25-ID-02

Committee: Infectious Disease

Title: Update to Standardized Surveillance Case Definition for Campylobacteriosis

☒Check this box if this position statement is an update to an existing standardized surveillance case definition and include the most recent position statement number here: 14-ID-09

Synopsis: This position statement updates the standardized surveillance case definition for campylobacteriosis to address confusion in implementing the previous position statement (14-ID-09). Updates include:

- Broadening the case ascertainment criteria so that clinically compatible illness is no longer necessary to trigger a report to public health, and a symptomatic person who is epidemiologically linked to a confirmed OR probable case, rather than just a confirmed case, should trigger a report to public health.
- Explicating the case classification criteria; laboratory evidence alone can be used to classify a case as confirmed or probable.
- Extending the enumeration period for distinguishing a new case from 30 days to 90 days.

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I. Statement of the Problem

Campylobacter spp. are estimated to be the leading cause of bacterial diarrheal illness in the United States (U.S.), with incidence of reported infections increasing since the early 2000s. Surveillance for campylobacteriosis is necessary for detecting and controlling outbreaks, identifying sources of infection of public health concern (e.g., contaminated commercial raw [unpasteurized] milk, public water supplies, infected animals), and preventing further transmission. Surveillance is an important tool for monitoring the incidence and burden of illness from campylobacteriosis. This position statement updates the standardized surveillance case definition for campylobacteriosis (14-ID-09) by refining case classification criteria (e.g., adding a case classification section and updating the classification tables to reflect the narrative) and extending the enumeration period for new cases from 30 days to 90 days.

II. Background and Justification

Medical care and lost productivity due to campylobacteriosis are estimated to cost $11.3 billion in the U.S. each year [1]. Since 1996, active, sentinel-based surveillance for culture-confirmed *Campylobacter* spp. infections has been conducted in the Foodborne Diseases Active Surveillance Network (FoodNet), which covers approximately 16% of the U.S. population. The overall incidence of *Campylobacter* spp. measured in FoodNet sites in 2023 was 22% higher than in the 2016-2018 baseline period [2]. Although *Campylobacter* outbreaks are not commonly reported, the number of outbreaks has generally increased since the early 2000s [3]. An estimated 1.5 million campylobacteriosis cases occur annually in the U.S., with approximately two of every three cases attributed to foodborne sources [4,5]. *Campylobacter* spp. cause a self-limited clinical illness, typically characterized by diarrhea (bloody or non-bloody), abdominal cramps, fever, and nausea, sometimes with vomiting. Severe symptoms and extra-intestinal infections such as bacteremia, meningitis, or other localized infections can occur. Additionally, some individuals may experience asymptomatic infections. Persons infected with *Campylobacter* spp. are at increased risk for post-infectious complications including Guillain-Barré syndrome (GBS), reactive arthritis (ReA), and irritable bowel syndrome (IBS) [5]. *C. jejuni* is the most identified antecedent of GBS, preceding paralysis in at least 5% and possibly as many as 41% of GBS cases [6]. ReA is estimated to occur in 2-5% and IBS in 4-12% of patients following *Campylobacter* spp. infection, and both can last for months to years after symptoms of infection have resolved [7-10]. Immunocompromised persons have a higher risk of *Campylobacter* spp. infection, recurrence, severe disease, and death.

Campylobacter spp. are transmitted via the fecal-oral route, typically through ingestion of contaminated food or water or through direct contact with infected animals. Person-to-person transmission, although uncommon, can occur between household contacts and sexual partners. The most common outbreak vehicles are raw milk and dairy products, while sporadic infections may be linked to poultry (particularly organ meats and restaurant-prepared dishes), cattle, ground beef, and berries [11-15]. Most *Campylobacter* spp. infections are acquired domestically, but it remains a major cause of traveler's diarrhea [16]. Infections exhibit seasonal variation, with incidence peaking during the summer months. Increased temperatures and precipitation are associated with higher infection rates [17,18]. Control of *Campylobacter* spp. is of great concern to federal regulatory agencies. Since 2011, the Food Safety and Inspection Service (FSIS) of the U.S. Department of Agriculture (USDA) has provided recommendations and guidelines to reduce poultry-associated *Campylobacter* spp. infections and outbreaks at poultry processing facilities including live-poultry markets [19]. In 2021, FSIS released guidelines which included use of microbial sampling and testing, sanitation standards, and pre-harvest and processing interventions and management practices for pathogen reduction. Additionally, the Food Safety Modernization Act (FSMA) gives the U.S. Food and Drug Administration (FDA) additional authority to regulate food facilities, establish standards for safe produce, recall contaminated foods, oversee imported foods, and requires CDC to strengthen surveillance and response to outbreaks. Combined with national surveillance for *Campylobacter* spp., these measures have allowed public health to track and respond to outbreaks across the U.S.

In 2011, CSTE created a national campylobacteriosis case definition to facilitate standardized case reporting and ascertainment across jurisdictions (position statement 11-ID-10). In 2014, CSTE position statement 14-ID-09 added campylobacteriosis to the Nationally Notifiable Conditions (NNC) List. In 2025, this position statement adds telephone, text, or online survey to Table V as recommended data sources for surveillance to accommodate jurisdictions who may be conducting case management through web-based applications such as REDCap. To address confusion regarding requirements to trigger a report to public health, this position statement clarifies that

clinically compatible illness is not necessary to trigger a report to public health and that symptomatic persons who are epidemiologically linked to a confirmed or probable campylobacteriosis case should trigger a report to public health. Also, this position statement updates laboratory evidence to be sufficient to classify a case as confirmed or probable, without requiring clinical evidence. Finally, the enumeration period has been extended based on evidence that *Campylobacter* spp. can be shed in feces for prolonged periods of time [20,21], suggesting that reinfection in fewer than 90 days is uncommon, and so extending the enumeration period would not likely result in underreporting of reinfections and may reduce duplicative reporting and investigations for patients with prolonged infection.

III. Statement of the Desired Action(s) to be Taken

CSTE recommends the following actions:

1. Implement a standardized surveillance case definition for **campylobacteriosis**.
    A. Utilize recommended reporting* sources for case ascertainment for **campylobacteriosis**. Surveillance for campylobacteriosis should use the recommended sources of data to the extent of coverage presented in Section V.
    B. Utilize standardized criteria for case ascertainment for **campylobacteriosis** presented in Section VI and Table VI in Technical Supplement.
    C. Utilize standardized criteria for case classification for **campylobacteriosis** presented in Section VII and Table VII in Technical Supplement.
2. Utilize standardized criteria for case ascertainment and classification (based on Sections VI and VII and Technical Supplement) for **campylobacteriosis** and **update campylobacteriosis** on the *Nationally Notifiable Condition List* using the following notification** timeframe:
    ☐ Immediately notifiable, extremely urgent (within 4 hours)
    ☐ Immediately notifiable, urgent (within 24 hours)
    ☒ Routinely notifiable
    ☐ No longer notifiable
3. CSTE recommends that all jurisdictions (e.g., States, Localities, or Territories) with legal authority should conduct public health surveillance and use the case classifications included in this position statement.
4. Expectations for Message Mapping Guide (MMG) development for a newly notifiable condition: the National Notifiable Diseases Surveillance System (NNDSS) is transitioning to HL7-based messages for case notifications; the specifications for these messages are presented in MMGs. When CSTE recommends a new condition be made nationally notifiable, CDC must obtain Office of Management and Budget Paperwork Reduction Act (OMB PRA) approval prior to accepting case notifications for the new condition. Under anticipated timelines, notification using the Generic V2 MMG would support transmission of the basic demographic and epidemiologic information common to all cases and could begin with the new MMWR year following the CSTE annual conference. Input from CDC programs and CSTE would prioritize development of a disease-specific MMG for the new condition among other conditions waiting for MMGs.
5. CDC should publish data on campylobacteriosis as appropriate (see Section IX).
    CSTE recommends the following case statuses be included in the CDC Print Criteria:
    ☒Confirmed
    ☒Probable
    ☐Suspect
    ☐Unknown

** Reporting: process of a healthcare provider, laboratory, or other entity submitting a report (case information) of a condition under public health surveillance to local, state, or territorial public health.*

*** Notification: process of a local or state public health authority submitting a report (case information) of a condition on the* Nationally Notifiable Conditions List *to CDC.*

IV. Goals of Surveillance

To provide standardized information on the temporal, geographic, and demographic occurrence of campylobacteriosis to facilitate its prevention and control. Surveillance can help identify outbreaks and determine sources of public health concern to improve public health response.

V. Recommended Data Sources and Methods for Surveillance

Surveillance for campylobacteriosis should use the following recommended sources of data and/or methodologies and the extent of coverage listed in Table V.

Table V. Recommended Sources of Data, Surveillance Methods, and Extent of Coverage for Ascertainment of Cases of Campylobacteriosis

Source of Data/Methodology for Case Ascertainment	Coverage	
	Population-Wide	Sentinel Sites
Clinician reporting	X	
Laboratory reporting	X	
Reporting by other entities, specify: hospitals, veterinarians, pharmacies, poison centers	X	
Death certificates	X	
Hospital discharge or outpatient records	X	
Data from electronic medical records	X	
Telephone, text or online survey	X	
School-based survey		
Other, specify: N/A		

VI. Criteria for Case Ascertainment

Case ascertainment is the process through which public health identifies potential cases of a disease or condition using data reported or provided to public health by healthcare, laboratories, and other reporting entities. This public health reporting is triggered by the case ascertainment criteria (a single criterion or a combination of criteria) included in this position statement, and each initial report sent to public health should include common data elements and disease-specific data elements. Case ascertainment criteria are not intended to be used for clinical diagnosis purposes.

A. Narrative: A description of suggested criteria for case ascertainment of a specific condition and recommended reporting procedures.

A1. Clinical Criteria for Reporting*

- In the absence of an alternative etiology, a person with a clinically compatible illness. Common presentations of illness include diarrhea (bloody or non-bloody), abdominal cramps, or vomiting.**

**Must be paired with epidemiologic linkage criteria for reporting to trigger a report to public health.*
*** Other common symptoms include fever and nausea and extra-intestinal infections such as bacteremia, meningitis, or other localized infections may occur but will not trigger a report to public health without laboratory evidence.*

A2. Laboratory Criteria for Reporting

- Isolation of any *Campylobacter* spp. by culture in a clinical specimen from any source,
  OR
- Detection of any *Campylobacter* spp. using a culture-independent diagnostic test (CIDT) in a clinical specimen from any source.

A3. Epidemiologic Linkage Criteria for Reporting***

- A person who shares an exposure with a confirmed or probable case of campylobacteriosis,
  OR
- A person who is exposed to a confirmed case of campylobacteriosis.
  OR
- A person who is exposed to a probable case with presumptive laboratory evidence of campylobacteriosis.

****Must be paired with clinical criteria for reporting to trigger a report to public health*

A4. Vital Records Criteria for Reporting

- A person whose death certificate lists campylobacteriosis as an underlying cause of death or a significant condition contributing to death.

A5. Healthcare Records Criteria for Reporting

- A person whose healthcare record contains a new diagnosis of campylobacteriosis.

B. Disease-Specific Data Elements to be Included in the Initial Report

Disease-specific data elements should be included in addition to the common data elements that are to be reported for all initial individual case reports (see CSTE Position Statement 09-SI-01 "Common Core Data Elements for Case Reporting and Laboratory Result Reporting" https://cdn.ymaws.com/www.cste.org/resource/resmgr/PS/09-SI-01.pdf). Public health authorities do not expect that an initial report will contain all the information necessary for case investigation and case classification.

Clinical Information

- Presence of clinically compatible signs and symptoms (e.g., diarrhea [bloody or non-bloody], abdominal cramps, fever [measured or subjective], nausea, vomiting, or extra-intestinal infections such as bacteremia, meningitis, or other localized infections)
- Hospitalization data (if applicable): admission and discharge dates; ICU admission
- Date of death (if applicable)
- Date of onset (if available) and outcome

Epidemiologic Risk Factors

History of the following potential exposures during the 10 days before illness onset:

- Consumption of or contact with undercooked meat or raw meat, including poultry and shellfish
- Drinking untreated water or contact with untreated recreational water including location and dates of exposure
- Consumption of raw milk or unpasteurized dairy products including date(s) of exposure
- Contact with pets or farm animals or animal excreta
- Occupational exposure on farms or at meat, poultry, or egg processing facilities
- Non-occupational exposure on farms or at meat, poultry, or egg processing facilities
- Exposure to human excreta
- Contact with a confirmed or probable case of campylobacteriosis
- Travel history (e.g., international travel in the past 10 days)

VII. Case Definition for Case Classification

This case definition for case classification is intended solely for public health surveillance purposes and does not recommend criteria for clinical diagnosis purposes. Once a public health agency has ascertained data on potential cases of a disease or condition from reporting entities, the public health agency assigns case statuses based on the case classifications included within this position statement.

A. Narrative: A description of criteria to determine how public health should classify a case of campylobacteriosis.

A1. Clinical Criteria^

- In the absence of an alternative etiology, a person with clinically compatible illness. Common presentations of illness include diarrhea (bloody or non-bloody), abdominal cramps, or vomiting.

^ *Post-infectious, immune-mediated syndromes such as Guillain-Barré syndrome, reactive arthritis, and irritable bowel syndrome are not directly caused by the infection and are not included as part of the clinical criteria. Common symptoms including fever and nausea, as well as extra-intestinal infections such as bacteremia, meningitis, or other localized infections may occur but are not included to classify a case without laboratory evidence.*

A2. Laboratory Criteria^^

Confirmatory Laboratory Evidence:

- Isolation of any *Campylobacter* spp. by culture in a clinical specimen from any source.

Presumptive Laboratory Evidence:

- Detection of any *Campylobacter* spp. using a CIDT in clinical specimen from any source.

Supportive Laboratory Evidence:

- *N/A*

^^ *Note: The categorical labels used here to stratify laboratory evidence are intended to support the standardization of case classifications for public health surveillance. The categorical labels should not be used to interpret the utility or validity of any laboratory test methodology.*

A3. Epidemiologic Linkage Criteria

- A person who shares an exposure with a confirmed or probable case of campylobacteriosis,
  OR
- A person who is exposed to a confirmed case of campylobacteriosis,
  OR
- A person who is exposed to a probable case with presumptive laboratory evidence of campylobacteriosis.

A4. Case Classifications

Confirmed:

- Meets the confirmatory laboratory evidence.

Probable:

- Meets the presumptive laboratory evidence,
  OR
- Meets the clinical criteria **AND** epidemiologic linkage criteria.

B. Criteria to Distinguish a New Case of Campylobacteriosis from Reports or Notifications which Should Not be Enumerated as a New Case for Surveillance

- A repeat positive culture or CIDT test result on a specimen collected more than 90 days since previous specimen collection date should be enumerated as a new case for surveillance.
- When two or more *Campylobacter* species are identified or detected from one or more specimens from the same individual, each identified infection with a unique species should be enumerated as a separate case.

VIII. Period of Surveillance

Surveillance is expected to be ongoing.

IX. Data Sharing/Release and Print Criteria

CSTE recommends the following case statuses* be included in the 'case' count released outside of the public health agency:

☒Confirmed
☒Probable
☐Suspect
☐Unknown

**Which case statuses are included in case counts constitute the "print criteria."*

Jurisdictions (e.g., States and Territories) conducting surveillance under this case definition can voluntarily submit de-identified case information to CDC, if requested and in a mutually agreed upon format.

Production of national data summaries and national data re-release for non-NNCs:

- Prior to release of national data summaries CDC should follow the CDC/ATSDR Policy on Releasing & Sharing Data, issued on April 16, 2003 and referenced in 11-SI-01 and custodians of such data should consult the CDC-CSTE Intergovernmental Data Release Guidelines Working Group report (www.cste2.org/webpdfs/drgwgreport.pdf) which contains data release guidelines and procedures for CDC programs re-releasing state, local, or territorial-provided data.
- CDC programs have a responsibility, in collaboration with states, localities, and territories, to ensure that CDC program-specific data re-release procedures meet the needs of those responsible for protecting data in the states and territories.

X. Revision History

Position Statement ID	Section of Document	Revision Description
25-ID-02	Table V. Recommended Sources of Data, Surveillance Methods, and Extent of Coverage for Ascertainment of Cases of Campylobacteriosis	Added telephone, text, or online survey option to selection in Table V as a recommended data source for case ascertainment.
25-ID-02	Section VI. Criteria for Case Ascertainment and Section VII. Case Definition for Case Classification	Clarified clinical criteria must be present in the absence of an alternative etiology.
25-ID-02	Section VI. Criteria for Case Ascertainment	Epidemiologic linkage criteria updated to include a symptomatic person who is epidemiologically linked to a confirmed OR probable case, rather than just a confirmed case, may be reported to public health.
25-ID-02	Section VI. Criteria for Case Ascertainment and Section VII. Case Definition for Case Classification	Laboratory criteria updated to indicate specimen collection from any source.
25-ID-02	Section VI.B. Disease-Specific Data Elements	Added occupational exposures on farms or at mean, poultry, or egg processing facilities; explicated non-occupational exposure on farms or at meat, poultry, or egg processing facilities; separated out exposure to animal excreta from exposure to human excreta.

25-ID-02	Section VII.A2. Case Definition for Case Classification	Epidemiologic linkage criterion added for a person who is exposed to a probable case who has presumptive laboratory evidence of campylobacteriosis.
25-ID-02	Section VII.A4. Case Definition for Case Classification	Explicated case classification to include laboratory evidence alone for use to classify a case as confirmed or probable.
25-ID-02	Section VII.B. Case Definition for Case Classification	Updated by extending the enumeration period for distinguishing a new case from 30 days to 90 days.
14-ID-09	11-ID-10	Standardized Surveillance for Campylobacteriosis and Addition to the Nationally Notifiable Conditions List
N/A	11-ID-10	Creation of National Campylobacteriosis Case Definition

XI. References

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Technical Supplement

Table VI. Table of criteria to determine whether a case should be reported to public health authorities.

Criterion	Campylobacteriosis	
*Clinical Criteria for Reporting**		
Absence of an alternative etiology		N
Diarrhea (bloody or non-bloody)		O
Abdominal cramps		O
Vomiting		O
Laboratory Criteria for Reporting		
Isolation of any *Campylobacter* spp. by culture in a clinical specimen from any source	S	
Detection of any *Campylobacter* spp. using a culture-independent diagnostic test (CIDT) in a clinical specimen from any source	S	
Epidemiologic Linkage Criteria for Reporting		
A person who shares an exposure with a confirmed or probable case of campylobacteriosis		O
A person who is exposed to a confirmed case of campylobacteriosis		O
A person who is exposed to a probable case with presumptive laboratory evidence campylobacteriosis		O
Vital Record Criteria for Reporting		
A person whose death certificate lists campylobacteriosis as an underlying cause of death or a significant condition contributing to death	S	
Healthcare Record Criteria for Reporting		
A person whose healthcare record contains a new diagnosis of campylobacteriosis	S	

Notes:
S = This criterion alone is SUFFICIENT to report a case.
N = All "N" criteria in the same column are NECESSARY to report a case.
O = At least one of these "O" (ONE OR MORE) criteria in each category (categories=clinical, laboratory, epidemiologic linkage, vital records, etc.) in the same column—in conjunction with all "N" criteria in the same column—is required to report a case.
* *Other common symptoms include fever and nausea and extra-intestinal infections such as bacteremia, meningitis, or other localized infections may occur but will not trigger a report to public health without laboratory evidence.*

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Table VII.A. Classification Table: Criteria for defining a case of campylobacteriosis

Criterion	Confirmed	Probable	
*Clinical Evidence***			
Absence of an alternative etiology			N
Diarrhea (bloody or non-bloody)			O
Abdominal Cramps			O
Vomiting			O
Laboratory Evidence			
Isolation of any *Campylobacter* spp. by culture in a clinical specimen from any source	S		
Detection of any *Campylobacter* spp. using a CIDT in a clinical specimen from any source		S	
Epidemiologic Linkage Evidence			
A person who shares an exposure with a confirmed or probable case of campylobacteriosis			O
A person who is exposed to a confirmed case of campylobacteriosis			O
A person who is exposed to a probable case with presumptive laboratory evidence of campylobacteriosis			O

Notes:
S = This criterion alone is SUFFICIENT to classify a case.
N = All "N" criteria in the same column are NECESSARY to classify a case.
O = At least one of these "O" (ONE OR MORE) criteria in each category (categories=clinical evidence, laboratory evidence, and epidemiologic evidence) in the same column—in conjunction with all "N" criteria in the same column—is required to classify a case.
*** Post-infectious, immune-mediated syndromes such as Guillain-Barré syndrome, reactive arthritis, and irritable bowel syndrome are not directly caused by the infection and are not included as part of the clinical criteria. Common symptoms including fever and nausea, as well as extra-intestinal infections such as bacteremia, meningitis, or other localized infections may occur but are not required to classify a case.*

Table VII.B. Classification Table: Criteria to distinguish a new case of campylobacteriosis from reports or notifications which should not be enumerated as a new case for surveillance.

Criterion	Confirmed	Probable
Criteria to distinguish a new case		
A repeat positive culture test result on a specimen collected more than 90 days since previous specimen collection date should be enumerated as a new case for surveillance.	S	
A repeat positive CIDT test result on a specimen collected more than 90 days since previous specimen collection date should be enumerated as a new case for surveillance.		S
When two or more *Campylobacter* species are identified or detected from one or more specimens from the same individual, each identified infection with a unique species should be enumerated as a separate case.	S	S

S = This criterion alone is SUFFICIENT to enumerate as a new case.