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Publication Date

2017

Data Availability

The data associated with this publication are available at: <https://osf.io/hvn7s>

Peer reviewed



Original Contribution

Acute Illness Among Surfers After Exposure to Seawater in Dry- and Wet-Weather Conditions

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Initially submitted September 8, 2016; accepted for publication January 23, 2017.

Rainstorms increase levels of fecal indicator bacteria in urban coastal waters, but it is unknown whether exposure to seawater after rainstorms increases rates of acute illness. Our objective was to provide the first estimates of rates of acute illness after seawater exposure during both dry- and wet-weather periods and to determine the relationship between levels of indicator bacteria and illness among surfers, a population with a high potential for exposure after rain. We enrolled 654 surfers in San Diego, California, and followed them longitudinally during the 2013–2014 and 2014–2015 winters (33,377 days of observation, 10,081 surf sessions). We measured daily surf activities and illness symptoms (gastrointestinal illness, sinus infections, ear infections, infected wounds). Compared with no exposure, exposure to seawater during dry weather increased incidence rates of all outcomes (e.g., for earache or infection, adjusted incidence rate ratio (IRR) = 1.86, 95% confidence interval (CI): 1.27, 2.71; for infected wounds, IRR = 3.04, 95% CI: 1.54, 5.98); exposure during wet weather further increased rates (e.g., for earache or infection, IRR = 3.28, 95% CI: 1.95, 5.51; for infected wounds, IRR = 4.96, 95% CI: 2.18, 11.29). Fecal indicator bacteria measured in seawater (*Enterococcus* species, fecal coliforms, total coliforms) were strongly associated with incident illness only during wet weather. Urban coastal seawater exposure increases the incidence rates of many acute illnesses among surfers, with higher incidence rates after rainstorms.

diarrhea; *Enterococcus*; rain; seawater; waterborne diseases; wound infection

Abbreviations: CI, confidence interval; IRR, incidence rate ratio.

Freshwater runoff after rainstorms increases levels of fecal indicator bacteria measured in seawater (1), but little is known about whether persons who participate in ocean recreation have a higher risk of acute illness after rainstorms. Absent epidemiologic studies to inform beach management guidelines after rainstorms, California beach managers post advisories at beaches that discourage contact with seawater for 72 hours after rainfall—a practice that is based on fecal indicator bacteria profiles in storm water outflows, which typically decline to prerinestorm levels within 3–5 days (2, 3).

In prospective cohorts in California, investigators have found increased incidence of gastrointestinal illness and other acute symptoms (e.g., eye and ear infections) associated with seawater exposure during dry summer months (4–8). In the

same studies, researchers found that levels of fecal indicator bacteria in seawater were positively associated with incident gastrointestinal illness if there was a well-defined source of human fecal contamination impacting the seawater (4–8). Individual cases of acute infections and deaths associated with waterborne pathogens have been reported among surfers in southern California who surfed during or after rainstorms (9), and 2 cross-sectional studies of surfers found that seawater exposure after heavy rainfall increased reported illness (10, 11). To our knowledge, there have been no prospective studies to determine whether rainstorms increase illness among persons who participate in ocean recreation and no studies that have evaluated whether levels of fecal indicator bacteria are associated with incident illness during wet weather periods.

We conducted a longitudinal cohort study among surfers in San Diego, California. We focused on surfers because they are a well-defined population that regularly enters the ocean year-round, even during and immediately after rainstorms, given that surfing conditions often improve during storms (12). Our objectives were to determine whether exposure to seawater increased rates of incident illness among surfers compared with periods when they did not surf in order to determine whether exposure during or immediately after rainstorms increased rates more than did exposure during dry weather. We also sought to evaluate the relationship between levels of fecal indicator bacteria in seawater and incident illness rates during dry and wet weather.

METHODS

Setting

Southern California has one of the most urbanized coastlines in the world, and it receives nearly all of its annual rainfall during the winter months (November–April). San Diego County beaches have some of the best water quality in California based on levels of fecal indicator bacteria, but water quality deteriorates after rainstorms (13). The most heavily used beaches in the region are affected by urban runoff after storms, and local beach managers post advisories that discourage water contact within 72 hours of rainfall. In the present study, we focused enrollment and conducted extensive water quality measurement at 2 monitored beaches within San Diego city

limits—Ocean Beach and Tourmaline Surfing Park. Both monitored beaches have storm-impacted drainage, attract surfers year-round, and have water quality levels similar to those of other beaches in the county (13). Ocean Beach is adjacent to the San Diego river, which drains a 1,088-km² varied land-use watershed with many flow-control structures; Tourmaline Surfing Park is adjacent to Tourmaline Creek and a storm drain, which together drain an urban, largely impervious, 6-km² watershed (Figure 1). The study's technical report includes additional details (14).

Study design and enrollment

We conducted a longitudinal cohort study of surfers recruited in San Diego over 2 winters, with enrollment and follow-up periods chosen to capture most rainfall events in the region. During the first winter (open enrollment from January 14, 2014, to March 18, 2014; end of follow-up on June 4, 2014), we enrolled surfers through in-person interviews at the 2 monitored beaches and through targeted online advertising on Surflife.com, a popular website on which surf conditions are reported. We enrolled participants at monitored beaches and online to assess whether individuals enrolled through these 2 modes were similar in their exposures and other characteristics. Participants enrolled on the beach were very similar to those enrolled online (Table 1), so we exclusively enrolled participants through the study's website during the second winter (open enrollment from December 1, 2014,

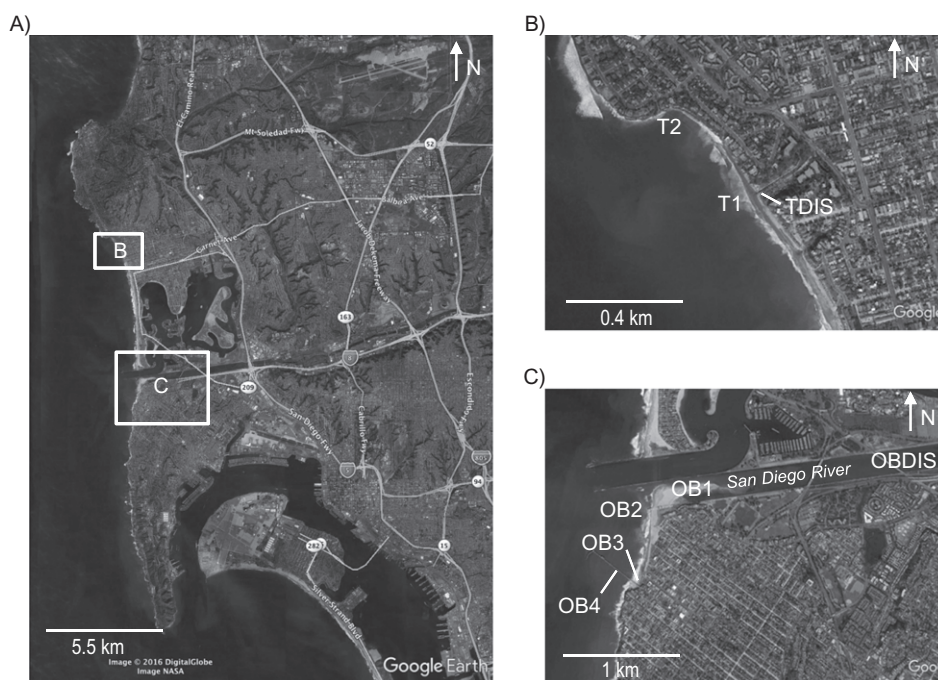


Figure 1. Monitoring beach water quality sampling locations in San Diego, California, winters of 2013–2014 and 2014–2015. Shown are the locations of the 2 monitored beaches along the San Diego coastline (A) and the water quality sampling sites at Tourmaline Surfing Park (B) and Ocean Beach (C). Samples were only collected at Ocean Beach and Tourmaline Surfing Park discharge locations (OBDIS and TDIS, respectively) during wet weather. Wet weather was defined as 0.25 cm or more of rain in 24 hours. T1 and T2, Tourmaline Surfing Park sampling sites 1 and 2; OB1–OB4, Ocean Beach sampling sites 1–4. Map Data: Google, Digital Globe, NASA.

Table 1. Characteristics of the Study Population by Mode of Enrollment, San Diego, California, 2013–2015

| Characteristic | Beach ^a | | Online ^a | | Total | |
|---------------------------------------|--------------------|-----|---------------------|-----|--------|-----|
| | No. | % | No. | % | No. | % |
| No. of participants | 89 | | 565 | | 654 | |
| Participants with background survey | 72 | 100 | 535 | 100 | 607 | 100 |
| Age, years ^b | | | | | | |
| 18–30 | | 35 | | 35 | | 35 |
| 31–40 | | 22 | | 26 | | 26 |
| 41–50 | | 11 | | 16 | | 16 |
| ≥51 | | 29 | | 13 | | 15 |
| Unreported | | 3 | | 9 | | 8 |
| Female sex | | 19 | | 21 | | 21 |
| College educated | | 68 | | 63 | | 63 |
| Currently employed | | 74 | | 76 | | 75 |
| Household income ^b | | | | | | |
| <\$15,000 | | 11 | | 6 | | 7 |
| \$15,000–\$35,000 | | 15 | | 10 | | 11 |
| \$35,001–\$50,000 | | 11 | | 7 | | 7 |
| \$50,001–\$75,000 | | 8 | | 13 | | 12 |
| \$75,001–\$100,000 | | 17 | | 14 | | 14 |
| \$100,001–\$150,000 | | 17 | | 14 | | 14 |
| >\$150,000 | | 7 | | 13 | | 12 |
| Unreported | | 14 | | 23 | | 22 |
| Days of surfing per week ^b | | | | | | |
| ≤1 | | 11 | | 15 | | 14 |
| 2 | | 12 | | 18 | | 17 |
| 3 | | 26 | | 26 | | 26 |
| 4 | | 26 | | 20 | | 21 |
| ≥5 | | 24 | | 18 | | 19 |
| Unreported | | 1 | | 3 | | 3 |
| Chronic health conditions | | | | | | |
| Ear problems | | 12 | | 14 | | 14 |
| Sinus problems | | 7 | | 8 | | 8 |
| Gastrointestinal condition | | 0 | | 3 | | 2 |
| Respiratory condition | | 4 | | 3 | | 3 |
| Skin condition | | 1 | | 6 | | 5 |
| Allergies | | 10 | | 16 | | 15 |
| Total days of observation | 2,623 | 100 | 30,754 | 100 | 33,377 | 100 |
| Days of observation by exposure | | | | | | |
| Unexposed | | 46 | | 47 | | 47 |
| Dry-weather exposure | | 48 | | 43 | | 43 |
| Wet-weather exposure | | 6 | | 10 | | 10 |

^a Beach enrollment only took place during the first winter (2013–2014); online enrollment spanned both winters (2013–2014 and 2014–2015). The study enrolled 73 individuals online during the first winter.

^b Percentages within categories might not sum to 100 because of rounding.

to March 22, 2015; end of follow-up on April 16, 2015). We recruited surfers through postcards distributed at the monitored beaches and through an electronic newsletter distributed

by the Surfrider Foundation's San Diego County chapter. Surfers were eligible if they were 18 years of age or older, could speak and read English, planned to surf in southern California

during the study period, had a valid e-mail address or mobile telephone number, and could access the internet with a computer or smartphone.

Participants completed a brief enrollment questionnaire, and each Tuesday they received a text message or e-mail reminder to complete a short weekly survey. Participants reported daily surf activity (location, date, and times of entry and exit) and illness symptoms (details below) for the previous 7 days using the study's web or smartphone (iOS or Android) application. We used an open cohort design in which participants were allowed to enter and exit the cohort over the follow-up period. We excluded follow-up time during which participants reported surfing outside of southern California. The study protocol was reviewed and approved by the institutional review board at the University of California, Berkeley, and all participants provided informed consent. Participants received a modest incentive for participation (\$20 gift certificate per 4 weekly surveys completed). Web Table 1 (available at <http://aje.oxfordjournals.org/>) includes a Strengthening the Reporting of Observational Studies in Epidemiology checklist.

Outcome definition and measurement

In weekly surveys, participants reported daily records of the following symptoms: diarrhea (defined as ≥ 3 loose/watery stools in 24 hours), sinus pain or infection, earache or infection, infection of an open wound, eye infection, skin rash, and fever. During the second winter, we added sore throat, cough, and runny nose. We created composite outcomes from the symptoms, including: gastrointestinal illness, which was defined as 1) diarrhea, 2) vomiting, 3) nausea and stomach cramps, 4) nausea and missed daily activities due to gastrointestinal illness, or 5) stomach cramps and missed daily activities due to gastrointestinal illness (15); and upper respiratory illness, which was defined as any 2 of the following: 1) sore throat, 2) cough, 3) runny nose, and 4) fever (16). We created a composite outcome of "any infectious symptom" defined as having any 1 of the following: gastrointestinal illness, diarrhea, vomiting, eye infection, infection of open wounds or fever. Our rationale was that it would exclude outcomes that could potentially have noninfectious causes (earache or infection, sinus pain or infection, skin rash, upper respiratory illness) and would capture a broad spectrum of sequelae associated with waterborne pathogens. We defined incident episodes as the onset of symptoms preceded by 6 or more symptom-free days to increase the likelihood that separate episodes represented distinct infections (17, 18).

Exposure definition and measurement

We classified the 3 days after each seawater exposure as exposed periods and all other days of observation as unexposed periods. We defined wet-weather exposure as exposure to seawater within 3 days of 0.25 cm or more of rainfall in a 24-hour period, which is the rainfall criterion used by San Diego County for posting wet-weather beach advisories; we classified all other seawater exposure as dry-weather exposure. We used rainfall measurements from the National Oceanic and Atmospheric Administration Lindbergh Field

Station. Among surfers, most exposure took place during the morning hours, so if a storm's precipitation started after 12:00 PM, we did not classify that day as wet weather (only the following day) to reduce exposure misclassification.

Staff collected daily water samples from January 15, 2014, to March 5, 2014, and from December 2, 2014, to March 31, 2015, at 6 sites across the 2 monitored beaches (Figure 1). Staff collected 1-liter water samples in the morning (08:30 AM \pm 2 hours) just below the water surface (0.5–1.0 meters) in sterilized, sample-rinsed bottles. We sampled discharges during 6 rainstorms immediately upstream from where Tourmaline Creek and the San Diego River discharge to the sea (Figure 1). We tested samples for culturable *Enterococcus* (US Environmental Protection Agency method 1600), fecal coliforms (standard method 9222D), and total coliforms (standard method 9222B). All laboratory analyses met quality-control objectives for absence of background contamination (blanks) and precision (duplicates).

Statistical analysis

We prespecified all analyses (19). Web Appendices 1 and 2 contain statistical details and sample size calculations. In the seawater exposure analysis, we calculated incidence rates by dividing incident episodes by person-days in unexposed and exposed periods during follow-up. If participants missed weekly surveys during follow-up, we did not include those periods in the analysis. We measured the association between seawater exposure and subsequent illness using an incidence rate ratio, which we estimated using a log-linear rate model with robust standard errors to account for repeated observations within individuals (20, 21). To examine illness rates separately for dry- and wet-weather exposures, we created a 3-level categorical exposure that classified each participant's follow-up time into unexposed, dry-weather exposure, and wet-weather exposure periods. We calculated a log-linear test of trend in the incidence rate ratios for dry- and wet-weather exposures (22).

In the fecal indicator association analysis, we estimated the association between levels of fecal indicator bacteria and illness using the subset of surf sessions matched to water-quality indicator measurements at the monitored beaches. We matched daily geometric mean indicator levels to surfers by beach and date (weighted by time in water if recent exposure included multiple days). We modeled the relationship between indicator levels and illness using a log-linear model and estimated the incidence rate ratio associated with a 1- \log_{10} increase in indicator level. We also estimated the incidence rate ratio associated with exposures to water above versus below US Environmental Protection Agency regulatory guidelines (geometric mean *Enterococcus* >35 colony-forming units per 100 mL) (23) or, in a second definition, if any single sample on the exposure day exceeded 104 colony-forming units per 100 mL. We hypothesized that the relationship between fecal indicator bacteria and illness could be modified by dry- or wet-weather exposure and allowed the exposure-response relationship to vary during dry and wet weather by including an indicator for wet-weather periods and a term for the interaction between indicator bacteria levels and the indicator of wet weather. We controlled for potential confounding (24) from demographic,

exposure-related, and baseline health characteristics (Web Appendix 1). In Web Appendices 3–6 we describe additional analyses, including conversion of estimates to the absolute risk scale, sensitivity analyses, and negative control exposure analyses (25, 26).

RESULTS

Study population

We enrolled 654 individuals who contributed on average 51 days of follow-up (range, 6–139 days). The study population's median age was 34 years (interquartile range, 27–45), and the majority of participants were male (73%), college-educated (63%), and employed (75%) (Table 1). Follow-up included 33,377 person-days of observation after excluding time spent outside of southern California (623 person-days). We excluded from adjusted analyses 47 individuals (1,599 person-days of observation) who provided outcome and exposure information but failed to complete a background questionnaire and thus had missing covariate information.

Water quality and surfer exposure

There were 10 rainstorms with 0.25 cm or more of rain during the study. Field staff collected 1,073 beach water samples and 92 wet-weather discharge samples for fecal indicator bacteria analysis. Median *Enterococcus* levels were higher during wet weather than during dry weather (Figure 2). During follow-up, surfers entered the ocean twice per week on average and experienced 10,081 total days of seawater exposure, including 1,327 days of wet-weather exposure. Surfers were less likely to enter the ocean during or within 1 day of rain. The median ocean entry time was 08:00 AM (interquartile range, 06:45–10:30 AM), and the median time spent in the water was 2 hours (interquartile range, 1–2 hours) (Web Figure 1). Of the 10,081 exposure days, surfers reported wearing a wetsuit during 95%, immersing their head during 96%, and swallowing water during 38%. The most frequented surf locations were the 2 monitored beaches: Tourmaline Surfing Park (25% of surf days) and Ocean Beach (16% of surf days), which reflected targeted enrollment at those beaches (Web Figure 2). There were 5,819 days of observation matched to water-quality measurements at monitored beaches, including 1,358 days during wet weather.

Illness associated with seawater exposure

Seawater exposure in the past 3 days was associated with increased incidence rates of all outcomes except for upper respiratory illness (Web Table 2). Unadjusted and adjusted incidence rate ratio estimates were similar, and for most outcomes, adjusted incidence rate ratios were slightly attenuated toward the null (Web Table 2). With the exception of fever and skin rash, incidence rates increased from unexposed to dry-weather exposure to wet-weather exposure periods (Table 2), a pattern also present on the risk scale (Web Figure 3). Compared with unexposed periods, wet-weather exposure led to the largest relative increase in earaches/infec-

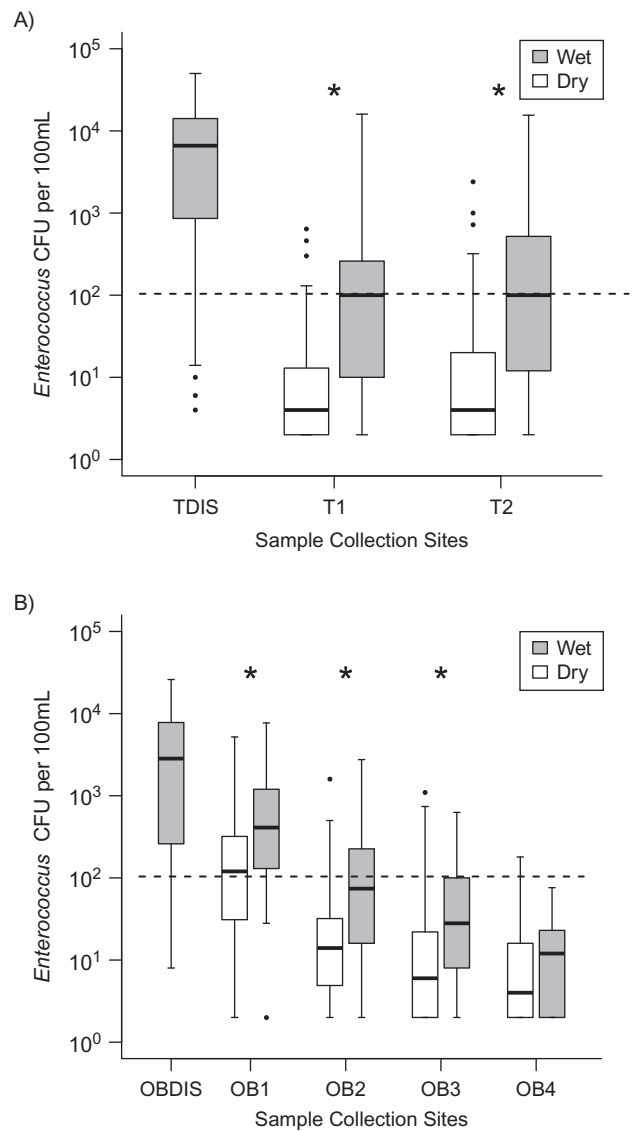


Figure 2. *Enterococcus* levels during dry and wet weather at the sampling locations at Tourmaline Surfing Park (A) and Ocean Beach (B) mapped in Figure 1. Boxes mark interquartile ranges, vertical lines mark 1.5 times the interquartile range, and points mark outliers. Horizontal dashed lines mark the single-sample California recreational water quality guideline (104 CFU/100mL). Asterisks (*) identify sampling locations with levels that differ between wet and dry periods based on a 2-sample, 2-sided t-test ($P < 0.05$) assuming unequal variances. Samples were only collected at Ocean Beach and Tourmaline Surfing Park discharge locations (OBDIS and TDIS, respectively) during wet weather. Wet weather was defined as 0.25 cm or more of rain in 24 hours. CFU, colony-forming units; T1 and T2, Tourmaline Surfing Park sampling sites 1 and 2; OB1–OB4, Ocean Beach sampling sites 1–4.

tions (Table 3; adjusted incidence rate ratio (IRR) = 3.28, 95% confidence interval (CI): 1.95, 5.51) and infection of open wounds (Table 3; adjusted IRR: 4.96, 95% CI: 2.18, 11.29). Sensitivity analyses that shortened the wet-weather window increased the difference between dry- and wet-weather incidence rates for most outcomes (Web Figure 4).

Table 2. Incidence Rates Among Surfers by Type of Seawater Exposure, San Diego, California, 2013–2015

| Outcome | Unexposed Periods | | | Dry-Weather Exposure | | | Wet-Weather Exposure ^a | | |
|----------------------------------------|-------------------|---------------------|----------------|----------------------|---------------------|----------------|-----------------------------------|---------------------|----------------|
| | No. of Episodes | No. of Days at Risk | Rate per 1,000 | No. of Episodes | No. of Days at Risk | Rate per 1,000 | No. of Episodes | No. of Days at Risk | Rate per 1,000 |
| Gastrointestinal illness | 90 | 14,884 | 6.0 | 116 | 13,769 | 8.4 | 31 | 3,037 | 10.2 |
| Diarrhea | 75 | 15,086 | 5.0 | 88 | 13,909 | 6.3 | 27 | 3,061 | 8.8 |
| Sinus pain or infection | 109 | 14,475 | 7.5 | 139 | 13,391 | 10.4 | 37 | 2,998 | 12.3 |
| Earache or infection | 59 | 14,931 | 4.0 | 111 | 13,618 | 8.2 | 37 | 3,008 | 12.3 |
| Infection of open wound | 14 | 15,456 | 0.9 | 30 | 14,080 | 2.1 | 11 | 3,119 | 3.5 |
| Skin rash | 42 | 15,024 | 2.8 | 66 | 13,750 | 4.8 | 15 | 3,007 | 5.0 |
| Fever | 51 | 15,156 | 3.4 | 69 | 14,138 | 4.9 | 6 | 3,152 | 1.9 |
| Upper respiratory illness ^b | 117 | 12,001 | 9.7 | 111 | 11,025 | 10.1 | 31 | 2,543 | 12.2 |
| Any infectious symptom ^c | 138 | 14,445 | 9.6 | 181 | 13,176 | 13.7 | 47 | 2,926 | 16.1 |

^a Defined as entering the sea within 3 days of 0.25 cm or more of rain in 24 hours.

^b Only measured in year 2 of the study.

^c Includes gastrointestinal illness, eye infections, infected wounds, and fever.

Illness associated with fecal indicator bacteria levels

Enterococcus, total coliform, and fecal coliform levels were positively associated with increased incidence of almost all outcomes during the study (Web Table 3). Rainfall was a strong effect modifier of the association (Table 4). During dry weather, there was no association between *Enterococcus* levels and illness except for infected wounds, but *Enterococcus* was strongly associated with illness after wet-weather exposure (e.g., for each log₁₀ increase, gastrointestinal illness IRR = 2.17, 95% CI: 1.16, 4.03; Table 4, Web Figure 5, and Web Table 4). Associations were attenuated in adjusted analyses, but relationships were similar (e.g., for gastrointestinal illness, wet-weather IRR = 1.75, 95% CI: 0.80, 3.84; Table 4). There was evidence for excess risk of gastrointestinal illness at higher *Enterococcus* levels only during wet-weather periods (Web Figure 6): The predicted excess risk that corresponded to the current US Environmental Protection Agency regulatory guideline of 35 colony-forming units per 100 mL was 16 episodes per 1,000 (95% CI: 5, 27). Negative control analyses showed no consistent association between fecal indicator bacteria and illness among participants during periods in which they had no recent seawater contact (Web Table 5).

DISCUSSION

Key results

To our knowledge, this is the first prospective cohort study in which the association between incident illness and exposure to seawater in wet weather has been measured, and the findings represent novel empirical measures of incident illness associated with storm water discharges. There was a consistent increase in acute illness incidence rates between unexposed, dry-weather, and wet-weather exposure periods (Tables 2 and 3). Rainstorms led to higher levels of fecal indicator bacteria (Figure 2), and a sensitivity analysis illustrated that a 2–3 day window after rainstorms captured the majority of excess incidence associated with wet-weather ex-

posure (Web Figure 4). Fecal indicator bacteria matched to individual surf sessions were strongly associated with illness only during wet weather periods (Table 4, Web Figure 5).

Interpretation

Swimmers are more rare during the winter months, and surfers' frequent and intense exposure made them an ideal population in which to study the relationship between illness and exposure to seawater in wet weather (27). The associations estimated in this study may not reflect those of the general population, but among a highly exposed subgroup of athletes, our results measure the illness associated with seawater exposure after rainstorms in southern California. Enrolling surfers led to some important differences between the present study population and most swimmer cohorts. We enrolled adults because we could not guarantee adequate consent for minors through online enrollment, whereas swimmer cohorts have historically enrolled predominantly families with children (28); children are more susceptible and have greater risk than do adult swimmers (15). Participants surfed twice per week for 2 hours each session, with nearly universal head immersion (96% of exposures) and frequent water ingestion (38% of exposures). This far exceeds exposure levels recorded in swimmer cohorts. Likely because of surfers' repeated exposures to pathogens in seawater, studies have found higher levels of immunity to hepatitis A and more frequent gut colonization by antibiotic-resistant *Escherichia coli* among surfers than among the general population (29, 30).

Despite surfers' intense and frequent exposures, gastrointestinal illness rates observed in the present study were similar to those measured among beachgoers California cohorts in the summer (Web Appendix 6, Web Figure 7), and the increase in gastrointestinal illness rates associated with seawater exposure (adjusted IRR = 1.33, 95% CI: 0.99, 1.78; Web Table 2) was similar to estimates measured in marine swimmer cohorts in California and elsewhere in the United States (15, 31). However, the 3-fold increase in rates of

Table 3. Incidence Rate Ratios for Surfer Illnesses Within 3 Days of Dry- and Wet-Weather Seawater Exposure Compared With Unexposed Periods, San Diego, California, 2013–2015

| Outcome | Unadjusted ^a | | | | Adjusted ^{a,b} | | | |
|----------------------------------------|-------------------------|------------|--------------------------|------------|-------------------------|------------|--------------------------|-------------|
| | Dry Weather | | Wet Weather ^c | | Dry Weather | | Wet Weather ^c | |
| | IRR | 95% CI | IRR | 95% CI | IRR | 95% CI | IRR | 95% CI |
| Gastrointestinal illness | 1.39 | 1.05, 1.86 | 1.69 | 1.10, 2.59 | 1.30 | 0.95, 1.76 | 1.41 | 0.92, 2.17 |
| Diarrhea | 1.27 | 0.92, 1.76 | 1.77 | 1.11, 2.83 | 1.22 | 0.86, 1.73 | 1.51 | 0.95, 2.41 |
| Sinus pain or infection | 1.38 | 1.05, 1.80 | 1.64 | 1.12, 2.40 | 1.23 | 0.93, 1.64 | 1.51 | 1.01, 2.26 |
| Earache or infection | 2.06 | 1.47, 2.90 | 3.11 | 1.94, 4.98 | 1.86 | 1.27, 2.71 | 3.28 | 1.95, 5.51 |
| Infection of open wound | 2.35 | 1.27, 4.36 | 3.89 | 1.83, 8.30 | 3.04 | 1.54, 5.98 | 4.96 | 2.18, 11.29 |
| Skin rash | 1.72 | 1.16, 2.54 | 1.78 | 0.98, 3.24 | 1.64 | 1.11, 2.41 | 1.80 | 0.97, 3.35 |
| Fever | 1.45 | 0.99, 2.12 | 0.57 | 0.24, 1.31 | 1.56 | 1.04, 2.34 | 0.64 | 0.27, 1.52 |
| Upper respiratory illness ^d | 1.03 | 0.79, 1.35 | 1.25 | 0.84, 1.86 | 1.04 | 0.79, 1.36 | 1.17 | 0.79, 1.74 |
| Any infectious symptom ^e | 1.44 | 1.14, 1.82 | 1.68 | 1.19, 2.38 | 1.50 | 1.17, 1.92 | 1.62 | 1.14, 2.30 |

Abbreviations: CI, confidence interval; IRR, incidence rate ratio.

^a Unadjusted and adjusted incidence rate ratios compare incidence rates in the 3 days after seawater exposure during dry or wet weather with incidence rates during unexposed periods. Table 2 includes the underlying data. Tests of trend in the IRR between exposure categories are significant ($P < 0.05$) if the confidence interval for wet-weather exposure excludes 1.0 (22).

^b We controlled for the following time-invariant potential confounders: age, sex, educational level, employment status, household income, years the individual had surfed, reported behavior of typically avoiding the ocean after wet weather, surfboard length, mode of enrollment (beach vs. Internet). We controlled for chronic health conditions only for the corresponding outcomes: ear problems, sinus problems, gastrointestinal conditions, respiratory conditions, skin conditions. We also controlled for the following time-varying potential confounders: entered the ocean for an activity other than surfing, any illness symptoms in the week preceding the risk window, day of recall, day of the week, and rainfall total during the past 3 days.

^c Defined as entering the sea within 3 days of 0.25 cm or more of rain in 24 hours.

^d Only measured in year 2 of the study.

^e Includes gastrointestinal illness, eye infections, infected wounds, and fever.

earache/infection and 5-fold increase in infected open wounds associated with exposure after rainstorms (Table 3) are stronger associations than have been reported in previous studies, and they provide evidence for increased incidence of a broad set of infectious symptoms after seawater exposure within 3 days of rain.

Fecal indicator bacteria were a reliable marker of human illness risk in this setting only within 3 days of rainfall (Table 4). Our results are consistent with summer studies in California in which investigators found associations between *Enterococcus* levels and illness only if there was a well-defined source of human fecal contamination (4–8). Our findings are also consistent with model predictions of higher gastrointestinal illness risk among southern California surfers after storms (32). Molecular testing for pathogens in storm water discharge to study monitored beaches identified near-ubiquitous presence of norovirus and *Campylobacter* species, and models parameterized with pathogen measurements predicted higher illness risk after rainstorms (14). The association between fecal indicator bacteria measured during wet weather and a range of nonenteric illnesses, such as sinus pain or infection and fever (Table 4), suggests that fecal indicator bacteria may mark broader bacterial or viral pathogen contamination in seawater after rainstorms.

Some study outcomes could have noninfectious causes associated with surfing. Earache and sinus pain can result

from physical incursion of saltwater through surfing's high-intensity exposure, ingestion of saltwater can cause gastrointestinal symptoms, and wetsuit use could cause skin rashes. If the association between surf exposure and symptoms resulted from noninfectious causes, we would expect similar incidence rates after wet- and dry-weather exposures. This was observed for skin rash, but incidence rates for sinus, ear, and gastrointestinal illnesses were higher after wet-weather exposure (Table 2), and the strong association between fecal indicator bacteria and fever during wet-weather conditions was consistent with an infectious etiology (Table 4).

It is also possible that some infections acquired during surfing could result from nonanthropogenic sources. The ocean was warmer than usual during the second winter because of a weak El Niño, which caused conditions favorable to naturally occurring *Vibrio parahaemolyticus* and toxin-producing marine algae that can cause human illness (33). Wound infection was the single outcome strongly associated with fecal indicator bacteria measured during dry weather (Table 4), an observation consistent with a pathogen source like *V. parahaemolyticus* that covaries with fecal indicator bacteria even in nonstorm conditions. Yet, the consistently higher rates of infected wounds and other symptoms after wet-weather exposure compared with dry-weather exposure (Tables 2 and 3) suggests that storm water runoff impacted by anthropogenic sources constitutes an important pathogen source in this setting.

Table 4. Surfer Illness Associated With a log₁₀ Increase in Fecal Indicator Bacteria Levels, Stratified by Exposure During Dry and Wet Weather, Tourmaline Surfing Park and Ocean Beach, San Diego, California, 2013–2015

| Fecal Indicator Bacteria and Illness Symptom | Dry Weather | | Wet Weather | | Unadjusted | | | | | Adjusted ^a | | | | |
|----------------------------------------------|-------------|--------------|-------------|--------------|-------------|-------------|-------------|-------------|----------------------|-----------------------|-------------|-------------|-------------|----------------------|
| | Episodes | Days at Risk | Episodes | Days at Risk | Dry Weather | | Wet Weather | | P Value ^b | Dry Weather | | Wet Weather | | P Value ^b |
| | | | | | IRR | 95% CI | IRR | 95% CI | | IRR | 95% CI | IRR | 95% CI | |
| <i>Enterococcus</i> | | | | | | | | | | | | | | |
| Gastrointestinal illness | 30 | 4,251 | 10 | 1,297 | 0.86 | 0.47, 1.58 | 2.17 | 1.16, 4.03 | 0.04 | 0.85 | 0.46, 1.56 | 1.75 | 0.80, 3.84 | 0.16 |
| Diarrhea | 24 | 4,285 | 9 | 1,305 | 1.13 | 0.62, 2.07 | 2.38 | 1.27, 4.46 | 0.11 | 1.16 | 0.63, 2.14 | 2.00 | 0.92, 4.32 | 0.31 |
| Sinus pain or infection | 44 | 4,130 | 19 | 1,262 | 1.34 | 0.79, 2.26 | 1.93 | 1.17, 3.19 | 0.33 | 0.96 | 0.53, 1.76 | 1.61 | 0.96, 2.69 | 0.22 |
| Earache or infection | 38 | 4,233 | 14 | 1,274 | 0.74 | 0.37, 1.47 | 1.23 | 0.50, 3.02 | 0.38 | 0.70 | 0.35, 1.40 | 1.32 | 0.51, 3.41 | 0.31 |
| Infection of open wound | 19 | 4,360 | 6 | 1,332 | 2.69 | 1.05, 6.90 | 2.24 | 0.65, 7.69 | 0.83 | 2.79 | 1.12, 6.95 | 2.94 | 0.79, 10.97 | 0.95 |
| Skin rash | 19 | 4,230 | 5 | 1,267 | 1.46 | 0.68, 3.14 | 0.89 | 0.21, 3.82 | 0.56 | 1.09 | 0.42, 2.80 | 0.51 | 0.06, 4.04 | 0.50 |
| Fever | 22 | 4,366 | 2 | 1,342 | 1.33 | 0.69, 2.56 | 3.29 | 2.35, 4.59 | 0.01 | 1.29 | 0.66, 2.52 | 3.53 | 2.37, 5.24 | 0.01 |
| Upper respiratory illness ^c | 37 | 3,679 | 15 | 1,090 | 0.89 | 0.55, 1.45 | 1.94 | 0.85, 4.42 | 0.10 | 0.74 | 0.44, 1.25 | 1.89 | 0.87, 4.11 | 0.06 |
| Any infectious symptom ^d | 50 | 4,080 | 17 | 1,264 | 1.12 | 0.69, 1.83 | 2.51 | 1.49, 4.24 | 0.04 | 1.06 | 0.64, 1.76 | 2.52 | 1.41, 4.50 | 0.03 |
| <i>Fecal coliforms</i> | | | | | | | | | | | | | | |
| Gastrointestinal illness | 30 | 4,251 | 10 | 1,297 | 0.82 | 0.42, 1.61 | 2.96 | 1.50, 5.83 | 0.01 | 0.76 | 0.38, 1.54 | 2.59 | 1.02, 6.56 | 0.04 |
| Diarrhea | 24 | 4,285 | 9 | 1,305 | 1.04 | 0.53, 2.04 | 3.34 | 1.72, 6.47 | 0.02 | 1.05 | 0.51, 2.16 | 3.20 | 1.31, 7.85 | 0.08 |
| Sinus pain or infection | 44 | 4,130 | 19 | 1,262 | 1.57 | 0.87, 2.84 | 2.18 | 1.11, 4.26 | 0.48 | 0.75 | 0.35, 1.58 | 1.52 | 0.62, 3.73 | 0.22 |
| Earache or infection | 38 | 4,233 | 14 | 1,274 | 0.83 | 0.39, 1.76 | 1.46 | 0.63, 3.39 | 0.29 | 0.99 | 0.51, 1.92 | 1.59 | 0.84, 3.01 | 0.32 |
| Infection of open wound | 19 | 4,360 | 6 | 1,332 | 2.76 | 0.91, 8.36 | 2.67 | 0.85, 8.41 | 0.97 | 3.21 | 1.03, 10.03 | 4.12 | 0.95, 17.91 | 0.79 |
| Skin rash | 19 | 4,230 | 5 | 1,267 | 1.69 | 0.72, 3.99 | 1.03 | 0.24, 4.43 | 0.56 | 1.18 | 0.39, 3.56 | 0.54 | 0.09, 3.06 | 0.42 |
| Fever | 22 | 4,366 | 2 | 1,342 | 1.15 | 0.49, 2.70 | 4.99 | 3.19, 7.79 | 0.00 | 1.16 | 0.49, 2.73 | 6.22 | 3.88, 9.96 | 0.00 |
| Upper respiratory illness ^c | 37 | 3,679 | 15 | 1,090 | 0.97 | 0.50, 1.89 | 2.33 | 0.75, 7.23 | 0.19 | 0.73 | 0.38, 1.40 | 2.03 | 0.70, 5.89 | 0.11 |
| Any infectious symptom ^d | 50 | 4,080 | 17 | 1,264 | 1.17 | 0.69, 1.97 | 3.21 | 1.84, 5.58 | 0.01 | 1.11 | 0.65, 1.91 | 3.42 | 1.76, 6.66 | 0.01 |
| <i>Total coliforms</i> | | | | | | | | | | | | | | |
| Gastrointestinal illness | 30 | 4,251 | 10 | 1,297 | 0.77 | 0.40, 1.47 | 2.62 | 1.63, 4.24 | 0.01 | 0.83 | 0.42, 1.63 | 1.96 | 1.22, 3.15 | 0.08 |
| Diarrhea | 24 | 4,285 | 9 | 1,305 | 0.66 | 0.29, 1.51 | 2.59 | 1.53, 4.38 | 0.02 | 0.78 | 0.35, 1.70 | 1.99 | 1.19, 3.35 | 0.09 |
| Sinus pain or infection | 44 | 4,130 | 19 | 1,262 | 1.52 | 0.84, 2.77 | 2.02 | 1.04, 3.93 | 0.55 | 1.08 | 0.54, 2.19 | 1.79 | 0.93, 3.44 | 0.33 |
| Earache or infection | 38 | 4,233 | 14 | 1,274 | 1.03 | 0.54, 1.96 | 1.67 | 0.63, 4.41 | 0.40 | 0.92 | 0.46, 1.82 | 1.72 | 0.64, 4.61 | 0.32 |
| Infection of open wound | 19 | 4,360 | 6 | 1,332 | 3.46 | 0.79, 15.20 | 2.16 | 0.46, 10.16 | 0.69 | 4.02 | 0.91, 17.67 | 2.38 | 0.60, 9.43 | 0.63 |
| Skin rash | 19 | 4,230 | 5 | 1,267 | 1.58 | 0.73, 3.40 | 1.14 | 0.34, 3.81 | 0.65 | 1.30 | 0.48, 3.53 | 1.11 | 0.28, 4.41 | 0.86 |
| Fever | 22 | 4,366 | 2 | 1,342 | 1.59 | 0.78, 3.22 | 7.48 | 4.28, 13.08 | 0.00 | 1.62 | 0.77, 3.37 | 9.24 | 4.64, 18.41 | 0.00 |
| Upper respiratory illness ^a | 37 | 3,679 | 15 | 1,090 | 0.87 | 0.49, 1.52 | 2.04 | 0.84, 4.96 | 0.12 | 0.72 | 0.40, 1.30 | 1.87 | 0.84, 4.19 | 0.08 |
| Any infectious symptom ^d | 50 | 4,080 | 17 | 1,264 | 1.35 | 0.78, 2.34 | 3.26 | 1.76, 6.01 | 0.06 | 0.69 | 0.23, 2.07 | 3.02 | 1.56, 5.38 | 0.10 |

Abbreviations: CI, confidence interval; IRR, incidence rate ratio.

^a We controlled for the following time-invariant potential confounders: age, sex, educational level, employment status, household income, years the individual had surfed, reported behavior of typically avoiding the ocean after wet weather, surfboard length, mode of enrollment (beach vs. Internet). We controlled for chronic health conditions only for the corresponding outcomes: ear problems, sinus problems, gastrointestinal conditions, respiratory conditions, skin conditions. We also controlled for the following time-varying potential confounders: entered the ocean for an activity other than surfing, any illness symptoms in the week preceding the risk window, day of recall, day of the week, and rainfall total during the past 3 days.

^b P value for multiplicative effect modification of dry versus wet weather.

^c Only measured in year 2 of the study.

^d Includes gastrointestinal illness, eye infections, infected wounds, and fever.

Limitations

The use of self-reported symptoms could bias the association between seawater exposure and illness away from the null if surfers overreported illness after exposure; conversely, random (nondifferential) errors in exposures or outcomes could bias associations toward the null (34). The survey measured daily exposure and outcomes in separate modules—an intentional decision to separate the measurements and inhibit systematic reporting bias. Adjusted analyses controlled for day of recall and day of the week to reduce nondifferential bias from recall errors but would not control for systematic bias. Negative control exposure analyses found no association between *Enterococcus* levels and illness on days with no recent water exposure (Web Table 5), which suggests that unmeasured confounding or reporting bias is unlikely to explain the association between *Enterococcus* levels and illness. Moreover, the use of daily average levels of fecal indicator bacteria could bias the association between water quality and illness toward the null if the averaging resulted in nondifferential misclassification error (35).

We measured incident outcomes within 3 days of seawater exposure because the population regularly entered the ocean, a 3-day period captures the incubation period for the most common waterborne pathogens (e.g., norovirus, *Campylobacter* species, *Salmonella* species) (36), and past studies found that most excess episodes of gastrointestinal illness associated with seawater exposure occurred in the first 1–2 days (15). Illness caused by waterborne pathogens with longer incubation periods (e.g., *Cryptosporidium* species) (37) could have been misclassified in this study, which could bias results toward the null by artificially increasing incidence rates in unexposed periods and decreasing rates in exposed periods.

Conclusions

Surfing was associated with increased incidence of several categories of symptoms, and associations were stronger if surfing took place shortly after rainstorms. Higher levels of fecal indicator bacteria were strongly associated with fever, sinus pain/infection, wound infection, and gastrointestinal symptoms within 3 days of rainstorms. The internal consistency between water-quality measurements, patterns of illness after dry- and wet-weather exposures, and incidence profiles with time since rainstorms lead us to conclude that seawater exposure during or close to rainstorms at beaches impacted by urban runoff in southern California increases the incidence rates of a broad set of acute illnesses among surfers. These findings provide strong evidence to support the posting of beach warnings after rainstorms and initiatives that would reduce pathogen sources in urban runoff that flows to coastal waters.

ACKNOWLEDGMENTS

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Chung, John M. Colford, Jr.); Southern California Coastal Water Research Project, Costa Mesa, California (Kenneth C. Schiff, Joshua A. Steele, John F. Griffith, Steven J. Steinberg, Paul Smith, Stephen B. Weisberg); Orange County Sanitation District, Fountain Valley, California (Charles D. McGee; retired); and Surfrider Foundation, San Clemente, California (Richard Wilson, Chad Nelsen).

The study was funded by the city and county of San Diego, California.

We thank the field team members who enrolled participants at the beach and collected water samples throughout the study. We also thank Laila Othman, Sonji Romero, Aaron Russell, Joseph Toctocan, Laralyn Asato, Zaira Valdez, and the staff at City of San Diego Marine Microbiology Laboratory who generously provided laboratory space to test water specimens, and Jeffrey Soller, Mary Schoen, and members of the study's external advisory committee for earlier comments on the results.

The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Conflict of interest: none declared.

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