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EMERGING FOOD BORNE DISEASES

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ABSTRACT

The epidemiology of food borne diseases is rapidly changing. Recently described pathogens, such as *Escherichia coli* and the epidemic strain of Salmonella serotype Typhimurium Definitive Type 104 (which is resistant to at least five antimicrobial drugs), have become important public health problems. Well- recognized pathogens, such as Salmonella serotype Enteritidis, have increased in prevalence or become associated with new vehicles. Emergence in food borne diseases is driven by the same forces as emergence in other infectious diseases: changes in demographic characteristics, human behavior, industry, and technology; the shift toward a global economy; microbial adaptation; and the breakdown in the public health infrastructure. Addressing emerging food borne diseases will require more sensitive and enhanced methods of laboratory identification and sub typing, and effective prevention and control. The epidemiology of food borne disease is changing. New pathogens have the contamination of human food with sewage or animal manure.

KEYWORDS

Food borne diseases, E.coli and Pathogens.

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INTRODUCTION

Food borne illness is any illness resulting from the consumption of contaminated food, pathogenic bacteria, viruses, or parasites that contaminate food, as well as chemical or natural toxins such as poisonous mushrooms. It also referred to food poisoning. Food borne illness usually arises from improper handling, preparation, or food storage. Bacteria are a common cause of food borne illness. Here we are mainly discussing about four food borne pathogens - *Campylobacter jejuni*, *E.coli*, *vibrio vulnificus* and *Listeria monocytogene*. Some

types of microbes stay in the intestine, some produce a toxin that is absorbed into the bloodstream, and some can directly invade deeper body tissues^{1,2}.

Campylobacter jejuni

Campylobacter jejuni, an emerging food borne pathogen not recognized as a cause of human illness until the late 1970s, is now considered the leading cause of food borne bacterial infection⁴. An estimated four million *C. jejuni* infections occur each year in the United States; most sporadic infections are associated with improper preparation or consumption of mishandled poultry products⁴. Incidence of campylobacteriosis is particularly high among young men. The high incidence of disease in this group may reflect poor food preparation skills⁴. Most *C. jejuni* outbreaks, which are far less common than sporadic illnesses, are associated with consumption of raw milk or unchlorinated water⁴. The Guillain-Barré syndrome, an acute paralytic illness that may leave chronic deficits, may follow *Campylobacter* infections³. In a multicenter study of 118 patients with Guillain-Barré syndrome in the United States, 36% had serologic evidence of *C. jejuni* infection in the weeks before neurologic symptoms developed⁸.

E. coli O157:H7

E. coli O157:H7 was first recognized as a human pathogen in 1982 when two outbreaks in the United States were associated with consumption of undercooked hamburgers from a fast-food restaurant chain⁸. The pathogen has since emerged as a major cause of bloody and non-bloody diarrhea, causing as many as 20,000 cases and 250 deaths per year in the United States^{9,8}. Outbreaks have been reported in Canada, Japan, Africa, the United Kingdom, and elsewhere. In addition to causing bloody diarrhea, *E. coli* O157:H7 infection is the most common cause of the hemolytic uremic syndrome, the leading cause of acute kidney failure in children in the United States. The syndrome is associated with long-term complications; 3% to 5% of patients with hemolytic uremic syndrome die, and approximately 12% have sequelae including end-stage renal disease, hypertension, and

neurologic injury⁸. Consumption of ground beef⁸, lettuce¹⁰, raw cider¹¹, raw milk, and untreated water have been implicated in outbreaks, and person-to-person transmission is well documented.

Vibrio vulnificus

In the late 1970s, *Vibrio vulnificus* was recognized to cause an usually severe syndrome of food borne *V. vulnificus* infection called primary septicemia. *V. vulnificus* primary septicemia generally affects people with underlying disease, particularly liver disease. Patients become ill within 7 days after eating raw molluscan shellfish. Tracebacks implicate shellfish harvested from warm water areas. The symptoms may include shock and bullous skin lesions and may quickly progress to death. Most reported shellfish-associated *V. vulnificus* infections are fatal¹².

Listeria monocytogenes

Since the early 1980s, food borne transmission has been recognized as a major source of human listeriosis¹³. Listeriosis can cause stillbirths, miscarriages, meningitis, or sepsis in immunocompromised hosts. Case-fatality rates as high as 40% have been reported during outbreaks¹³. Outbreaks have been associated with ready-to-eat foods, including cole slaw, milk probably contaminated after pasteurization, pate, pork tongue in jelly, and soft cheese made with inadequately pasteurized milk¹³. The U.S. Department of Agriculture and U.S. Food and Drug Administration established zero tolerance policies for *L. monocytogenes* in foods in 1989. From 1989 to 1993, the food industry launched efforts to reduce *Listeria* contamination in processed foods, and dietary recommendations were established and publicized for persons at increased risk for invasive listeriosis. During this 4-year interval, the incidence of listeriosis declined by 40% in nine surveillance areas across the United States¹⁴.

Prevention of food borne diseases

Meeting the complex challenge of food borne disease prevention will require the collaboration of regulatory agencies and industry to make food safely and keep it safe throughout the industrial chain of production. Prevention can be “built in” to

the industry by identifying and controlling the key points-from field, farm, or fishing ground to the dinner table-at which contamination can either occur or be eliminated. The general strategy known as Hazard Analysis and Critical Control Points (HACCP) replaces the strategy of final product inspection. Some simple control strategies are self-evident, once the reality of microbial contamination is recognized. For example, shipping fruit from Central America with clean ice or in closed refrigerator trucks, rather than with ice made from untreated river water, is common sense. Similarly, requiring oyster harvesters to use toilets with holding tanks on their oyster boats is an obvious way to reduce fecal contamination of shallow oyster beds. Pasteurization provides the extra barrier that will prevent *E. coli* O157:H7 and other pathogens from contaminating a large batch of freshly squeezed juice.

For many food borne diseases, multiple choices for prevention are available, and the best answer may be to apply several steps simultaneously. For *E. coli* O157:H7 infections related to the cattle reservoir, pasteurizing milk and cooking meat thoroughly provide an important measure of protection but are insufficient by themselves. Options for better control include continued improvements in slaughter plant hygiene and control measures under HACCP, developing additives to cattle feed that alter the microbial growth either in the feed or in the bovine rumen to make cows less hospitable hosts for *E. coli* O157, immunizing or otherwise protecting the cows so that they do not become infected in the first place, and irradiating beef after slaughter. For *C. jejuni* infections related to the poultry reservoir, future control options may include modification of the slaughter process to reduce contamination of chicken carcasses by bile or by water baths, freezing chicken carcasses to reduce *Campylobacter* counts, chlorinating the water that chickens drink to prevent them from getting infected, vaccinating chickens, and irradiating poultry carcasses after slaughter. Outbreaks are often fertile sources of new research questions. Translating these questions into research

agendas is an important part of the overall prevention effort. Applied research is needed to improve strategies of sub typing and surveillance. Veterinary and agricultural re- search on the farm is needed to answer the questions about whether and how a pathogen such as *E. coli* O157:H7 persists in the bovine reservoir, to establish the size and dynamics of a reservoir for this organism in wild deer, and to look at potential routes of contamination connecting animal manure and lettuce fields. More research is needed regarding foods defined as sources in large outbreaks to develop better control strategies and better barriers to contamination and microbial growth and to understand the behavior of new pathogens in specific foods. Research is also needed to improve the diagnosis, clinical management, and treatment of severe food borne infections and to improve our understanding of the pathogenesis of new and emerging pathogens. To assess and evaluate potential prevention strategies, applied research is needed into the costs and potential benefits of each or of combinations^{15,16}.

Risk Assessment and International Food Standards

The movement of ever-increasing quantities of food across borders has resulted in a transnationalization of disease risk¹⁷. Therefore, the globalization of food trade and the open access to foreign markets need to be accompanied by effective means of health protection for populations. In the food sector, international regulatory instruments need to be integrated with strengthened surveillance and monitoring. As a result of the Uruguay Round of Multilateral Trade Negotiations and the increased liberalization of trade facilitated by this agreement, concern about the safety of imported food has grown. However, provisions in the Agreement on the Application of Sanitary and Phytosanitary Measures, which entered into force with the establishment of the World Trade Organization on January 1, 1995, are designed to address these concerns: according to the work of the Codex Alimentarius Commission, its standards, guidelines, and recommendations are recognized as the

reference for national food safety requirements. Countries that are members of the World Trade Organization may no longer be able to reject foods that meet Codex standards, guidelines, and recommendations without providing justification. Moreover, the increased volume of the global food trade underscores the need for sound epidemiologic information and international risk assessment. In this regard, Article 5 of the Sanitary and Phytosanitary Measures agreement explicitly requires World Trade Organization members to conduct scientific and consistent risk assessments. Furthermore, the World Health Organization has recommended that the application of the HACCP system at every stage of the food chain represents an effective approach for governments to meet the terms outlined in the agreement¹⁸. Another issue receiving more attention from regulatory agencies and underlined during the Food and Agriculture Organization/World Health Organization Conference on Food Standards, Chemicals in Food, and Food Trade (1991), is the scientific basis of the Codex standards. The Conference recommended that the Codex, in its norm-setting work on health and safety, place greater emphasis on risk assessment¹⁹. Epidemiologic data on food borne diseases have an important role in risk assessment. One example is assessing the risk of contracting listeriosis associated with different levels of *Listeria monocytogenes* in smoked fish and meat products²⁰. However, the need for risk assessment as the basis for setting standards has shown a great gap in knowledge about food borne pathogens and their relation to human illness²¹⁻²². To address the national/ transnational risks caused by food borne diseases, this gap must be narrowed.

CONCLUSION

The globalization of the risks associated with food borne illness, specifically increased international travel and trade in food, has resulted in greater interdependence in terms of food safety. Therefore, internationally agreed-upon food safety standards and other types of agreements are becoming increasingly important in addressing the complex

transnational challenge of food borne disease control. Epidemiologic data provide a common ground for reaching international consensus on food safety issues. As Morris Potter has said, "If one recognizes that ensuring food safety is inherently uncertain, food borne illnesses become opportunities to learn rather than failures to predict. Food borne disease will occur, and we must be prepared to react quickly to reduce the risk of new food borne hazards"²³.

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CONFLICT OF INTEREST

We declare that we have no conflict of interest.

BIBLIOGRAPHY

1. Food poisoning at dorland's medical dictionary.
2. US UDC food poisoning guide.
3. Tauxe R V. Epidemiology of *Campylobacter jejuni* 25. infections in the United States and other industrialized nations. In: Nachamkin I, Tompkins S, Blaser M, editors. *Campylobacter jejuni: Current Status and Future Trends*. Washington (DC): American Society for 26, *Microbiology*, 1992.
4. Mishu B, Ilyas A A, Koski C L, Vriesendorp F, Cook S D, Mithen F A, *et al*. Serologic evidence of previous *Campylobacter jejuni* infection in patients with the Guillain-Barré syndrome, *Ann Intern Med*, 118(12), 1993, 947-53.
5. Boyce T G, Swerdlow D L, Griffin P M. *Escherichia coli* O157:H7 and the hemolytic-uremic syndrome, *N Engl J Med*, 333(6), 1995, 364-8.
6. Council for Agricultural Science and Technology. Foodborne pathogens: risks and consequences. *Ames (IA): The Council*, 1994, 87.

7. Altekrose S F, Hyman F H, Klontz K C, Timbo B T, Tollefson L K. Foodborne bacterial infections in individuals with the human immunodeficiency virus, *South Med J*, 87, 1994, 169-73.
8. Swerdlow D L, Lee L A, Tauxe R V, Bean N H, Jarvis J Q. Reactive arthropathy following a multistate outbreak of *Salmonella typhimurium* infections [abstract], Proceedings of the 30th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1990, 21- 24. Atlanta G A. Washington (DC): *American Society for Microbiology*, 1990, Abstract No. 916.
9. Blake P A, Merson M H, Weaver R E, Hollis D G, Heublin P C. Disease caused by a marine *Vibrio*. Clinical characteristics and epidemiology, *N Engl J Med*, 300(1), 1979, 1-5.
10. Schuchat A, Swaminathan B, Broome C V. Epidemiology of human listeriosis, *Clin Microbiol Rev*, 4(2), 1991, 169-83.
11. Tappero J W, Schuchat A, Deaver K A, Mascola L, Wenger J D. Reduction in the incidence of human 31, listeriosis in the United States, Effectiveness of prevention efforts?, *JAMA*, 273(14), 1995, 1118-22.
12. Tauxe R V, Vandepitte J, Wauters G, Martin S M, Goosens V, DeMol P, *et al.* *Yersinia enterocolitica* infections and pork: the missing link, *The Lancet*, 329(8542), 1987, 1129-32.
13. World Health Organization. Worldwide spread of infections with *Yersinia enterocolitica*. *WHO Chronicle*, 30, 1976, 494-6.
14. Nakajima H. Global disease threats and foreign policy, *Brown Journal of World Affairs*. *In press*, 4(1), 1997, 319-332.
15. WTO. Selected World Health Organization activities relevant to the application of sanitary and phytosanitary measures. *Geneva: WTO*, 1995, G/SPS/W/37.
16. FAO/WHO. Report of the Joint FAO/WHO Conference on Food Standards, *Chemicals in Food and Food Trade*. Rome: FAO, 1991.
17. Van Schothorst M. Sampling plan for *Listeria monocytogenes*, *Food Control*, 7(4-5), 1996, 203-8.
18. FAO/WHO. Report of the Joint FAO/WHO Expert Consultation on Application of Risk Analysis to Food Standards Issues, Geneva, 1995, 13-17. Geneva: World Health Organization, unpublished document, 1995, WHO/FNU/FOS/95.3.
19. FAO/WHO. Report of the Joint FAO/WHO Expert Consultation on Risk Management and Food Safety Issues, Rome, 1997, 27-31. *FAO Food Nutr Pap*, 1997, 62.
20. Potter M, Gonzalez-Ayala S, Silarug N. The epidemiology of food borne diseases. In: Doyle M P, Beuchat L, Montville T, editors. *Fundamentals of Food Microbiology*, Washington (DC): *American Society for Microbiology*, 1997.
21. Riley L W, Remis R S, Helgerson S D, McGee H B, Wells J B, Davis B R, *et al.* Hemorrhagic colitis associated with a rare *Escherichia coli* serotype, *N Engl J Med*, 308(12), 1983, 681-5. 27.
22. Ackers M, Mahon B, Leahy E, Damrow T, Hutwagner L, Barrett T, *et al.* An outbreak of *Escherichia coli* O157:H7 infections associated with leaf lettuce consumption, Western Montana [abstract], Proceedings of the 36th Interscience Conference on Antimicrobial Agents and Chemotherapy, 1996, 15-18. New Orleans, LA. Washington (DC): American Society for 28, *Microbiology*; 1996, 257. Abstract No. K43.
23. Besser R E, Lett S M, Weber T, Doyle M P, Barrett T J, Wells J G, *et al.* An outbreak of diarrhea and hemolytic 29. Uremic syndrome from *Escherichia coli* O157:H7 in fresh pressed apple cider, *JAMA*, 269(17), 1993, 2217-20.

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