypt epithelial cell apoptosis, patchy chronic inflammation of a random colon biopsy, including granulomas that were not associated with crypt rupture, focal Paneth cells, without evidence of neutrophilic inflammation. Again, the absence of active (neutrophilic) colitis would be unusual for cord colitis syndrome.

She completed a course of ciprofloxacin and metronidazole by day 203 with improvement in her symptoms. Her subsequent course was complicated by an intensivecare unit admission for *Citrobacter spp*. Bacteremia and *Clostridium difficile* infection. Ultimately, her diarrhea returned and the patient has remained on chronic suppressive ciprofloxacin and her symptoms have been relatively well controlled.

Clinically, the patient has a relapsing, antibiotic-responsive, chronic diarrheal syndrome that could be consistent with the cord colitis syndrome. However, the onset of symptoms as early as day 33 or 48 is early relative to the original cohort of cord colitis syndrome patients (median onset day 131, range 88 to 314). Later in the patient's course, she seems to have developed worsening diarrhea while taking ciprofloxacin and metronidazole, which has not been seen in prior cases of cord colitis syndrome. The hepatic granulomas would be unusual for cord colitis syndrome and may suggest an alternate inflammatory or infectious etiology. Similarly, the absence of increased crypt epithelial cell apoptosis and neutrophilic cryptitis argue against cord colitis syndrome. The introduction of sorafenib with subsequent upper GI symptoms and diarrhea is also a confounding factor.

DNA was extracted from all available tissue blocks from this "variant cord colitis syndrome" case, as described in a previous section of the supplementary appendix. All samples were subjected to PCR as was described in section V of this Appendix. *B. enterica.* PCR was negative for all samples studied. As deep sequencing is an inherently more sensitive method for investigation of the presence of components of the microbiome, a subset of samples for which adequate amounts of DNA were available (stomach and duodenum from the day 98 EGD) were taken forward for sequencing-based analysis. Sequencing demonstrated the presence of *B. enterica* reads, although in low abundance, in both of these samples (Table S6, Figure S8).

These findings confirm the existence of *B. enterica* outside of the original institution where it was discovered. Given the relatively small number of samples that were studied and the lack of a very clearly defined case, it is not possible to ascertain the existence of cord colitis syndrome outside of the original institution where it was described. Based on the data presented, it is not possible to establish the generalizability of the association between *B. enterica* presence and cord colitis syndrome.

#### **IX. Immunoglobulin levels in cord colitis syndrome patients**

Hypogammaglobulinemia post-HSCT was common in this population with four of the original 11 patients receiving intravenous immunoglobulin (IVIG) post-transplantation. Immunoglobulin levels were available for the two months before or after presumed onset of cord colitis syndrome for 11 of the 11 patients. Immunoglobulin levels were available for the one month before or after presumed onset of cord colitis syndrome for nine of the 11 patients. Of the five patients who had lower GI biopsies that were included as a part of this study, four of the five patients were hypogammaglobulinemic at the time of cord colitis syndrome. Two of the patients required treatment with IVIG. Only one patient, patient 4, was not hypogammaglobulinemic at a time point of two weeks after clinical onset of cord colitis syndrome. Given the relative hypogammaglobulinemia of patients within this cohort and the well-described defects of adaptive immunity in post-HSCT patients, the likelihood of serological evidence of an adaptive immune response against *B. enterica* would be unlikely. Details of clinical status of patients and immunoglobulin status are presented (Table S7).

# **X. Figures**



Figure S1. BLASTN of contigs >2.5kb generated by the ALLPATHS assembly of nonhuman reads of Samples 5b and 5c. Each contig was subjected to nucleotide BLAST against the NCBI nt database. The top hit was taken for each contig and the organism corresponding to the top hit is indicated on the scatter plot as described in the legend. The *x*-axis indicates the percentage of the contig that was contained in the top hit and the *y*axis indicates the contig size.



Contig GC, Coverage, and Relative Size in XBJW/CCCOMB

Figure S2. GC content, size and read coverage for contigs generated by the ALLPATHS assembly of samples 5b and 5c. Each contig is indicated as a colored circle (the color corresponds to the organism encoded by the top nucleotide BLAST hit as described in Figure 1). The size of the circle correlates with the relative size of each contig. Percent GC content is indicated on the *x*-axis and read coverage is indicated on the *y*-axis.



Figure S3. Histogram indicating the number of predicted *B. enterica genes* based on percentage global amino acid sequence identity to the closes *B. japonicum* homologue.



Figure S4. PCR (in duplicate) to detect *B. enterica*. PCR was performed using the conditions indicated in the main text with the exception that 40 cycles of PCR were carried out. Lanes are indicated with red text and correspond to the following:

- 1. 100bp MW marker
- 2. CC006 (positive control) middle scroll
- 3. CC011 top scroll
- 4. CC010 top scroll
- 5. Non template control
- 6. Hemo-D
- 7. Wash 2/3 (bottle 1)
- 8. Wash 2/3 (bottle 2)
- 9. Digestion buffer
- 10. Wash 1 (bottle 1)
- 11. Wash 1 (bottle 2)
- 12. Wash 1 (bottle 3)
- 13. Isolation additive
- 14. Digestion buffer
- 15. Nuclease free water







Figure S5. PathSeq quantification of viral reads in sequences from cord colitis syndrome samples.



Figure S6. Competition assay with unlabeled Bradyrhizobium 16S RNA probe. The panel on the left demonstrates diffuse staining with the Bradyrhizobium 16S RNA labeled probe, panel on the right demonstrates that staining with the Brady probe is abrogated in the presence of unlabeled probe).



Figure S7. PCR based identification of *B. enterica* in upper GI biopsies from cord colitis syndrome-affected patients. (Left to R, 1kb plus MW marker, non-template control, patient 5 sample 1, patient 5 sample 2, patient 6 sample 1, patient 11 sample 1, positive control). PCR of all samples except for the non-template control also amplified human actin, to varying degrees (data not shown).



Figure S8. Sequencing-based identification of *Bradyrhizobium enterica* in post-HSCT colitis patients from a second institution. Shotgun DNA sequencing and PathSeq-based taxonomic classification of reads from gastrointestinal biopsies of patients with post-HSCT colitis syndromes suggests that *B. enterica* exists outside of the original institution in which it was discovered.

## **XI. Tables**



Table S1. Classification of reads from whole genome shotgun sequencing of formalinfixed, paraffin embedded colon biopsy samples from patients with cord colitis. Computational analysis of massively parallel DNA sequencing from human tissue samples was performed using PathSeq software. Human reads were computationally subtracted, followed by taxonomic classification with BLASTN to microbial and viral databases. A large proportion of non-human reads were "unmappable" to available reference genomes.



Table S2. Results of contig generation from unmapped read assembly. The ALLPATHS software program was used to assemble unmapped reads from pooled samples (11b and 11d) into longer, contiguous sequences.



















Table S3. A list of genes present in *B. enterica* that are absent in *B. japonicum* or have homologues with less than 5% identity to *B. japonicum.*



Table S4. The abundance (number of reads) of a subset of known human viruses is also presented. All viral read assignments reported in this table have been manually confirmed by BLASTN analysis against the complete nt database.



Table S5. Relative abundance of *B. enterica* reads. The relative abundance of *B. enterica* compared to human reads is represented in this table, as is the fold-reduction in *B. enterica* abundance with antibiotic-initiation. Note that the post-antibiotic biopsies were not taken at convalesence; rather, they were taken in the clinical setting of continued diarrhea.



Table S6. PathSeq-based quantification of reads assigned to non-human organisms (viruses, bacteria, fungi) in sequenced samples from MGH. Biopsies from the duodenum and stomach of a patient with a diarrheal syndrome, with some features suggestive of cord colitis syndrome, were subjected to shotgun whole genome sequencing and subsequent PathSeq analysis. Non-human, non-phage reads are assigned as demonstrated (the top twenty non-human, non-phage organisms to which reads mapped are presented).



Table S7. Clinical status and Immunoglobulin levels of cord colitis syndrome patients. Abbreviations are as follows: \*Lost to follow up in May 2011; TMP/SMX: Trimethoprim, Sulfamethoxazole; PCP: Pneumocystis (carinii) jiroveci; Ig: Immunoglobulin; IVIG: Intravenous immunoglobulin; TP: Time point; GD: Gut decontamination

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