

Gastroenteritis Associated with a Restaurant

January

Pope County

On January 5, 2011, the Minnesota Department of Health (MDH) foodborne illness hotline received a complaint of gastrointestinal illness among two individuals from different households who had dined together at a restaurant in Glenwood on January 3. The complainants did not report any other common meals or events. MDH notified Douglas and Pope Counties Public Health Department (DPCPHD), and an investigation was initiated.

On January 5, DPCPHD sanitarians inspected the restaurant, interviewed food workers about illness history and work duties, and collected credit card receipts for patrons who had dined at the restaurant from January 2 to January 4. MDH interviewed patrons regarding food consumption and illness history. A case was defined as a restaurant patron who subsequently developed vomiting and/or diarrhea (≥ 3 loose stools in a 24-hour period).

Thirty-five restaurant patrons were interviewed and four (11%) met the case definition. One additional patron reported gastrointestinal illness prior to their meal date and was excluded from analysis. All four cases reported diarrhea, three (75%) reported vomiting, two (50%) reported cramps, and no cases reported bloody stools or fever. All four cases ate at the restaurant on January 3. The median incubation period was 16 hours (range, 6.5 to 33 hours). Illness duration information was unavailable as all four cases were still ill at the time of interview. No stool specimens were submitted.

The cases reported consuming chicken Caesar wrap, tomato soup, bourbon-marinated sirloin, mashed potatoes, and dieter's salad. The 30 controls reported eating a wide variety of food items. No food item was significantly associated with illness.

DPCPHD sanitarians interviewed all 28 restaurant employees. Two employees reported recent gastrointestinal illness. A server reported developing vomiting of 9 hour duration on December 27. A second server reported developing vomiting of 29 hour duration on December 29; this server reported working on January 3. Stool specimen kits were provided to both ill employees but were not returned. All employees with vomiting and/or diarrhea were excluded from work until 72 hours after the resolution of symptoms. During the investigation, sanitarians and restaurant management established a screening protocol for employee illness. The restaurant was ordered to implement an employee illness log and prevent bare-hand contact with ready-to-eat foods. The sanitarian also discussed the importance of handwashing for the prevention of norovirus transmission.

This was a probable foodborne outbreak of gastroenteritis associated with eating at a restaurant. The most likely etiology was norovirus, but this was not confirmed. There was gastrointestinal illness among food workers prior to the outbreak, and contamination of ready-to-eat foods by restaurant employees is the most plausible explanation for the patron illnesses. However, this was not confirmed.