

計: [ ][ ][ ][ ] [問 63 へ進む]

不明 [問 64 へ進む]

問 63. 上記の数字は検査記録からですか？それとも概算ですか？

検査記録

概算

問 64. 1996 年に何件の Cyclospora 陽性がありましたか？

計: [ ][ ][ ][ ] [問 65 へ進む]

不明 [問 66 へ進む]

問 65. 上記の数字は検査記録からですか？それとも概算ですか？

検査記録

概算

問 66. どの Cyclospora 検便検査法を使用していますか？

直説法 [問 68 へ進む]

濃縮法濃縮法: \_\_\_\_\_

直接および濃縮法濃縮法: \_\_\_\_\_

問 67. Cyclospora 濃縮法では遠心分離を使用しますか？

はい \_\_\_\_\_(分) @ \_\_\_\_\_ X g.

いいえ

問 68. Cyclospora 検査(定期および確認検査)にはどの染色法を使用しますか？[複数回答可]

[どちらかを選択してください]

非染色湿マウント

一時染色湿マウント

染料: \_\_\_\_\_

自動蛍光湿マウント

速性酸染料: \_\_\_\_\_

サフラニン 具体的に: \_\_\_\_\_

PCR

その他 1 具体的に: \_\_\_\_\_

その他 2 具体的に: \_\_\_\_\_

問 69. Cyclospora 検査の参考文献として使用しているものを選びなさい。

[複数回答可]

ASM Clinical Microbiology

Procedures Handbook (Ed. Isenberg) \_\_\_\_\_ 年および/または \_\_\_\_\_ 版

Manual of Clinical Microbiology (Ed. Murray) \_\_\_\_\_ 年および/または \_\_\_\_\_ 版

NCCLS Procedures, \_\_\_\_\_ 年および/または \_\_\_\_\_ 版

その他 1 具体的に: \_\_\_\_\_ \_\_\_\_\_ 年 \_\_\_\_\_ 版

その他 2 具体的に: \_\_\_\_\_ 年 \_\_\_\_ 版

問 70. Cyclospora 検査を他研究所に依頼したことがありますか? (複数回答可)

陽性標本の確認のため 研究所名: \_\_\_\_\_

医師の指示により 研究所名: \_\_\_\_\_

疑いが認められたため 研究所名: \_\_\_\_\_

その他の理由 具体的に: \_\_\_\_\_

研究所名: \_\_\_\_\_

いいえ [最後へ進む]

不明 [最後へ進む]

問 71. 検査結果を受け取りましたか?

はい [最後へ進む]

いいえ。検査結果は医師あるいは医療施設に対してのみ報告されます。[問 63 へ進む]

問 72. 他研究所の検査結果にアクセスできますか?

はい

いいえ

不明

終了: FoodNet へのご協力有難うございました。

#### 4. 臨床医調査アンケート用紙

本アンケートは、食品衛生指導における医師の役割の現状について把握するために行っています。本アンケートに対する回答義務もありませんし、また、どの時点で中止されてもかまいません。法律に従い回答の匿名性は厳守され、回答者に関する一切の情報は開示されません。下記のアンケートへの回答はおよそ 5 分間程度で終了し、また、これにより得られる情報は重要ですので、ご協力いただけますよう宜しくお願いいたします。

本アンケートに対する回答義務がないことを承知し、自己の意志により回答する。

[問 1 へ進む前に必ずチェックしてください。]

本アンケートに協力することはできません。

[チェック後、アンケートには回答せずに返送してください。]

#### セクション A. 背景情報

問 1. 回答日: \_\_/\_\_/\_\_

問 2. (\*\*\*\*\*)州において医療活動に従事している。

- はい
- いいえ [ここで終了しご返送ください]

問 3. 患者と直接の接触することが週 8 時間以上ある。

- はい
- いいえ [ここで終了しご返送ください]

問 4. 専門分野 [適切なものを 1 つ選択]

- 腫瘍または血液学
- 産科
- 感染症
- 他の内服薬 (具体的に) \_\_\_\_\_
- その他 (具体的に) \_\_\_\_\_

問 5. 施設規模 [適切なものを 1 つ選択]

- 外来中心の私立病院あるいは無料クリニック
- 外来 HMO/管理医療
- 入院中心
- その他 [具体的に]

問 6. 現在、インターン、研修医、またはフェローですか？

- はい [問 8 へ進む]
- いいえ

問 7. 経験年数 \_\_\_ 年

問 8. 患者のおよそ何%が低免疫患者あるいは妊婦ですか？ [適切なものを 1 つ選択]

- 0%
- 1-25%
- 26-50%
- 51-75%
- 76-100%

## セクション B. 患者指導

問 9. 食品衛生および食品媒介感染症に関してどれくらい患者と話しますか？ [適切なものを 1 つ選択]

- はなさない
- まれにはなす
- 時々はなす
- よくはなす

問 10. 食品媒介感染症および予防法について指導していますか？ [適切なものを 1 つ選択]

- はい [問 12 へ進む]
- いいえ [問 11 へ進む]

問 11.患者に食品媒介感染症予防法についての指導をしたいと思いますか？

- はい [問 16 へ進む]
- いいえ [問 16 へ進む]

問 12. 患者への食品衛生指導は誰が担当していますか？ [適切なものを1つ選択]

- 自分 (医師)
- 看護婦またはナース—プラクティショナー
- 栄養士
- その他 [具体的に] \_\_\_\_\_
- 不明

問 13. 食品媒介感染症予防に関する情報はどのような形で患者に提供されていますか？ [複数回答可]

- 話し合いを中心とした口述
- 簡単な話し合い含む口述
- パンフレット
- 病室/待合室におけるポスター
- ビデオ
- 自己学習資料 [具体的に] \_\_\_\_\_

問 14. 食品衛生に関してどのような情報を提供していますか？ [複数回答可]

- 食品の取り扱いおよび準備法
- 危険な食品 (例: 調理不十分な肉、低温殺菌未処置チーズ)
- サルモネラ食中毒予防
- リステリア食中毒予防
- その他の食中毒予防法 (具体的に) \_\_\_\_\_
- HIV/AIDS 患者に対する食品衛生指導
- 妊婦に対する食品衛生指導
- その他の特定の患者に対する食品衛生指導 (具体的に) \_\_\_\_\_
- その他 (具体的に) \_\_\_\_\_

問 15. いつ食品衛生に関する情報を提供していますか？ [複数回答可]

- 初診時
- 定期的な診察
- 患者の依頼がある場合
- 食中毒と診断された場合
- その他の場合 [具体的に] \_\_\_\_\_
- 不明

### セクション C. 食品媒介感染症

下記の表記について5段階で評価してください。

1: 強く賛成する、2: 賛成、3: どちらともいえない、4: 反対 5: 強く反対する。

- 問 16. 免疫機能が低下している患者においては食品媒介感染症は重篤な問題である。
- 問 17. 担当患者の多くが食品媒介性を含む感染症のリスクにある。
- 問 18. 患者に食品媒介感染症の予防の指導を行うことも医師の役割であると思う。
- 問 19. 患者の食品媒介感染症のリスクについて把握したいと思う。
- 問 20. 患者が食品媒介感染症の予防に興味があると思う。
- 問 21. 3分程度の簡単な指導であれば、食品媒介感染症の予防指導を積極的に行うつもりである。
- 問 22. 患者指導により食品媒介感染症を減らすことができると考える
- 問 23. 患者の多くは食中毒予防の指導にしたがう。
- 問 24. 効果的な患者指導には時間がかかりすぎる。
- 問 25. 食品媒介感染症予防に関する十分な知識がある。
- 問 26. 食品媒介感染症予防の診断および治療を行えるだけの知識がある。
- 問 27. 食品媒介感染症予防に関する指導を行えるだけの知識がある。
- 問 28. 患者にとって食品媒介感染症の重要な情報源である

コメント記入欄 \_\_\_\_\_

### おわりに

食品媒介感染症の実態を把握するために、わが国でもいろいろ試みがなされている。しかし何れも十分なものとは言えないのが現状である。

最大の問題はアメリカ同様、日本でも食品媒介感染症として認識されていないケースも多く、当然のことながら統計のデータに含まれることなく対応されているということである。従ってそれらが感染症対策や食品衛生行政に反映されることもないままになっている。

アメリカでの食品媒介感染症に対する取り組みは、長い歴史があり、それなりに時間をかけ試行錯誤しながら取り組みがなされて来た。そして今、更に時代背景を敏感に取り込んだ調査システム、FoodNet などの構築がなされている。

更にこのシステムは食品媒介感染症の発生報告から集まる感染症の発生動向調査に終わらせることなく、能動的な発生動向調査を行うことによって、隠れた感染症も明確にする可能性も増え、感染症のより正確な実態把握も可能となると思われる。

実態を把握し分析して、初めて食品行政に反映させることも可能となり、それで初めて有効な感染症対策が構築できると考える。

今回の調査で知りえた、この能動的な食品媒介感染症監視ネットワーク FoodNet について、日本にも取り入れ、応用し、日本の食品媒介感染症対策に役立てることも可能であり、このようなシステムの導入の検討が望まれる。

19990713

これ以降「p107-140」は雑誌/図書等に掲載された論文となりますので、  
「研究成果の刊行に関する一覧表」をご参照ください。

「研究成果の刊行に関する一覧表」

Surveillance for Foodborne Disease Outbreaks –United States  
1993–1997. MMWR. March 17,2000/49(SS01);1–51

## What is Foodnet?

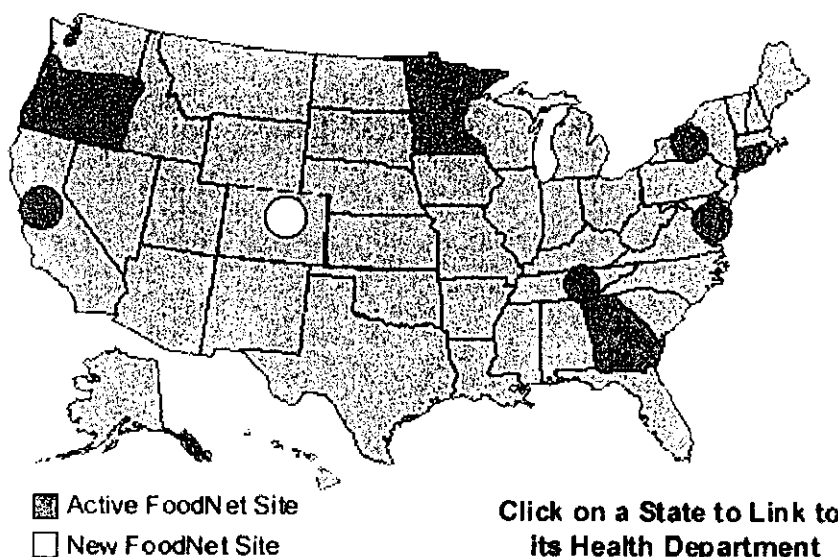
### CDC's Emerging Infections Program

#### Foodborne Diseases Active Surveillance Network (FoodNet)

The Foodborne Diseases Active Surveillance Network (FoodNet) is the principal foodborne disease component of CDC's Emerging Infections Program (EIP). FoodNet is a collaborative project of the CDC, nine EIP sites (California, Colorado, Connecticut, Georgia, New York, Maryland, Minnesota, Oregon and Tennessee), the U.S. Department of Agriculture (USDA), and the Food and Drug Administration (FDA). The project consists of active surveillance for foodborne diseases and related epidemiologic studies designed to help public health officials better understand the epidemiology of foodborne diseases in the United States.

Foodborne diseases include infections caused by bacteria such as Salmonella, Shigella, Campylobacter, Escherichia coli O157, Listeria monocytogenes, Yersinia enterocolitica, and Vibrio, and parasites such as Cryptosporidium and Cyclospora. In 1995, FoodNet surveillance began in five locations: California, Connecticut, Georgia, Minnesota and Oregon. Each year the surveillance area, or catchment, has expanded, with the inclusion of additional counties or additional sites (New York and Maryland in 1998, Tennessee in 2000 and Colorado in 2001). The total population of the current catchment is 25.4 million persons, or 10% of the United States population.

FoodNet provides a network for responding to new and emerging foodborne diseases of national importance, monitoring the burden of foodborne diseases, and identifying the sources of specific foodborne diseases.



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Oregon, Pennsylvania, Rhode Island, S. Carolina, S. Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington D.C., Washington, West Virginia, Wisconsin, Wyoming

## **FoodNet goals**

Describe the epidemiology of new and emerging bacterial, parasitic, and viral foodborne pathogens.

Estimate the frequency and severity of foodborne diseases that occur in the United States per year.

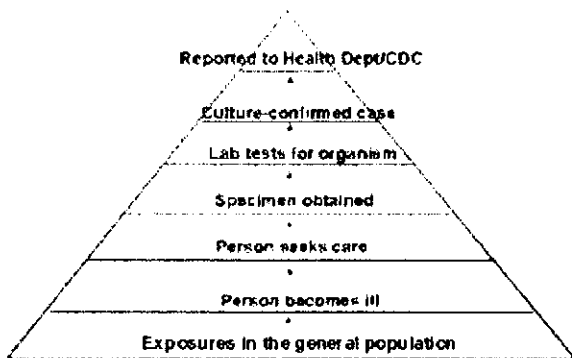
Determine how much foodborne illness results from eating specific foods, such as meat, poultry, and eggs.

## **Why is FoodNet important to public health?**

Foodborne diseases are common; an estimated 76 million cases occur each year in the United States. Although most of these infections cause mild illness, severe infections and serious complications do occur. The public health challenges of foodborne diseases are changing rapidly; in recent years, new and emerging foodborne pathogens have been described and changes in food production have led to new food safety concerns. Foodborne diseases have been associated with many different foods, including some previously thought to be safe, such as eggs and fruit juice, both of which have transmitted Salmonella during recent outbreaks. Public health officials in the nine EIP sites are monitoring foodborne diseases, conducting epidemiologic and laboratory studies of these diseases, and responding to new challenges from these diseases. Information gained through this network will lead to new interventions and prevention strategies for addressing the public health problem of foodborne diseases.

## **How is FoodNet different from other foodborne disease surveillance systems?**

## Burden of Foodborne Diseases Pyramid



Current "passive" surveillance systems rely upon reporting of foodborne diseases by clinical laboratories to state health departments, which in turn report to CDC. Although foodborne diseases are extremely common, only a fraction of these illnesses are routinely reported to CDC via these surveillance systems. This is because a complex chain of events must occur before such a case is reported, and a break at any link along the chain will result in a case not being

reported. FoodNet is an "active" surveillance system, meaning public health officials frequently contact laboratory directors to find new cases of foodborne diseases and report these cases electronically to CDC. In addition, FoodNet is designed to monitor each of the events that occurs along the foodborne diseases pyramid and thereby allow more accurate and precise estimates and interpretation of the burden of foodborne diseases over time. Because most foodborne infections cause diarrheal illness, FoodNet focuses these efforts on persons who have a diarrheal illness.

## FoodNet Has 5 Components:

- Active laboratory-based surveillance
- Survey of clinical laboratories
- Survey of physicians
- Survey of the population
- Epidemiologic Studies

### Component 1. Active laboratory-based surveillance

The core of FoodNet is laboratory-based active surveillance at over 300 clinical laboratories that test stool samples in the nine participating sites. In active surveillance, the laboratories in the catchment areas are contacted regularly by collaborating FoodNet investigators to collect information on all of the laboratory-confirmed cases of diarrheal illness. Information is being collected on every laboratory-diagnosed case of bacterial pathogens including Salmonella, Shigella, Campylobacter, Escherichia coli O157, Listeria monocytogenes, Yersinia enterocolitica, and Vibrio and parasitic organisms including Cryptosporidium and Cyclospora infection among residents of the catchment areas of the nine EIP sites; this information is transmitted electronically to CDC. In addition to collecting laboratory-diagnosed cases of foodborne pathogens, investigators at FoodNet sites began active surveillance for hemolytic uremic syndrome (HUS) (a serious complication of E. coli O157 infection), Guillain-Barré syndrome (a serious complication of Campylobacter infection) and toxoplasmosis. The result is a comprehensive and timely database of foodborne illness in a well-defined population.

#### Component 2. Survey of clinical laboratories

In October 1995, collaborating FoodNet investigators conducted a baseline survey of all clinical laboratories in the five original catchment areas to determine which pathogens are included in routine bacterial stool cultures, which tests must be specifically requested by the physician, and what specific techniques are used to isolate the pathogens. In 1997, a baseline survey was conducted in the two new sites, and a follow-up survey in the five original sites to assess any recent changes in laboratory practices. Practices in clinical laboratories have been found to vary; some laboratories look for a wider variety of bacteria than others. The methods used to collect and examine specimens are being investigated because these can influence whether the laboratory finds disease-causing bacteria.

#### Component 3. Survey of physicians

To obtain information on physician stool culturing practices, collaborating FoodNet investigators mailed a survey questionnaire to 5,000 physicians during 1996 in five sites and 750 physicians in 1997 in the two new sites. Because laboratories test stool specimens from a patient only upon the request of a physician or other health care provider, it is important to measure how often and under what circumstances physicians order these tests. As changes occur in the way health care is provided in the United States, stool culturing practices may also change over time. The practices of physicians who send stool samples to laboratories within the catchment areas will be monitored by surveys and validation studies.

#### Component 4. Survey of the population

Collaborating FoodNet investigators contact randomly selected residents of a catchment area and ask if the person has had a recent diarrheal illness, whether he or she sought treatment for the illness, and whether he or she had consumed certain foods known to have caused outbreaks of foodborne illness. During 1996, 750 residents of the catchment areas were interviewed by telephone each month (9,000/year). Because many people who become ill with diarrhea do not see a physician, little is known about the number of cases of diarrhea in the general population and how often persons with diarrhea seek medical care. The population survey is an essential part of active surveillance for foodborne illness because it allows for an estimate of the population who seeks medical care when affected by diarrheal illness.

#### Component 5. Epidemiologic Studies

In 1996, FoodNet began epidemiologic studies of *E. coli* O157 and *Salmonella* serogroups B and D infections. More than 60% of *Salmonella* infections in the United States are caused by serogroups B and D *Salmonella*. In 1998, FoodNet began a case-control study of *Campylobacter*. *Campylobacter* is consistently the most frequently isolated pathogen in FoodNet sites. These large epidemiologic studies will provide more precise information about which food items or other exposures might be risk factors for infections with these organisms. To allow the most precise classification of the isolates from the patients in these studies, *Salmonella*, *E. coli* O157, and *Campylobacter* isolates from these patients are sent from FoodNet sites to CDC for further study, including

antibiotic resistance testing, phage typing, and molecular subtyping.

### **Future FoodNet Projects**

Conduct epidemiologic studies of sporadic E. coli O157, Cryptosporidium, and Listeria monocytogenes infections.

Validate results of physician, laboratory, and population surveys.

Conduct a study of restaurants involved in foodborne outbreaks.

Begin rapid reporting of foodborne outbreaks in FoodNet sites.

### **What is CDC's Emerging Infections Program?**

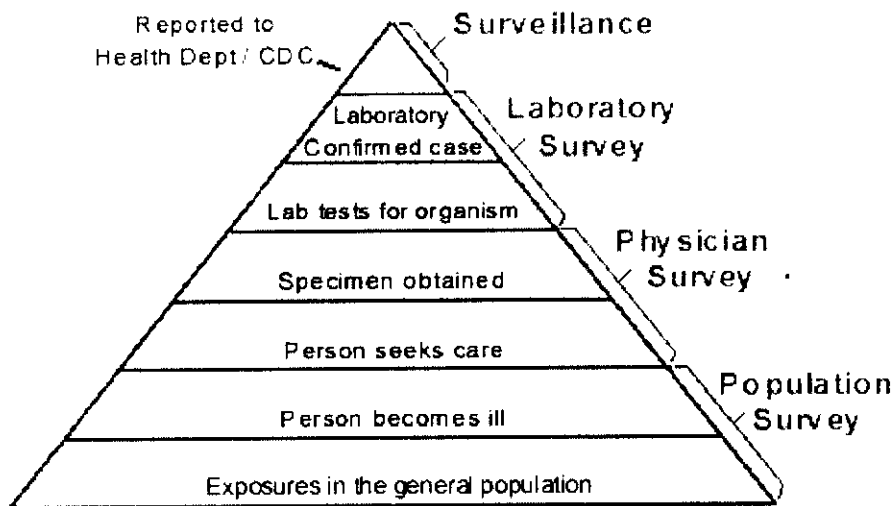
In the early 1990s, the National Academy of Science's Institute of Medicine published a report that emphasized the ongoing threat of emerging infectious diseases, and the Centers for Disease Control and Prevention (CDC) developed a strategy to respond to this threat. A central feature of this strategy was the establishment of the Emerging Infections Program (EIP) in nine sites across the United States (California, Colorado, Connecticut, Georgia, New York, Maryland, Minnesota, Oregon and Tennessee). The goals of the EIP network are to improve national surveillance for new and emerging infectious diseases, conduct applied epidemiologic and laboratory research, develop prevention and control measures, and strengthen the national public health infrastructure.

## **FoodNet Data Sources**

In addition to ongoing active surveillance, FoodNet activities include surveys of clinical laboratory practices, physician practices, and a survey of the general population. The pyramid below shows how these surveys contribute to our understanding of the burden of foodborne illness.

### **Burden of Illness Pyramid**

*(Click on a layer to view more information.)*



### What is this Pyramid?

The burden of illness pyramid is a model for understanding foodborne disease reporting. This illustration shows the chain of events that must occur for an episode of illness in the population to be registered in surveillance. At the bottom of the pyramid, **1)** some of the general population is exposed to an organism; **2)** some exposed persons become ill ; **3)** the illness is sufficiently troubling that some persons seek care; **4)** a specimen is obtained from some persons and submitted to a clinical laboratory; **5)** a laboratory appropriately tests the specimen; **6)** the laboratory identifies the causative organism and thereby confirms the case; **7)** the laboratory-confirmed case is reported to a local or state health department.

FoodNet conducts laboratory surveys, physician surveys, and population surveys to collect information about each of these steps.

## Surveillance

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### Surveillance: General Overview

FoodNet conducts surveillance for laboratory identification of confirmed cases of seven bacterial pathogens and two parasites. Clinical laboratories are contacted at least monthly to ascertain new isolations of the bacteria *Campylobacter*, *E. coli* O157, *Salmonella*, *Shigella*, *Listeria monocytogenes*, *Yersinia enterocolitica*, *Vibrio*, and the parasites *Cyclospora*, and *Cryptosporidium*. Information about cases is sent electronically to CDC via the Public Health Laboratory Information System (PHLIS) and is imported into a FoodNet database. In each FoodNet site, the surveillance methods differ slightly.

## Laboratory Survey

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### **Laboratory Survey: General Overview**

Clinical laboratories have different practices for testing specimens, regarding both what pathogens are screened and which methods are used. Such differences may contribute to variation in the rate of pathogen isolation observed in surveillance.

To understand better the practices of clinical laboratories, FoodNet administers a survey of laboratories serving the catchment area. FoodNet has conducted laboratory surveys in 1995 and 1997, and will begin a third survey in 2000.

The laboratory surveys have collected information on the total number of stool specimens submitted for testing, the number of stool specimens submitted for specific pathogen testing, agar and media used, routine pathogen testing, practice setting served, and testing criteria for each laboratory. The year 2000 survey focuses on the use of new techniques (e.g., non-culture test methods) and changes in the use of reference facilities. Results from the third laboratory survey will be available in 2000.

### **Laboratory Survey Questionnaires**

[Survey of Clinical Laboratory Practices, 1995 - Questionnaire](#)

[Survey of Clinical Laboratory Practices, 1997 - Questionnaire](#)

## Physician Survey

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### **Physician Survey: General Overview**

In 1996, FoodNet conducted a survey of 5,074 randomly selected physicians in the five FoodNet sites. Physicians were selected from state physician license lists for nonsurgical specialties. The questionnaire collected information on hours per week involved in direct patient care, specialty, training, inpatient/outpatient information and estimates of patients seen who were HIV infected. The physician survey specifically asked questions about the last patient seen with diarrhea.

## **FoodNet Physician Survey 2000:**

### **The Role of Physicians as Food-Safety Educators**

In 2000, FoodNet sites will administer a knowledge, attitudes, and practices (KAP) survey to physicians. The primary purpose of the survey will be to determine the current role of physicians as food-safety educators for their patients. Adults considered "at-risk" for severe forms of foodborne diseases include pregnant women, persons undergoing chemotherapy, and persons with acquired immunodeficiency syndrome (AIDS)/ human immunodeficiency virus (HIV) infection. Because these populations are often targeted by food-safety educational materials, the survey will focus on physicians working in obstetric, oncology and infectious disease clinics. A report from the survey is anticipated in 2000.

### **Physician Survey Questionnaires**

[Physician Survey Questionnaire, 1996](#)

[Physician Survey Questionnaire, 2000](#)

## **Population Survey**

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### **Population Survey: General Overview**

FoodNet conducted population-based surveys, in 1996-1997, and 1998-1999. The purpose of the surveys is to more precisely estimate the burden of acute diarrheal illness in the United States, and the frequency of important exposures. FoodNet population survey data are useful in determining the prevalence and severity of self-reported diarrheal illness, common symptoms associated with diarrhea and the proportion of persons with diarrhea who seek care. Exposures that might be risk factors for foodborne illness, such as the consumption of potentially "risky" foods or recent travel out of the United States, are included as questions on the survey instrument and are asked in conjunction with illness questions. The third cycle of the population survey began in February 2000.

### **Methods**

The population surveys are administered by MACRO International using a standard Behavioral Risk Factor Surveillance System (BRFSS) methodology. During the study period, persons are contacted by using a single-stage random digit dialing technique called Genesys-ID. This sampling system allows for the removal of nonworking and business telephones. One respondent is randomly selected from each household contacted. A computer algorithm is used to select one household member, based upon the total number of males and females in the household. All age groups are eligible for inclusion; if a child aged 12 years or under is selected, a parent is interviewed to ascertain information about the child's exposures. In every site, approximately the same number of interviews are conducted each month. The study is restricted to persons who speak English.

### **1996-1997 FoodNet Population Survey**

The 1996-1997 population survey was conducted in five FoodNet sites (California, Connecticut, Georgia, Minnesota and Oregon) for 12 consecutive months from July 1996 through July 1997. In 1996, the total population in the five sites was approximately 14 million; this represented 8% of the U.S. population.

### **1998-1999 FoodNet Population Survey**

The 1998-1999 population survey was conducted in seven FoodNet sites (California, Connecticut, Georgia, Maryland, Minnesota, New York and Oregon) for 12 consecutive months from February 1998 through February 1999. The total population of these seven sites, according to 1998 United States Census Bureau estimates, was approximately 29 million, 11% of the U.S. population.

Based on the information collected in the 1998-1999 Population Survey, FoodNet created an Atlas of Exposures. The Atlas of Exposures contains an 8-way stratification of exposures responses. A link to the atlas is included below.

[Click here to view the Atlas of Exposures](#)

### **2000-2001 FoodNet Population Survey**

The 2000-2001 population survey was launched in February 2000 and will be conducted for 12 consecutive months.

## **Epidemiologic Studies**



## **Case-Control Studies**

As part of FoodNet, case-control and other epidemiologic studies are conducted to determine the proportion of foodborne diseases that are caused by specific foods or food preparation and handling practices. By determining this proportion, health officials can make prevention efforts more specific and document their effectiveness.

Cases of the pathogens under study are ascertained through hospitals and laboratories in the FoodNet catchment area. Patients reported through FoodNet surveillance are contacted by FoodNet staff and administered the questionnaire if eligible for the study. Outbreak-associated cases are excluded from these studies.

### **Salmonella Case-Control Study**

In 1996, the FoodNet Salmonella case-control study was conducted to determine the proportion of culture confirmed cases of non-typhoidal Salmonella serogroups B and D infections that are attributable to eating meat, egg, poultry, and other products, and the proportion of infections attributable to pet ownership.

Eating chicken and undercooked eggs was associated with sporadic Salmonella Enteritidis and Salmonella Heidelberg infections. Antimicrobial use in the month before illness was associated with multiresistant Salmonella Typhimurium DT104 infections. Reptile contact was associated with salmonellosis. Breast-feeding was found to be protective against infant salmonellosis.

### **E. coli O157 Case-Control Study**

The 1997 FoodNet E. coli O157 case-control study was conducted to determine the proportion of culture confirmed cases of E. coli O157 infections that are attributable to eating meat, poultry, and other products. The case-control study found that visiting a farm, living on or visiting a farm that had cattle, eating pink hamburger (either at home or away from home), eating at a table-service restaurant, and obtaining beef through a private slaughter arrangement were the principal risk factors for these infections.

A second E. coli O157 case-control study was conducted in 1999. This study includes subtyping of isolates by pulsed-field gel electrophoresis (PFGE), and will again evaluate the role of undercooked ground beef and examine the risk and prevention factors for E. coli O157 infections.

### **Campylobacter Case-Control Study**

In 1998, FoodNet conducted a case-control study to determine risk and prevention factors for Campylobacter infection and enrolled more than 1463 case-patients and 1317 controls. The objectives of the study include determining the proportions of

culture-confirmed cases of sporadic *Campylobacter* infections, and specific antimicrobial susceptibility patterns, that are attributable to eating meat, poultry, and other products, and the proportion of infections attributable to contact with farm or companion animals. The burden of illness associated with *Campylobacter* infections as measured by the number of culture-confirmed cases and by the number of days of hospitalization for each culture-confirmed case will be determined. Analysis is ongoing.

### **Cryptosporidium Case-Control Study**

In 1999, FoodNet began a 2 year case-control study to determine sources and risk factors for *Cryptosporidium* infection. Specific objectives for this study include determining the estimate of the burden of illness associated with *Cryptosporidium* infections in the population under study and determining the proportion of laboratory confirmed cases of sporadic *Cryptosporidium* infections attributable to consuming certain foods or water, and the proportion of infections attributable to contact with recreational water or farm animals.

### **Listeria monocytogenes Case-Control Study**

FoodNet began a case-control study in February 2000 to determine sources and risk factors for listeriosis. Eight FoodNet sites are participating in this survey. Specific goals of the study include identifying dietary, medical, and behavioral risk factors for listeriosis, describing the spectrum of illness in patients with listeriosis and describing the antimicrobial resistance patterns and molecular subtypes of *L. monocytogenes* isolates from these patients.



## Baseline Laboratory Survey of Bacterial Stool Culture Practices

### SECTION A

1. Name of laboratory
2. State
9. Date form completed

### SECTION B

10. Which of the following BEST describes the type of laboratory this is?

- 1=hospital-based laboratory
- 2=independent (that is, non-hospital-based) laboratory
- 3=other explain

11. Does your laboratory receive any stool specimens for bacterial culture?

- yes [continue questionnaire]
- no [stop here and return questionnaire in enclosed envelope]

12. Are the results of stool cultures processed in your laboratory recorded electronically (that is, using a computer)?

- 1=yes
- 2=no
- 9=don't know

13. Does your laboratory perform ANY on-site bacterial stool culture testing?

- 1=yes, our laboratory performs stool cultures on site  
[GO TO SECTION C, top of p. 2]
- 2=no, ALL stool specimens for culture are sent to another laboratory  
[answer the remaining questions on this page  
(Questions 14 and 15) and return questionnaire enclosed envelope]

14. To what laboratory are stool specimens usually sent?

15. Does that laboratory typically report the results back to your laboratory?

- 1=yes
- 2=no
- 9=don't know