

Gastroenteritis Probably Associated with Adolescent Treatment Facility

August

St. Louis County

On August 30, 2012, the director of an adolescent treatment facility contacted their Minnesota Department of Health (MDH) Environmental Health sanitarian to inform him that approximately 20 individuals at the facility for inpatient treatment had become ill with vomiting and diarrhea on August 24. An investigation was initiated immediately.

A MDH sanitarian visited the facility on August 30 to evaluate food preparation and handling procedures and interview food workers. MDH staff interviewed patients about food consumption and illness history. A case was defined as a treatment facility patient who developed vomiting or diarrhea (≥ 3 loose stools in a 24-hour period). Stool samples were not available for testing.

Five patients were interviewed; four (80%) met the case definition. One additional patient reported illness that did not meet the case definition and was excluded from analysis. The median duration of illness was 2.5 days (range, 1 to 6 days). Three (75%) cases reported diarrhea, three (75%) vomiting, three (75%) fever, one (25%) fever, and none bloody stools. Illness onset dates included August 24 ($n = 3$) and 25 ($n = 2$). Information provided by the staff at the facility indicated that 20 of 55 (36%) individuals in the inpatient program had recently developed gastrointestinal illness. No illness in outpatient program participants, who do not eat meals at the facility, was reported.

The lack of non-ill controls prevented a statistical analysis of specific food items

A MDH sanitarian interviewed both treatment facility employees who work in food service. Initially, both employees were reported as being ill with gastrointestinal symptoms; however, when they were interviewed, only one reported recent illness. The employee developed vomiting and cramps on August 16; recovered on August 18 and returned to work that day.

This was an outbreak of gastroenteritis associated with patients in the in-patient program at an adolescent treatment facility. Limited access to information regarding patient food consumption and illness symptoms prevented a full investigation. The etiologic agent and the vehicle of transmission were not identified. The presence of a recently ill food worker is the most plausible source of the contamination; however, person-to-person transmission could not be ruled out.