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Miami-Dade County HEALTH DEPARTMENT

Outbreak of Salmonella Associated with the Consumption of *"Papa Rellena"* in a Local Miami-Dade Restaurant

Alicia Camps Sotirescu, Edhelene Rico and Juan A. Suarez

BACKGROUND

On July 8, 2002, the Office of Epidemiology and Disease Control (OEDC), Miami-Dade County Health Department (MDCD) forwarded a complaint to the Department of Business and Professional Regulation (DBPR) reporting that a restaurant patron had a positive stool culture for *Salmonella group D*. The customer reported eating *papa rellena (*stuffed potato) at the restaurant on July 5, 2002 along with two other family members who also had gastroenteric symptoms. DBPR conducted an inspection on July 31, 2002. On August 8, 2002, OEDC identified two other case-patients who had tested positive for *Salmonella group D*. These two case-patients consumed *papas rellenas* on July 5th at the same restaurant as the previous group. Thus, three confirmed and two probable case-patients consumed *papas rellenas* on the same day at the same restaurant and consumed no other food item. The food item could not be confirmed as the vehicle for the *Salmonella* infection because there were no controls, no remaining food items were available for testing, and the salmonella isolate was not available for serotyping.

A similar situation occurred December 1996 when "*papa rellena*" was implicated in a *Salmonella* outbreak. In that outbreak there were 80 confirmed case-patients, 25 carriers, and over 420 suspected cases associated with eating in a local restaurant. The organism was isolated from the *papa rellena* and other foods. The theory was that the heat of cooking never reached the precooked "*picadillo*" meat at the center of the *papa rellena*.

Salmonella is a group of bacteria that can cause a diarrheal illness in humans. Most infected persons develop diarrhea, fever, and abdominal cramps 6 to 72 hours after infection. The illness usually lasts 4 to 7 days, and most persons recover without treatment. However, in some persons the diarrhea may be so severe that the patient needs to be hospitalized.

PREPARATION OF PAPA RELLENA

Papa rellena (stuffed potato) contains mashed potato and ground beef. Usually both items are individually cooked, but on the July 2002 outbreak the restaurant used canned instant mashed potato with pasteurized milk. This food item has a center of ground beef surrounded by a ball of mashed

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potatoes that is dipped in egg and breaded. The product is then fried in oil.

CONCLUSION AND PREVENTIVE MEASURES

No new cases were identified. Surveillance for *Salmonella*, especially group D, cases is ongoing. DBPR required the corrections of the following violations found during the inspection: temperature in the refrigerator was out of the required range, inaccessibility of hand washing sink, and presence of flies due to unscreened windows.

Possible points of contamination during the preparation process include 1) the handling of the cooked meat, 2) the forming of the mashed potato outer layer (by hand), 3) dipping the *papa rellena* in a bowl containing raw eggs which have the potential to contaminate the potatoes or meat, 4) the frying temperature and time were insufficient to kill the bacteria in the contaminated mashed potatoes or meat or 5) contamination after cooking.

The restaurant received educational materials about *Salmonella* and the importance of hand washing and avoidance of cross contamination.

Following these tips provided by Fight BAC can prevent food contamination:

Four Steps

- **Clean: Wash hands and surfaces often**
  - Wash hands in hot soapy water before preparing food and after using the bathroom, changing diapers, and handling pets. Use warm water to moisten hands and then apply soap and rub hands together for 20 seconds before rinsing thoroughly.
  - Wash cutting boards, knives, utensils and counter tops in hot soapy water after preparing each food item and before going on to the next one.
- **Separate: Don't cross-contaminate**
  - Keep raw meat, poultry and seafood in sealed containers or plastic bags so juices will not cross-contaminate.
  - Store raw meat, poultry and seafood on the bottom shelf of the refrigerator so juices don't drip onto other foods.

- **Chill: Refrigerate promptly**
  - Keep perishable foods such as meat, poultry, seafood, eggs, and mayonnaise-based salads cold or frozen until ready to cook.
  - When traveling, pack cooler with plenty of extra ice or freezer packs to ensure a constant cold temperature. Store drinks in a separate cooler to avoid frequent opening of the food cooler.
- **Cook: cook to proper temperature**
  - Cook ground meat to at least 160° F. If a thermometer is not available, do not eat ground beef that is still pink inside.
  - Cook eggs until the yolk and white are firm, not runny. Don't use recipes in which eggs remain raw or are only partially cooked.

Ciguatera Poisoning Outbreak in a Miami-Dade County Family Related to Amberjack Fish Consumption

Alvaro Mejia-Echeverry and Juan A. Suarez

Background

On August 6, the Office of Epidemiology and Disease Control (OEDC), Miami Dade County Health Department was notified by the infection control practitioner from a local hospital that a five-year-old child had been admitted to the ICU on August 3, 2002 with both neurological and gastrointestinal symptoms suggesting ciguatera poisoning. The OEDC started an investigation.

The whole family, the child, his parents, sibling, grandparents and uncle became sick after consuming the fish on August 2, 2002. The incubation period varied between 3 and 13.5 hours; median was 5.5 hours.

Investigation

It was noted that the consumed fillets of fish were bought at a marina on August 2. Two fillets were reported as amberjack, and one was from a different fish (probably barracuda). All family members ate the amberjack, except the uncle who ate the unidentified fish fillet. All the exposed, the child's father (37 years), mother (40 years), brother (2 years), grandfather (82 years), grandmother (80 years), and uncle (39 years) had the same kind of symptoms but different degrees of severity. The father was also admitted to a different hospital and needed intravenous fluids and osmotic diuretics to manage the neurological symptoms. The diarrhea was so severe for 3 of the victims that they had between 30 and 40 episodes during 24 hours. Neurological symptoms, according to the mother, included severe weakness, and temperature reversal plus tingling and numbness. Symptoms are reflected in table 1.

There was no alcohol consumption with the dinner. Family denied exposure to insecticides or herbicides.

The results of stool samples from family members were negative for bacterial pathogens and parasites. There was no leftover fish to be tested for ciguatoxin.

In order to prevent further distribution of this toxic fish in Miami-Dade County and other areas, the cases were reported to the Florida Department of Agriculture (DOACS), and to the Department of Business and Professional Regulation (DBPR).

Table 1. Symptoms present in patients consuming the amberjack fish on August 2, 2002 in Miami-Dade

Symptom	N	%
Numbness/ tingling	7	100
Weakness	7	100
Abdominal cramps	6	86
Diarrhea	5	71
Nausea	5	71
Fatigue	5	71
Temperature reversal	4	57
Body Aches	4	57
Prostration	3	43
Headache	3	43
Dizziness	3	43
Chills	2	29
Sweating	2	29
Vomiting	1	14
Fever	0	0

Conclusions

Ciguatera poisoning is the most common non-bacterial fish poisoning associated with fish in the United States. The poisoning involves almost exclusively tropical and semitropical marine coral reef fish. Of reported cases, 75% (except in Hawaii) involve the barracuda, snapper, jack (amberjack, horse-eye jack, black jack), or grouper. Other large species of jack, king mackerel, large groupers, and snappers are particularly likely to contain ciguatoxin. The ciguatera syndrome is associated with at least five toxins, all of which are unaffected by freeze-drying, heat, cold, and gastric acid and none of which affects the odor, color, or taste of fish.

The onset of symptoms may be as early as15 to 30 minutes after ingestion and typically takes place

within 1 to 3 hours. Symptoms then increase in severity over the ensuing 4 to 6 hours. Most victims develop symptoms over 12 hours of ingestion, and virtually all are affected within 24 hours. The more than 150 possible symptoms include abdominal pain, nausea, vomiting, diarrhea, chills, paresthesias, pruritus, tongue and throat numbness or burning, sensation of "carbonation" during swallowing, odontalgia or dental dysesthesias, dysphagia, dysuria, dyspnea, weakness, fatigue, tremor, fasciculations, ataxia, vertigo, pain and weakness in the lower extremities, maculopapular rash, diaphoresis, headache, arthralgias, myalgias, bradycardia, hypotension, central respiratory failure, and coma. Death is rare.

Diarrhea, vomiting and abdominal pain usually develop 3 to 6 hours after the ingestion of a ciguatoxic fish. Symptoms may persist for 48 hours and then generally resolve (even without treatment). A pathognomonic symptom is the reversal of hot and cold tactile perception, which develops in some persons after 3 to 5 days and may last for months.

The differential diagnosis of ciguatera includes paralytic shellfish poisoning, eosinophilic meningitis, type E botulism, organophosphate insecticide poisoning, tetrodotoxin poisoning, and psycogenic hyperventilation. At present, the diagnosis of ciguatera poisoning is made on clinical grounds because no routinely used laboratory test detects ciguatoxin in human blood. A ciguatoxin enzyme immunoassay may be used to test small portions of the suspected fish.

In this family outbreak, as of September 17, 2002 the patients still report some neurological symptoms including numbness, tingling and weakness. The symptoms, however, are now less severe. As an interesting observation, the uncle who ate the unnamed fish had symptoms that were significantly less severe and had a longer incubation period (13.5 hours, as compared with the median of 5.5 hours). It is also important to note that there is a difference in both the severity of symptoms and the length of the incubation periods, related to the amount of fish consumed; i.e., the larger the portion consumed, the more severe the symptoms and, the shorter the incubation period. It is difficult to determine if a fish has ciguatoxin unless a test is performed. However, some guidelines may be followed to reduce the chances of consuming a toxic fish. Large (over 10 pounds) reef feeding fish are more likely to have the toxin. This is due to bioaccumulation of the toxin in the food chain.

Recommendations

During recovery from ciguatera poisoning, the victim should exclude the following from the diet: fish (fresh or preserved), fish sauces, shellfish, shellfish sauces, alcoholic beverages, and nuts and nut oils. Consumption of fish in ciguatera-endemic regions should be avoided. All oversized fish (See figure) of any predacious reef species should be suspected of harboring ciguatoxin. Neither moray eels nor the viscera of tropical marine fish should ever be eaten.

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Update: Investigations of West Nile Virus Infections in Recipients of Organ Transplantation and Blood Transfusion

[The following article was selected from CDC MMWR September 20, 2002 / Vol. 51 / No. 37 The full article can be downloaded from http://www.cdc.gov/mmwr/PDF/wk/mm5137.pdf]

An investigation involving CDC, the Food and Drug Administration (FDA), the Health Resources and Services Administration (HRSA), the Georgia Division of Public Health, and the Florida Department of Health identified West Nile virus (WNV)--associated illnesses in four recipients of organs from the same donor (*1*,*2*). Although the transplanted organs were the source of infection for the four organ recipients, the source of the organ donor's infection remains unknown; an investigation of the numerous transfusions received by the organ donor is ongoing.

Since the report of these cases, CDC has been informed of other patients with suspected WNV-associated meningoencephalitis (WNME) after receiving blood products within 4 weeks of illness onset. One of these patients also received an organ transplant. All of these patients resided in areas with epidemic and epizootic WNV activity; investigations are ongoing to determine whether transfusion or transplantation was the source of WNV transmission. This report summarizes two investigations of recipients of organs and blood products, four investigations of transfusion recipients, and one investigation of a WNV-seronegative person with fever and encephalopathy who received a potentially contaminated unit of blood.

Investigation 1. On August 1, four organs were recovered from an organ donor and were transplanted into four persons (*1*,*2*). WNME was confirmed in three recipients and WNV fever in one recipient (Table). Illness began 7--17 days after transplantation. Although a sample of the donor's plasma collected at the time of the organ recovery was positive for WNV by kinetic quantitative PCR assay (TaqMan®), the source of the organ donor's infection is unknown. During treatment for injuries, which eventually were fatal, the organ donor received blood products from 63 unique donors. Donor follow-up has been initiated by the blood collection agency. Of 41 donors for whom retention segments* were available, 22 tested negative for WNV by TaqMan® and serology, and 19 tested negative for WNV by TaqMan®; serology testing on these 19 segments is in progress. In addition to the organ donor, 35 other persons received components derived from these 63 donors; follow-up of these recipients is pending. Untransfused components are being returned to the blood collection agency. One has tested negative for WNV by TaqMan®; testing on the others is under way.

Investigation 2. A man aged 47 years received a liver transplant on August 14 and during the next 7 days received 39 units of blood products. After discharge on August 24, he was readmitted to the hospital on September 3 with fever and subsequently developed encephalopathy. A lumbar puncture revealed elevated protein, a lymphocytic pleocytosis, and WNV IgM antibody; the patient recovered and was discharged. Before organ recovery, the donor received two units of albumin and one unit of fresh frozen plasma (FFP). In addition to the liver, two kidneys were recovered and were transplanted into one recipient, whose clinical status is being investigated.

Investigation 3. During July 27--28, a woman aged 24 years received 18 units of blood products (12 units of packed red blood cells [PRBC] and six units of FFP) because of postpartum hemorrhage. On August 1, she was discharged. The patient developed worsening headache and fever and 22 days later was readmitted to the hospital with meningitis. A lumbar puncture revealed a lymphocytic pleocytosis; serum and CSF samples were positive for WNV by IgM. Retention segments were available from 15 of the 18 donations administered in July; three (20%) were positive for WNV by TaqMan®. Of three components derived from a donation associated with these positive segments, one unit of FFP was retrieved, tested, and found to be positive for WNV by TaqMan®; viable WNV also was isolated from this plasma. The donor of this blood component sought medical care 4 days after donation because of fever, chills, and headache; follow-up WNV-antibody testing of this donor is in progress.

Investigation 4. A man aged 72 years with a history of myelodysplasia and frequent blood transfusions received four units of PRBC during July 18--August 7. The patient was admitted on August 8 with generalized weakness and fever. A serum sample obtained 2 days later was positive for WNV by IgM. No retention segments were available. Of five components derived from these four donations, four units of FFP were retrieved, and testing is in progress. One unit of platelets was transfused into another recipient, and follow-up is pending.

Investigation 5. On July 17, a woman aged 78 years received two units of PRBC 1 day after a surgical amputation. Three days after receiving the transfusions, she developed fever, altered mental status, and seizures. Acute- and convalescent-phase serum samples and CSF were positive for WNV by IgM. Retention segments associated with both units of PRBC were negative for WNV by TaqMan® and by IgM. Follow-up of the two donors and a patient who received platelets from one of these donors is in progress.

Investigation 6. During July 26--August 23, a man aged 77 years who required frequent blood transfusions for myelodysplasia received eight units of blood products (four units of PRBC and four units of single-donor platelets). On August 23, the patient developed fever and headache. Serum and CSF samples were positive for WNV-specific IgM. The patient had progressive encephalopathy and died. Four retention segments were available for four of the eight donations; all were negative for WNV by TaqMan®. Follow-up is ongoing for three patients who received platelets from three of the eight donors. In addition, four units of plasma have been withdrawn and are being tested.

Investigation 7. On July 26, a woman aged 55 years received three units of PRBC after an orthopedic procedure. The following day, she developed fever and encephalopathy. Serum samples collected on the fourth and 40th days after illness onset were negative for WNV by IgM. Retention segments were available from all donations; two were negative for WNV by TaqMan®. One was positive for WNV by TaqMan® but negative for WNV-specific IgM; serum collected from the donor 69 days after donation was positive for WNV-specific IgM, reflecting WNV seroconversion. The donor denied fever, headache, or other symptoms during the 3 weeks before or after the donation. A patient undergoing cardiac surgery received a unit of FFP from this donation. A serum sample collected from this patient was negative for WNV by IgM. Follow-up serum samples are being collected for the index case and for the recipient of the FFP.

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Editorial Note:

CDC, FDA, HRSA, blood collection agencies, and state and local health departments continue to investigate possible transmission of WNV through blood transfusion or organ transplantation. The initial investigation demonstrated transmission from a WNV-viremic organ donor to four recipients of those organs. In another investigation (Investigation 3), the isolation of live WNV from a unit of FFP

indicates that the virus can survive in some blood components and probably can be transmitted by transfusion. Although this case is highly suspicious for transfusion-associated transmission, this patient lived in an area where WNV was active, and the exact means of WNV acquisition cannot be determined. In contrast, the preliminary results of another case investigation (Investigation 7) indicate that not all recipients of potentially WNV-contaminated units (i.e., those that are positive for WNV by TaqMan®) will become infected with WNV.

The Public Health Service (PHS) recommends several precautionary measures to reduce the possible risk for WNV transmission by organ transplantation or blood transfusion. Patients with WNV infection who have received blood transfusions or organs within 4 weeks preceding symptom onset should be reported to CDC through local public health authorities to initiate an investigation. Serum or tissue samples should be retained for later studies. In addition, patients with WNV infection who have onset of symptoms within 1 week of blood or organ donation should be reported. Prompt reporting of these persons will facilitate withdrawal of potentially infected blood components. HRSA has alerted organ transplant organizations about the potential for transplantation-associated WNV infection.

Tests for WNV suitable for routine blood donor screening are not available. However, FDA is working with public and private partners to facilitate development of such tests to ensure their availability if screening is necessary. FDA is developing additional guidance for blood centers to enhance reporting of post-donation illnesses suggestive of WNV infection and to determine when retrieval of recent blood collections from these donors is warranted.

Approximately 4.5 million persons receive blood or blood products annually. Although persons needing blood transfusions or organ transplants should be aware of the risk for WNV infection, the benefits of receiving needed transfusions or transplants outweigh the potential risk for WNV infection. In addition, blood donation poses no risk to the donor for acquiring WNV, and PHS encourages blood donation.

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* Blood samples from tubing that had been attached to the original donor collection bag.

TABLE. Persons included in seven investigations of possible transfusion- and/or transplantation-related West Nile virus (WNV) infections

Investigation	Patient	Age (yrs)	Sex	Clinical diagnosis*	Status	Identified WNV exposure
1	Organ donor	≤20	Female	West Nile viremia	Fatal; not related to WNV	Under investigation
	Kidney recipient	38	Male	WNME	Fatal due to WNV	Organ from WNV-infected donor
	Kidney recipient	31	Female	WNME	Hospitalized	Organ from WNV-infected donor
	Liver recipient	71	Female	WNF	Recovered	Organ from WNV-infected donor
	Heart recipient	63	Male	WNME	Hospitalized	Organ from WNV-infected donor
2	Liver recipient	47	Male	WNME	Hospitalized	Under investigation
3	Transfusion recipient	24	Female	WNV-associated meningitis	Recovered	WNV-containing blood product
4	Transfusion recipient	72	Male	WNME	Recovered	Under investigation
5	Transfusion recipient	78	Female	WNME	Hospitalized	Under investigation
6	Transfusion recipient	77	Male	WNME	Fatal due to WNV	Under investigation
7	Transfusion recipient	55	Female	Unspecified encephalitis†	No evidence of WNV infection	WNV TaqMan®-positive blood product

* WNME=WNV-associated meningoencephalitis; WNF=WNV fever.
† Acute-phase (collected 4 days after illness onset) and convalescent-phase (collected 40 days after illness onset) serum samples negative for WNV by IgM.

Miami Regional Lab soliciting VZV and HSV I and II swabs

The Miami Regional Laboratory is soliciting swabs of lessions from patients with possible cases of varicella, herpes simplex virus type I, or herpes simplex type II. The Miami Regional Lab can run direct fluorescent antibody testing on these swabs that can aid in diagnosis. In addition, by frequent DFA testing the laboratory will maintain a high degree of proficiency that is very important to the community in cases where it is unclear if a patient has varicella or smallpox. The laboratory can rule in varicella within a few hours with DFA testing which effectively rules out smallpox. If you are interested in participating in this important project, please call Dr. Segaran Pillai at the Miami Regional Laboratory (305) 324-2432 for more information.

Specimen collection for Varicella-Zoster Virus Detection by DFA

Accurate detection of VZV is dependent upon proper sample collection, transport and storage.

Basal, parabasal and intermediate cells scraped from the base of the lesion should provide an appropriate specimen.

1. Collect vesicular fluid with a sterile needle and syringe and immediately inject into viral transport medium.
2. Remove the crusted scab of the vesicle and place it into a sterile screw capped microcentrifuge tube (Fisher Cat# 02-681-373; tel: 800-640-0640); ***do not place in transport medium.*** A minimum of 3 specimens should be collected. Specimen can be transported at ambient temperature or with cold packs.
3. Moisten a Dacron swab (Fisher Cat# 14-959-97B; tel: 800-640-0640) with sterile water or viral transport medium (Remel Cat# 12505; tel: 800-640-0640) and vigorously scrape the base of the lesion. Contamination of the swab with blood should be avoided.
4. Immediately place the swab into a screw-capped, snap cap tube or other suitable container with viral transport medium (break-off stick if necessary).
5. Collect multiple specimens in individual viral transport medium (a minimum of 5 swabs should be collected) if possible. **DO NOT FREEZE. SPECIMEN SHOULD BE TRANSPORTED WITH COLD PACKS.**
6. In addition, collect 5 swabs as described in Step 3 and place into a screw-capped, snap cap tube or other suitable container **(DO NOT PLACE SPECIMEN IN VIRAL TRANSPORT MEDIUM). SPECIMEN CAN BE TRANSPORTED AT AMBIENT TEMPERATURE OR WITH COLD PACKS.**
7. Using a sterile swab, scrub the base of the lesion vigorously, and apply the material in a glass microscope slide onto several spots, allow the air dry thoroughly, and place in a slide holder. Specimen should be transported at ambient temperature.

To report diseases or for information:

Office of Epidemiology and Disease Control

Childhood Lead Poisoning Prevention Program	(305) 324-2414
Hepatitis	(305) 324-2490
Other diseases and outbreaks	(305) 324-2413
HIV/AIDS Program	(305) 324-2459
STD Program	(305) 325-3242
Tuberculosis Program	(305) 324-2470
Special Immunization Program	(305) 376-1976
Nights, weekends, and holidays	**(305) 377-6751**

Monthly Report
Selected Reportable Diseases/Conditions in Miami-Dade County, August 2002

Diseases/Conditions	2002 this Month	2002 Year to Date	2001 Year to Date	2000 Year to Date	1999 Year to Date	1998 Year to Date
AIDS *Provisional	113	813	935	929	1013	1153
Campylobacteriosis	9	68	85	108	97	39
Chancroid	0	0	0	0	0	2
Chlamydia trachomatis	409	2764	2448	2056	3009	1464
Ciguatera Poisoning	0	0	0	1	0	0
Cryptosporidiosis	1	4	11	10	10	8
Cyclosporosis	0	1	0	0	0	1
Diphtheria	0	0	0	0	0	0
E. coli , O157:H7	0	0	0	1	4	2
E. coli , Other	0	1	1	1	0	1
Encephalitis	0	0	0	0	0	0
Giardiasis, Acute	16	141	182	145	62	40
Gonorrhea	166	1254	1266	1422	2056	1227
Granuloma Inguinale	0	0	0	0	0	0
Haemophilus influenzae B (invasive)	0	0	1	1	1	0
Hepatitis A	6	96	105	48	57	92
Hepatitis B	7	23	43	33	16	52
HIV *Provisional	162	1286	1023	974	1019	1199
Lead Poisoning	35	198	173	N/A	N/A	N/A
Legionnaire's Disease	0	1	1	0	0	0
Leptospirosis	0	0	0	0	0	0
Lyme disease	1	5	3	0	0	1
Lymphogranuloma Venereum	0	0	0	0	0	0
Malaria	0	8	12	18	14	18
Measles	0	0	0	0	0	0
Meningitis (except aseptic)	0	8	12	16	24	14
Meningococcal Disease	0	10	13	21	14	10
Mumps	0	0	0	1	2	0
Pertussis	0	3	1	7	10	14
Polio	0	0	0	0	0	0
Rabies, Animal	0	0	0	0	0	1
Rubella	0	0	0	1	0	0
Salmonellosis	43	193	175	183	187	120
Shigellosis	35	166	91	149	114	138
Streptococcus pneumoniae, Drug Resistant	0	75	130	149	136	63
Syphilis, Infectious	19	140	144	88	46	19
Syphilis, Other	87	613	550	500	540	440
Tetanus	0	0	1	0	0	0
Toxoplasmosis	0	14	10	0	1	0
Tuberculosis *Provisional	17	147	139	160	176	181
Typhoid Fever	0	2	0	2	15	3
Vibrio , *cholera*	0	0	0	0	0	0
Vibrio , Other	0	0	0	0	0	1

* Data on AIDS are provisional at the county level and are subject to edit checks by state and federal agencies.
** Data on tuberculosis are provisional at the county level.