

Sproutbreak at Jimmy John's

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Objectives

- Describe outbreak of E. coli O26
- Explain how agencies in Michigan responded to this outbreak
- Describe lessons learned during the outbreak
- Describe the teamwork within and between agencies which allowed a rapid response



Patients

- Case count: 29 (11 MI)
- Number of states: 11
- Hospitalizations: 7 (24%): 6 in MI (55%)
- 89% female
- Median age: 26
- No HUS
- No deaths



Isolates

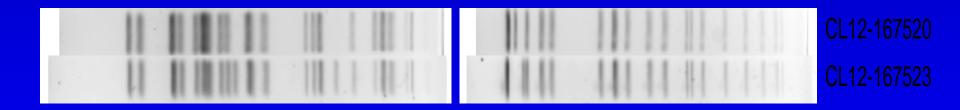
- Stx 1
- Serotype O26, the most common serotype
- Cluster code 1201KSEVC-1
- PFGE patterns are rare: pattern combination twice before outbreak, Xbal 6 other times
- One MI isolate had variant pattern, patient had outbreak exposure



Pattern variant

PFGE-Xbal

PFGE-Bini



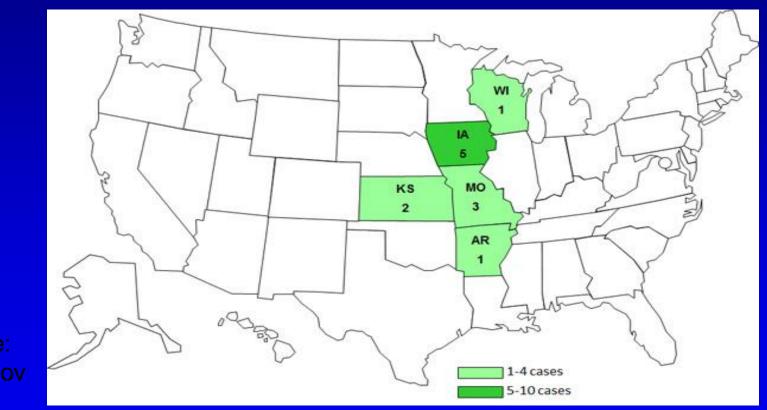


Epidemiology

- Onset dates: December 25-March 3
- MI onset dates: February 6-17
- 5 states initially involved: No more cases after 1/15 onset
- 6 more states later became involved



Initial cases: Onset 12/25-1/15



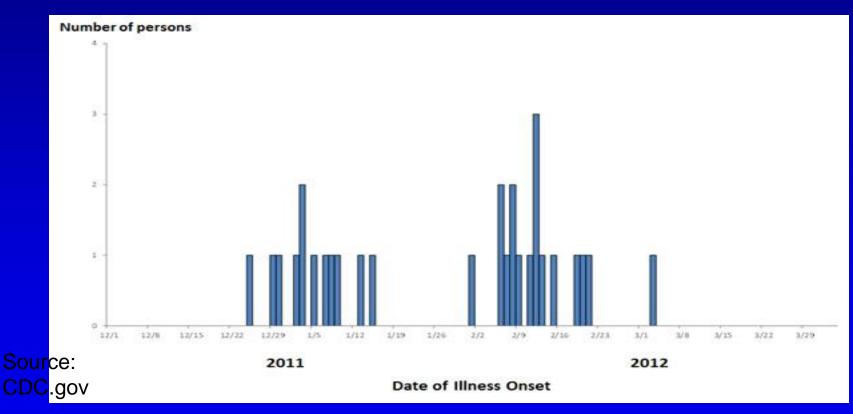


Final cases: Onset 2/6-3/3





Epi curve





Investigation

- Investigation indicated source of outbreak to be raw clover sprouts served at Jimmy John's restaurants
- Many JJ restaurants involved



Investigation

- Seeds were contaminated, sprouts grown at two sprouting facilities
- Seeds were recalled on Feb. 10
- STEC was not recovered from seeds or sprouts
- Sprouts are no longer served at JJ: will "shoots" be served?



Sproutbreaks:

- 55 outbreaks in past 14 years*
- 15,000 cases*
- Outbreaks caused by Salmonella, E. coli 0157 and other serotypes, Listeria

* Source: Foodsafetynews.com



- Detection of STEC
 - Variable degree of testing in clinical labs
 - Do labs send all isolates/stools to PHL's?
 - Long and variable time to isolate STEC from stools in PHL
 - Real time PFGE?



- Patient histories
 - Can be difficult to obtain, recall is imperfect
 - STEC are prioritized in MI
 - Local HD's are contacted to encourage timely interviews



- Sprout consumption can be difficult to detect:
 - patients might not knowingly consume sprouts
 - questionnaire targeting sprout consumption might be needed



- Contamination can occur in sprouts and seeds
- Sprouts are grown in conditions that are good for bacterial growth
- Sprouts are not typically cooked, washing seeds doesn't kill bacteria inside
- Seeds can be produced for agricultural use, not handled as for human consumption



Delayed involvement of MI and others:

- Might indicate incomplete recall of contaminated vehicle: Lack of awareness of/compliance with recall
- Might indicate other sources, seed lots, sprouters



 MI has had similar delayed involvement in other outbreaks: 2009 S. Saintpaul sprout outbreak, 2012 E. coli O45 outbreak (no source found), 2012 O121 outbreak (no source found)



Teamwork within lab

- PFGE and E. coli/bacteriology testing staff not always the same

- Don't let new isolates slip through the cracks: PFGE staff should talk often with E. coli testing staff to learn of new isolates, status of testing, when isolates will be available



- Communication can improve TAT, especially useful during known outbreaks
- **TAT**:
 - Isolation date-date received: 3 d, range 2-5 d
 - Date received-date received for PFGE:
 8 d, range 5-21 d



- PFGE staff should stay on top of national events for rapid detection of outbreak related isolates:
 - Put posted bundles in local database for matching to new patterns
 - If new local cluster occurs, be sure to check with posted clusters
 - Each Pulsenut should be in the loop



- Teamwork between lab and epidemiology

 Epis match case reports with isolate submissions to determine if isolates have not been submitted to PHL
 - Epis often notice if PFGE is incomplete on isolates or if they have not been submitted for PFGE



- Teamwork between lab and epidemiology
- Spreadsheet is maintained on common drive with patient, isolate data and dates received for PFGE and PFGE rundate
- Detect possible problems with testing: do patterns correlate with epidemiology?



 Teamwork between lab and epidemiology

> - Lab should do real-time reporting to epi: notify of new STEC and PFGE results

> - Inform epi of matches to posted clusters



Teamwork with local health departments

 LHD's enters patient info into epi statewide database and conduct patient interviews

- State PH informs LHD's of clusters and outbreaks, provide supplemental questionnaires



Teamwork with local health departments:

 PH epidemiologists sent sprout-specific questionnaire to LHD's, asked for 24 hour TAT

- HAN alert sent about outbreak and implicated seed lot



- Teamwork with local health departments
 - TAT: case report-initial interview: median 1 day (range 0-26 d)
 - TAT: case report-outbreak (sprout-specific) questionnaire: median 5 days (range 0-26 d)



- Teamwork with state Agriculture Department:
 - MI Agriculture Dept. has Rapid Response Team (RRT)

- Ag epidemiologist shares time and office with PH epidemiology



- Teamwork with state Agriculture Department:
 - Ag epidemiologists perform tracebacks
 - Knowledge of their needs helps PH design questionnaires to capture necessary information

- Quarterly debriefing meetings with PH lab, epi, and agriculture epi



- Teamwork with state Agriculture Department:
 - PH epidemiologists asked Ag about presence of contaminated seed lot in MI
 - PH epi shared patient food histories with Ag for traceback
 - Joint PH/Ag press release



Summary

- PulseNet detected another important outbreak: Small number of cases temporally and geographically diverse were linked with PFGE
- Sprouts will no longer be served at Jimmy John's



Summary

In Michigan:

- Good lab-lab interaction expedited PFGE

- Awareness of match to outbreak pattern allowed epidemiologists to immediately administer sprout-specific questionnaire

- Relationship with agriculture dept. facilitated traceback investigation



Summary

In Michigan:

- Lab-lab and lab-epi communication cleared up mistake in toxin testing

- Lab-epi communication clarified association of patient with variant pattern with outbreak source



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