

Association of Food & Drug Officials Annual Meeting
Oak Brook, Illinois
08 June 2009

Lessons learned from the Salmonella Saintpaul outbreak

Arthur P. Liang, MD, MPH
Director, Food Safety Office
National Center for Zoonotic, Vector-borne & Enteric Diseases
Centers for Disease Control & Prevention

Disclaimer

“The findings & conclusions in this presentation have not been formally disseminated by CDC & should not be construed to represent any agency determination or policy.”

Changing Epidemiology of Foodborne Outbreaks

Old scenario:

- Acute local event
- Sudden rise in acute illness
- Detected by cases, MD or lab
- Local investigation
- Point source
- ≥ 1 food handling error(s)
- Local solution
- Local implications

New Scenario:

- Multi-state, multi-county
 - Increase in "sporadic" cases
 - Detected by lab subtyping
 - Multi-state investigations
 - System error(s)?
 - Industry-wide implications
-
- Not simple investigations
 - Not easy to investigate
 - Scientifically/technically challenging

Changing Epidemiology of Foodborne Outbreaks

“Church picnic”:

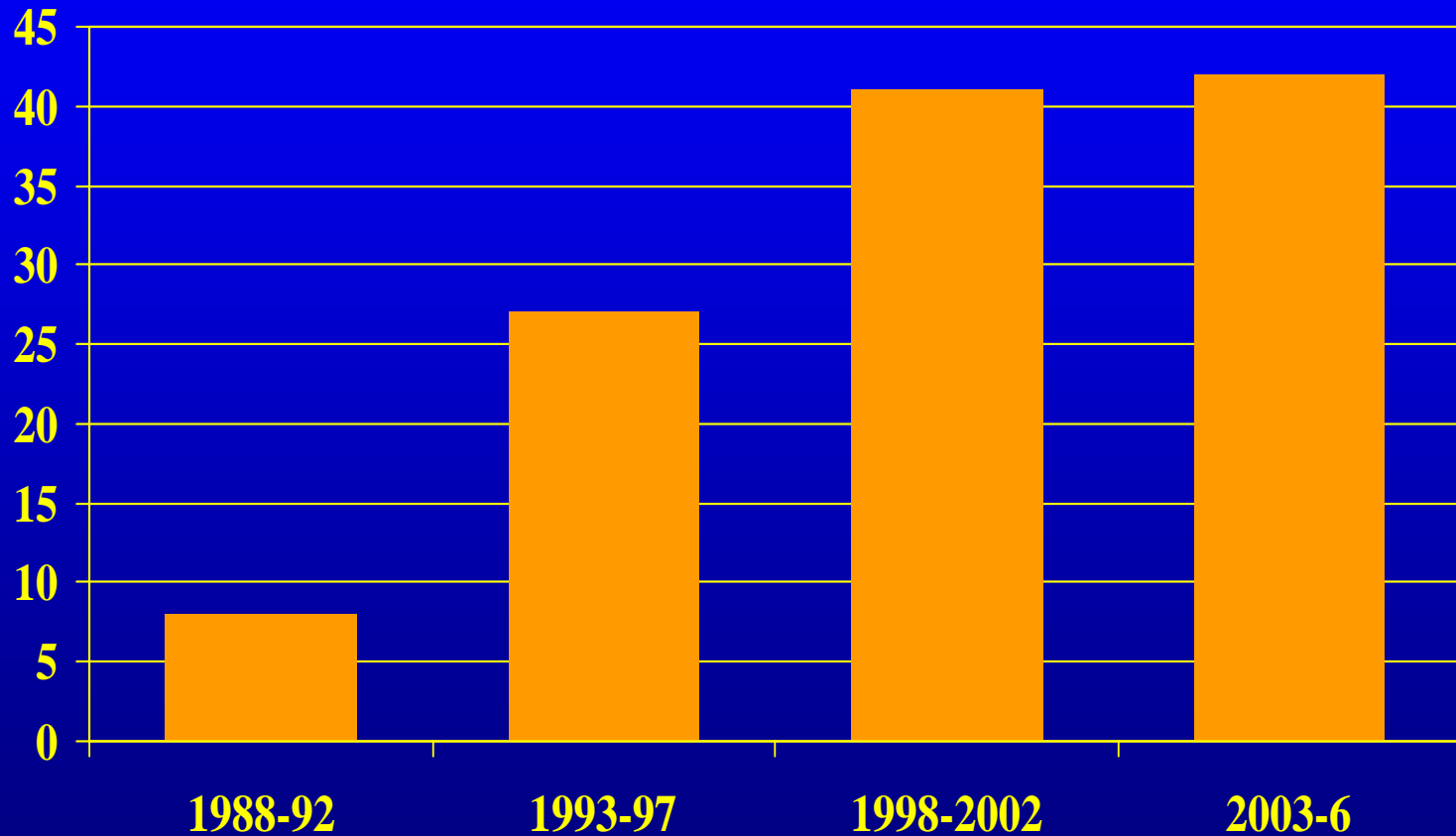
- Defined population at risk
- Quickly recognized acute illness
- Finite menu
- Local implications
- “When in doubt, throw it out”

Multi-state Scenario:

- Diffuse population at risk
- Many clusters, few outbreaks
- Difficult to define exposure(s)
 - especially “ingredients”
- Coordinate > 1 investigation
- Economic implications

Multi-state foodborne outbreaks

1988-2006

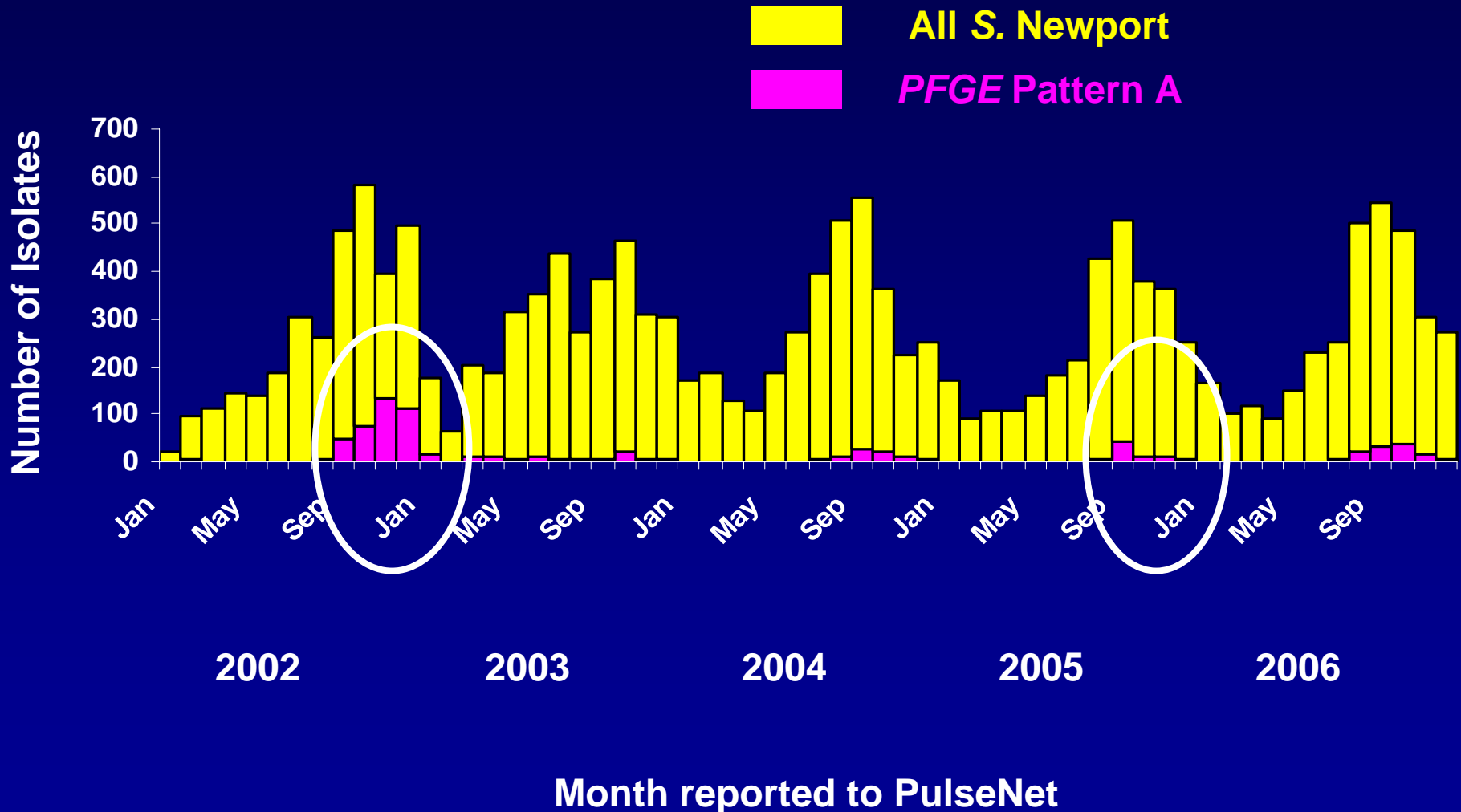


Preliminary data

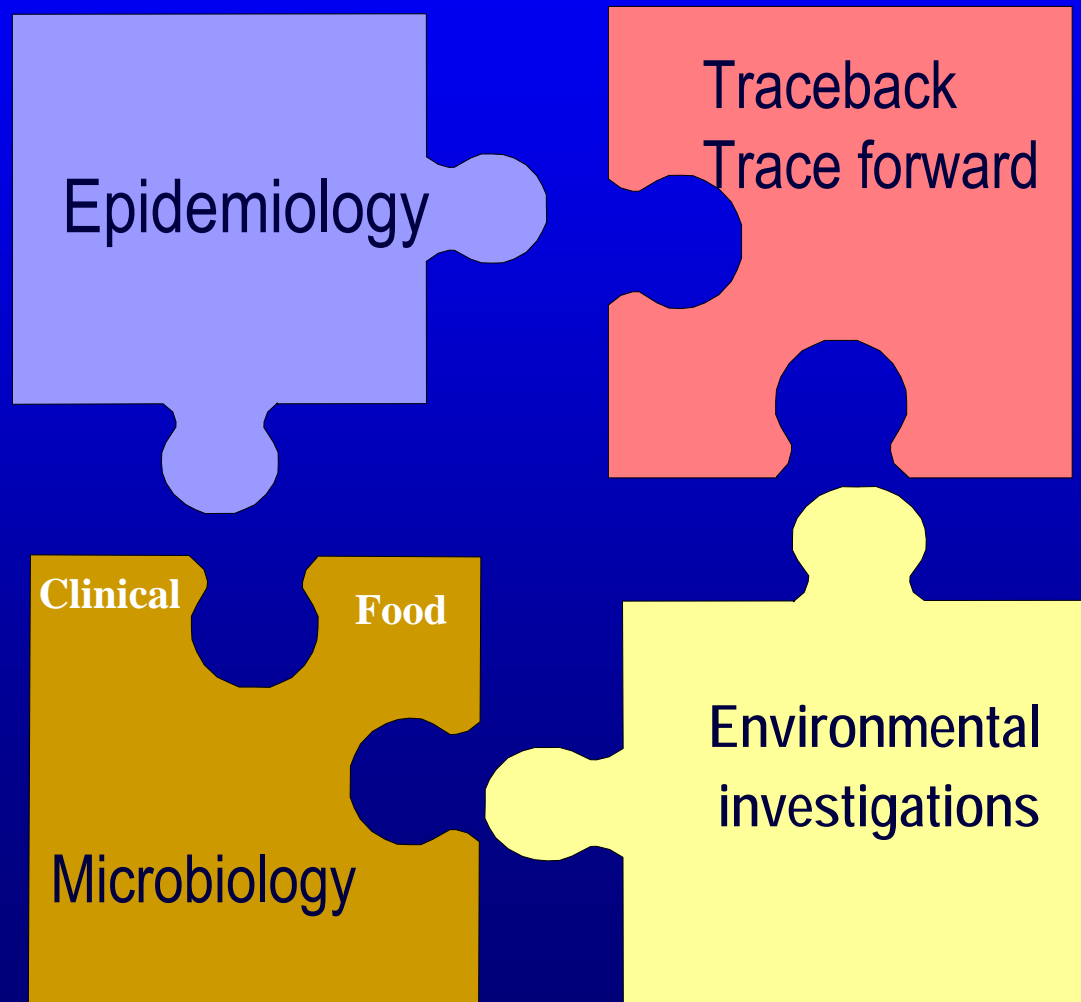
Source: CDC foodborne outbreak reporting system

defining a case vs defining exposure

Isolates of *S. Newport* Reported to PulseNet, 2002-2006



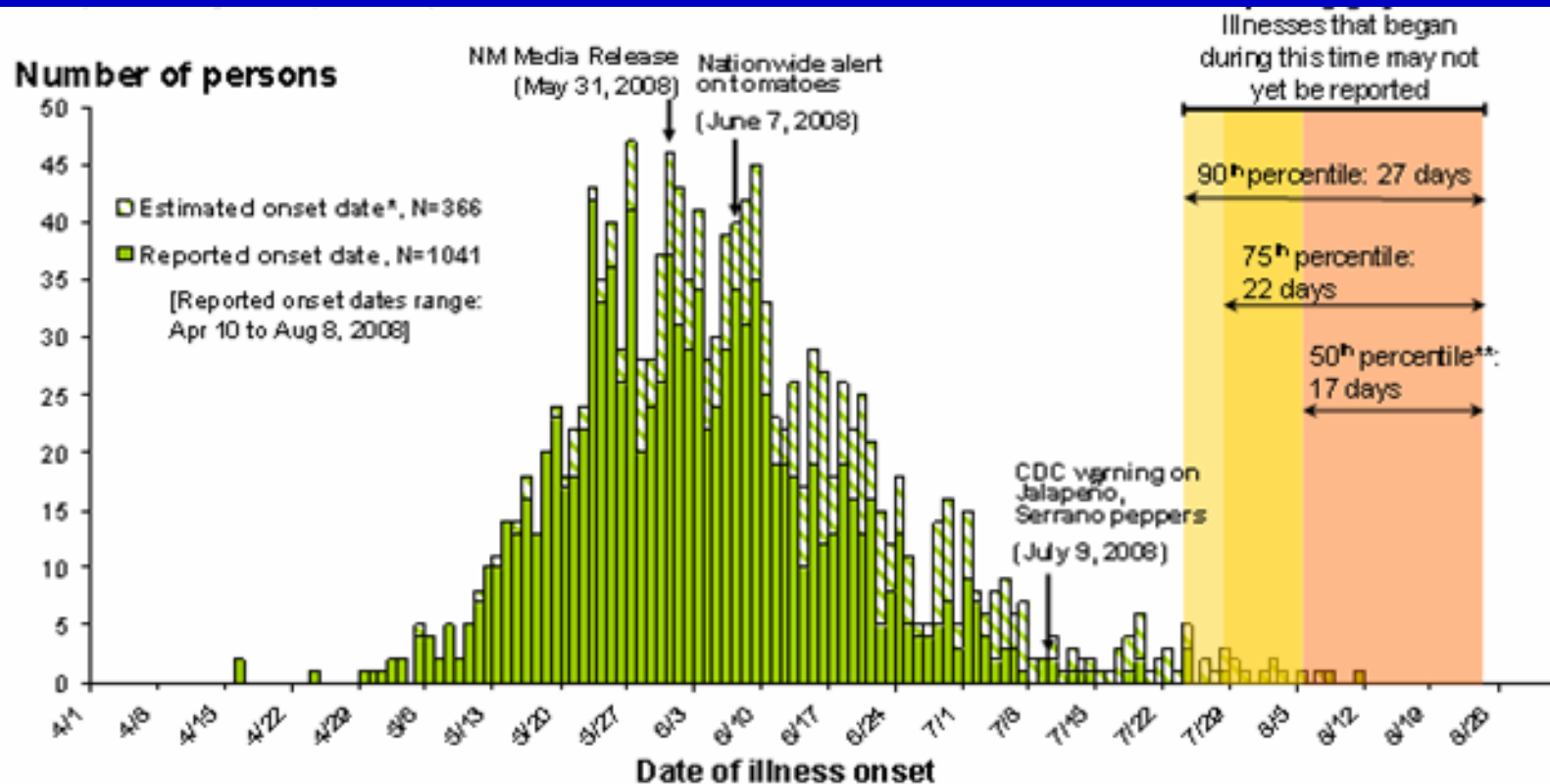
Improving epidemiologic methods: To generate & confirm hypotheses



Improving Accuracy & Precision

- Investigation of clusters within larger outbreak very helpful.
- Use standard questions & questionnaires
- Getting all clinical isolates to Public Health labs

Multistate outbreak of *Salmonella* Saintpaul, 2008



* Estimated by subtracting 3 days from the "isolate date" reported to PulseNet

**50% of cases are reported to PulseNet within 17 days of the illness onset; 75% of cases are reported to PulseNet within 22 days of illness onset; 90% of cases are reported to PulseNet within 27 days of illness onset.

Improving Timeliness

- Reduce time taken to interview cases & controls about exposures & product information.
- Reduce time to ship isolates from clinical to Public Health laboratories
- Reduce time taken to complete serotyping & 'fingerprinting' of important isolates at public health laboratories
- Electronic platform for collecting, storing, transmitting, & analyzing case information

Coordination/Communication

- Need to delineate roles & responsibilities of different agencies during outbreaks
- Need consistent messaging
 - Need to improve coordination of public communication among responding agencies & partners
- Need to manage public perception of risk
 - to motivate appropriate preventive actions
 - while minimizing needless economic disruption during & after outbreaks
- Need to create materials before an outbreak
 - that will help translate epidemiologic & microbiologic language & statistics into terms that are comprehensible to, & supported by, the media & the public

Thank you