FoodNet Data — Continued

clinical laboratories, health-care providers, and consumers will facilitate further interpretation of FoodNet data and help track temporal trends in foodborne illnesses. Further surveillance and comparison of the expanded geographic base are necessary to determine which changes represent year-to-year variation and which are definitive trends.

In 2001, selected counties in Colorado and Maryland will be added to the FoodNet area, bringing the FoodNet surveillance population to approximately 33.1 million persons (12% of the 1999 U.S. population). The 2000 FoodNet final report will include incidence figures and other information, such as illness severity, and will be available later in 2001 at the FoodNet World-Wide Web site, http://www.cdc.gov/foodnet. Because the population within the FoodNet sites has increased since 1999, the final 2000 rates will be somewhat lower than the preliminary rates. Preliminary reports from the 2000 decennial census suggest that population increases might have been greater than estimated by postcensal figures; therefore, the final adjusted rates might be lower than the preliminary rates by a greater margin than in previous years.

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Occupational and Take-Home Lead Poisoning Associated With Restoring Chemically Stripped Furniture — California, 1998

The Occupational Lead Poisoning Prevention Program (OLPPP) of the California Department of Health Services and a county health department investigated cases of lead poisoning in six furniture workers and their families in 1998. The investigation, initiated after a blood test of a worker's child revealed an elevated blood lead level (BLL), found that lead remaining in previously painted or coated stripped wood was carried from the workplace on clothes and shoes and was the source of the child's lead exposure and subsequent poisoning. Employers in industries in which workers restore or build using stripped wood should assess lead exposure and, when necessary, should establish a comprehensive lead safety program.

During a routine medical examination, the 18-month-old child of a worker received a BLL test at his mother's request. The result, 26 μg/dL, met the CDC-recommended criterion for a lead poisoning case requiring clinical management (i.e., BLLs $\geq$20 μg/dL) (*1*). A

Lead Poisoning — Continued

county public health nurse conducted a home visit and arranged blood testing of other family members. Laboratory tests revealed that the father, who worked for a company that refinished antique furniture, had a BLL of 46 μg/dL and his 4-month-old daughter a BLL of 24 μg/dL.

The nurse contacted OLPPP, the state program that provides follow-up for occupational lead poisoning cases. An OLPPP industrial hygienist interviewed the employer who described the process for repairing and restoring wood furniture. Before arriving at the shop, the furniture was chemically stripped of all paint or coatings and was believed to be free of lead. Four carpenters made necessary repairs using power tools such as saws and planers. In an adjacent outdoor courtyard, two refinishers smoothed the wood using manual and power sanders, washed the furniture, and applied wax. Workers routinely ate and drank in work areas, wore no protective equipment, and returned home in work clothes and shoes.

OLPPP instructed the employer to provide BLL and zinc protoporphyrin testing for the six workers and encouraged testing through the county of six family members who might have been affected by lead toxicity. All six workers had elevated BLLs: the two refinishers had BLLs of 29 and 54 μg/dL, and the four carpenters had BLLs of 46, 46, 47, and 56 μg/dL. The Occupational Safety and Health Administration lead regulation requires employees with BLLs ≥40 μg/dL to receive a medical examination, additional laboratory testing, and follow-up (*2*). Five of the six family members, aged 7–12 years, did not have elevated BLLs; however, a 7-month-old infant, whose father's BLL was >40 μg/dL, had a BLL of 16 μg/dL; it was 15 μg/dL on retesting 30 days later.

OLPPP recommended that the employer establish a comprehensive lead safety program that included exposure monitoring, good hygiene practices, medical examinations, protective clothing, respiratory protection, safe dust clean-up methods, and training. The employer arranged personal exposure monitoring and surface wipe sampling for lead and implemented workplace improvements, including a respiratory protection program; use of HEPA vacuum-attached power sanders; use of a high-efficiency toxic dust HEPA vacuum; daily clean uniforms; separate storage lockers, changing area with showers, and lunch room; warning signs; safety training addressing take-home lead; and a lead medical surveillance program. Workers' BLLs declined after these steps were taken, and the average BLL decreased 15 μg/dL in approximately 3 months.

The nurse advised the affected families on cleaning residences and vehicles. At the residence of the index case, a wipe sample taken on a carpet where the worker played with his children showed a lead surface concentration of 30 $\mu g/ft^2$. After steam cleaning the carpet, the level was 14 $\mu g/ft^2$. This lead level on interior floors is below 40 $\mu g/ft^2$, the threshold level the Environmental Protection Agency has determined to be harmful (*3*). In addition to the take-home lead contamination, the investigation identified deteriorated lead paint, which the landlord remediated. When the 4-month-old infant's BLL remained elevated several months later, more thorough testing of painted surfaces was performed, and the landlord was required to remediate additional lead painted surfaces. The infant's BLL then decreased steadily.

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Editorial Note: Exposure to lead in paints and coatings is a known health risk, and recommendations have been made to prevent exposure (*4,5*). This investigation revealed that wood chemically stripped of lead-containing coatings can retain harmful amounts

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of lead. The process of alkaline stripping can cause lead to migrate from the paint layer into the pores of the wood substrate (*6*). Although the wood appears uncoated, sufficient airborne lead dust is released while using power and hand tools to cause surface contamination and elevated BLLs in workers (*7*).

Employers in industries that sand or otherwise disturb lead-impregnated stripped wood (e.g., furniture refinishing and construction) may be unaware of the risk for lead exposure and therefore may not be taking adequate precautions. Public health agencies that address lead issues should send hazard alerts to trade associations and employers in the affected industries. The incident in this report illustrates that industries that handle chemically stripped wood need to comply with lead safety measures, including exposure assessment and control, provision of work clothing and shoes, good hygiene and workplace housekeeping practices, employee training, and medical surveillance. This incident also underscores that a thorough investigation of a childhood lead poisoning case should consider the occupations of adults in the household. Where take-home lead is suspected, BLL tests of the adults can help to confirm workplace exposure. Follow-up at the worksite, including screening of other workers and their young children, can identify others at risk.

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Notice to Readers

Satellite Broadcast on a Public Health Response to Asthma

CDC's National Center for Environmental Health, Public Health Program Practice Office, and Public Health Training Network, in collaboration with the American Pharmaceutical Association, will co-sponsor a live satellite broadcast, "A Public Health Response to Asthma," May 17, 2001, from 1 to 3:30 p.m. eastern time. The broadcast is designed for state and local health agency officials, health educators, epidemiologists, environmental health specialists, school health officials and nurses, managed care personnel, pharmacists, public health students, respiratory therapists, nurses, nonprofit asthma organization staff, and primary care providers who deal with asthma. The broadcast will describe why asthma is an escalating problem in the United States, discuss intervention programs, and provide tools and resources to use in local communities to combat the disease.

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WEEKLY REPORT

Preliminary FoodNet Data on the Incidence of Foodborne Illnesses — Selected Sites, United States, 2000

Each year in the United States, an estimated 76 million persons contract foodborne illnesses (*1*). CDC's Emerging Infections Program Foodborne Diseases Active Surveillance Network (FoodNet) collects data about nine foodborne diseases in eight U.S. sites to quantify and monitor foodborne illnesses (*2–5*). This report describes preliminary surveillance data for 2000 and compares them with 1996–1999 data. The data indicate the relative frequency of diagnosed infections, demonstrate substantial regional variation, and suggest trends in incidence. FoodNet provides data for monitoring foodborne illnesses and interventions designed to reduce them.

In 1996, active surveillance began for laboratory-confirmed cases of *Campylobacter, Escherichia coli* O157, *Listeria monocytogenes, Salmonella, Shigella, Vibrio,* and *Yersinia entercolitica* infections in Minnesota, Oregon, and selected counties in California, Connecticut, and Georgia. In 1997, surveillance for laboratory-confirmed cases of *Cryptosporidium* spp. and *Cyclospora cayetanensis* infections was added, and 12 Georgia counties and Fairfield County in Connecticut were added to the surveillance area. In 1998, the surveillance area for Connecticut became statewide and active surveillance began in selected counties in Maryland and New York. In 1999, the remaining counties in Georgia and eight counties in the metropolitan Albany, New York, area were added. In 2000, 11 counties in Tennessee and Contra Costa County in California were added, bringing the FoodNet surveillance population to 29.5 million persons (10.8% of the 1999 U.S. population) (*6*). To identify cases, surveillance personnel contact each clinical laboratory in their surveillance area either weekly or monthly depending on the size of the clinical laboratory. Cases represent the first isolation of a pathogen from a person by a clinical laboratory; most specimens were obtained for diagnostic purposes from ill persons.

Preliminary incidence figures for 2000 were calculated using the number of cases of diagnosed infections that FoodNet had identified at clinical laboratories as the numerator and 1999 population estimates as the denominator (*6*). Final incidence rates will be calculated when 2000 population census counts are available.

2000 Surveillance

The data for 2000 are presented in two ways: from the five original sites and from the expanded eight site population. The eight site data are likely to represent better the national picture. During 2000, 12,631 laboratory-confirmed cases of nine diseases under surveillance were identified: 4640 of campylobacteriosis, 4237 of salmonellosis, 2324 of