Legionella longbeachae, found in soil and compost-derived products, is a globally underdiagnosed cause of Legionnaires’ disease. We conducted a case–control study of L. longbeachae Legionnaires’ disease in Canterbury, New Zealand. Case-patients were persons hospitalized with L. longbeachae pneumonia, and controls were persons randomly sampled from the electoral roll for the area served by the participating hospital. Among 31 cases and 172 controls, risk factors for Legionnaires’ disease were chronic obstructive pulmonary disease, history of smoking >10 years, and exposure to compost or potting mix. Gardening behaviors associated with L. longbeachae disease included having unwashed hands near the face after exposure.
Legionnaires’ disease is a community-acquired severe pneumonia that causes substantial illness and death (1). Of the patients that are hospitalized with the disease, 30% require intensive care unit admission and ≈10% die (1,2). In most parts of the world, the majority of reported cases are caused by Legionella pneumophila (1), which sometimes contaminates water (e.g., water from cooling towers) and causes outbreaks. However, Legionnaires’ disease is often underdiagnosed because the tests required are not usually performed unless specifically requested. In addition, a substantial diagnostic bias exists in reported cases globally because the most commonly used test, the urinary antigen test, detects only L. pneumophila serogroup 1 (2).

In 2010, in Christchurch, New Zealand, implementation of an enhanced testing strategy that included PCR testing of respiratory specimens led to a >4-fold increase in the number of detected cases of Legionnaires’ disease (2). New Zealand has the highest reported incidence of Legionnaires’ disease in the world (1), and in part because of the more rigorous testing in this country, the epidemiology of detected Legionnaires’ disease in New Zealand differs from that of most other countries; a high proportion of cases are caused by L. longbeachae (3–5). L. longbeachae can be found in soil and compost-derived products (6–9). In 2013, a total of 51% of reported Legionnaires’ disease cases were caused by L. longbeachae, 28% by L. pneumophila, and 21% by other Legionella species (3).

Two small case–control studies on risk factors for L. longbeachae pneumonia conducted in South Australia have been published (10,11). These studies found that preexisting cardiac or respiratory disease, long-term smoking, gardening, exposure to hanging baskets, using potting mix, and eating or drinking after gardening without washing hands were risk factors for this disease. O’Connor et al. suggested that both inhalation and ingestion were potential modes of transmission and advised that long-term smokers and those with respiratory and cardiac conditions should take particular care of their hygiene during and after gardening (11).

We conducted a population-based, case–control study to assess the importance of various risk factors for L. longbeachae pneumonia hospitalization in a setting with high case ascertainment to build on the South Australia studies and inform public health efforts to prevent Legionnaires’ disease. Our main aim was to identify gardening behaviors or types of exposure to potting mix and compost that are associated with the increased risk for Legionnaires’ disease. In addition, we assessed several other possible risk factors that could facilitate the introduction of organisms from compost into the lungs.

Methods

Setting

This study was conducted in the region of Canterbury, New Zealand, which has a population of ≈530,000 (12). Canterbury contains the city of Christchurch, also known as The Garden City, as well as horticultural and agricultural areas. The Canterbury District Health Board is the publicly funded healthcare provider for the region and includes the local public health unit (Community and Public Health) to which all cases of Legionnaires’ disease must be notified. The study was conducted over the course of 2 summers during the peak of Legionnaires’ disease activity (October 1, 2013–March 31, 2014 and October 1, 2014–March 31, 2015). Because no cases of Legionnaires’ disease had been previously reported in this district in persons <30 years of age, the study population was persons ≥30 years of age who were listed on the electoral roll for the electorates with boundaries within the region served by the Canterbury District Health Board. This project was approved by the University of Otago Human Ethics Committee (H13/065).

Cases

Cases of pneumonia in which the patient was hospitalized and disease onset occurred during peak Legionnaires’ season were considered for inclusion into this study. Only confirmed cases that were positive by culture or by PCR for L. longbeachae or had a ≥4-fold increase in reciprocal L. longbeachae antibody titers were eligible for inclusion (2).

Controls

To obtain controls, before each summer, a random sample that was frequency-matched to the expected age distribution of case-patients was taken from the electoral roll. The list of potential controls was randomly sorted and broken into 3 groups; each group was sent an invitation to participate in the study at approximately monthly intervals starting in mid-September in 2013 and at the end of October in 2014. This strategy was used in an effort to interview controls at a rate similar to that of the case-patients. We aimed to recruit 3 controls per case-patient. If no response was received to the first letter, a follow-up letter was sent. If no response was received and the person appeared in the telephone book at the address on the electoral roll, we followed up by phone call.

Data Collection

All notified cases of Legionnaires’ disease are followed up by a Health Protection Officer (HPO) from the Public Health Unit. Follow-up usually includes a face-to-face
Legionnaires’ disease was not confirmed. Three
14
use of compost.
15
transfer in explaining the increased risk associated with the
causal paths that included aerosolization and hand-to-face
a multivariable analysis to assess the relative importance of
hands). We assumed that both of these types of activities
could result in inhalation of
organisms near or in the mouth (eating or drinking, smoking,
or touching the face after using compost without washing
hands). We assumed that both of these types of activities
could result in inhalation of Legionella, and we conducted
a multivariable analysis to assess the relative importance of
causal paths that included aerosolization and hand-to-face
transfer in explaining the increased risk associated with the
use of compost.

We used a causal diagram (15) as a guide for multivari-
able analyses (online Technical Appendix Figure, https://
Aerosolization of compost and hand-to-face transfer of
compost are intermediate factors between the use of com-
pot, which is known to be a risk factor for Legionnaires’
disease, and diagnosis of Legionnaires’ disease. Our study
had insufficient data to precisely estimate these intermediate
effects or to definitively determine whether a direct effect
of compost remained after adjusting for both aerosolization
and hand-to-face activities (which would suggest that other
causal pathways in addition to aerosolization or hand-to-
face activities exist). However, our assumption was that if
the OR associated with compost use reduced to close to 1
in a multiple regression model that included aerosolization
and hand-to-face variables, this finding would indicate that
we had identified the main causal pathways (16).

We did not have enough data to put all the separate rel-
vant variables into a single multivariable model. Our initial
intention was to create 1 composite variable indicating ex-
perience of any of the aerosolizing activities and 1 variable
indicating any of the hand-to-face activities and to include
those composite variables in a multivariable model along
with compost use. However, all of the case-patients who had
used compost in the 3 weeks previous to getting sick had also
engaged in ≥1 of the aerosolizing activities, so that compos-
ite variable could not be included in the multivariable model.
Therefore, we selected 1 of the aerosolization variables as a
representative aerosolizing activity as follows. First, we con-
structed separate models that each included compost use and
one of the aerosolizing activities. We then chose the model,
and therefore the activity, with the lowest Akaike informa-
tion criterion (a measure of the relative quality of statisti-
cal models) (17). This activity was then included in a model
with compost use and the composite hand-to-face variable
to determine whether there was any direct effect of compost
use after adjustment for these 2 mechanisms of exposure.
Population attributable fractions, which can be interpreted as
the percentage by which disease incidence would be reduced
if the risk factor was eliminated, were calculated for these
variables from this model (18).

Results
Thirty-seven cases of L. longbeachae Legionnaires’ dis-
ease were initially notified to Community and Public
Health during the study period (24 in the first summer and
13 in the second). One case was excluded because the pa-
tient was not on a Canterbury electoral roll, and 2 patients
were interviewed but later excluded from the analysis
when L. longbeachae infection was not confirmed. Three
case-patients declined to participate in the study, yield-
ing an overall response rate of 31 out of 34 (91%) for
eligible cases.

Analysis
We analyzed data using Stata 13 (13). All calculations of
odds ratios (ORs) used a logistic mixed model that adjusted
for age (a continuous variable) and included period (Octo-
ber 1, 2013–March 31, 2014 or October 1, 2014–March 31,
2015) as a random effect. We interpreted ORs as measures
of relative risk.

For exposures to purchased compost and potting
mix, the products were combined (and referred to as pur-
chased compost products or simply as compost) because
their manufacturing processes are similar and because we
grouped them together to help maximize precision. We as-
essed the effects of behaviors that have been encouraged
as protective (14) (e.g., wearing a mask, wearing gloves,
and wetting compost before use) in compost users only. We
stratified estimation of the OR of exposure to compost by
smoking status to assess whether smoking modifies the ef-
fect of exposure to compost.

We identified 2 groups of behaviors that could poten-
tially explain the increased risk for Legionnaires’ disease
through using compost: behaviors that increase the risk for
aerosolizing compost organisms (moving compost around,
opening compost bag, and using compost indoors) and
behaviors that increase the risk of getting compost organ-
isms near or in the mouth (eating or drinking, smoking,
or touching the face after using compost without washing
hands). We assumed that both of these types of activities
could result in inhalation of Legionella, and we conducted
an overall response rate of 31 out of 34 (91%) for
eligible cases.
Each summer, letters were sent to 301 potential controls (total 602 potential controls) identified from the electoral roll. In total, 214 potential controls (36% of all potential controls and 46% of those who could be contacted) agreed to take part in the study (Figure). Of these, 10 were ineligible, 172 were interviewed, 6 were unable to be interviewed, and 26 were not interviewed for administrative reasons. In the first study period, interviewing stopped after 69 controls had been interviewed (when 3 controls/case was reached), but afterward 2 case-patients who did not have L. longbeachae disease were excluded. For the second study period, all controls who agreed to take part were interviewed, except for the 6 whose consent was confirmed too late for the interview to take place.

**Demographic Characteristics, Health Conditions, and Smoking**

Case-patients were slightly older and more likely than controls to be men (Table 1). The health condition most strongly associated with Legionnaires’ disease was chronic obstructive pulmonary disease (COPD; OR 4.2, 95% CI 1.2–14.7) (Table 2). Smoking was associated with an increased risk for Legionnaires’ disease, and a dose-dependent response was evident.

**Gardening Environment and Pets**

All case-patients and all but 4 controls had an outdoor garden on their property, but case-patients were 3 times more likely than controls to have an indoor garden (defined as a glass or tunnel house, hydroponic system, or conservatory) (Table 3). Almost all case-patients had gardened during the 3 weeks before becoming ill, and almost all controls had gardened during the 3 weeks before being interviewed. Using purchased compost products was strongly associated with Legionnaires’ disease (OR 6.2, 95% CI 2.2–17.3) and using homemade compost was not. Case-patients were also 3 times as likely as controls to own >1 cat.

Behaviors such as moving the hands to the face before handwashing (OR 4.8) and aerosolizing compost (OR 9.9) with Legionnaires’ disease (OR 6.2, 95% CI 2.2–17.3) and using homemade compost was not. Case-patients were also 3 times as likely as controls to own >1 cat.

**Figure.** Flowchart of solicitation and participation of controls for study of Legionella longbeachae Legionnaires’ disease, New Zealand, October 1–March 31, 2013–2014 and 2014–2015.

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### Table 1. Demographic characteristics of Legionnaires’ disease case-patients and controls, New Zealand, October 1–March 31, 2013–2014 and 2014–2015

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Case-patients, no. (%)</th>
<th>Controls, no. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age, y</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30–39</td>
<td>1 (3)</td>
<td>3 (2)</td>
</tr>
<tr>
<td>40–49</td>
<td>4 (13)</td>
<td>8 (5)</td>
</tr>
<tr>
<td>50–59</td>
<td>4 (13)</td>
<td>36 (21)</td>
</tr>
<tr>
<td>60–69</td>
<td>7 (23)</td>
<td>56 (33)</td>
</tr>
<tr>
<td>70–79</td>
<td>10 (32)</td>
<td>49 (28)</td>
</tr>
<tr>
<td>≥80</td>
<td>5 (16)</td>
<td>20 (12)</td>
</tr>
<tr>
<td><strong>Median age</strong></td>
<td>69</td>
<td>66</td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>18 (58)</td>
<td>74 (43)</td>
</tr>
<tr>
<td>F</td>
<td>13 (42)</td>
<td>98 (57)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>European</td>
<td>30 (97)</td>
<td>156 (91)</td>
</tr>
<tr>
<td>Māori</td>
<td>1 (3)</td>
<td>6 (3)</td>
</tr>
<tr>
<td>Pacific</td>
<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>8 (5)</td>
</tr>
<tr>
<td>Not specified</td>
<td>0</td>
<td>1 (1)</td>
</tr>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤$70,000†</td>
<td>19 (61)</td>
<td>83 (48)</td>
</tr>
<tr>
<td>&gt;$70,000</td>
<td>6 (19)</td>
<td>53 (31)</td>
</tr>
<tr>
<td>Missing</td>
<td>6 (19)</td>
<td>36 (21)</td>
</tr>
<tr>
<td><strong>Possible occupational exposure‡</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2 (6)</td>
<td>7 (4)</td>
</tr>
<tr>
<td>No</td>
<td>28 (90)</td>
<td>165 (96)</td>
</tr>
<tr>
<td>Missing</td>
<td>1 (3)</td>
<td></td>
</tr>
</tbody>
</table>

*If Māori and other ethnicities were ticked, the person’s ethnicity was recorded as Māori; if Pacific but not Māori was ticked, the person’s ethnicity was recorded as Pacific.
†$70,000 was approximately the reported New Zealand median household income in 2013 (19).
‡For case-patients: 1 garden center worker and 1 farm manager. For controls: 4 farmers, 1 soil scientist, 1 gardener, and 1 landscaper.
were associated with the risk for disease (Table 4). None of the behaviors that have been considered possibly protective against Legionnaires’ disease were associated with a reduction in disease risk.

Among participants who had smoked for >10 years, those who had used compost had an OR for Legionnaires’ disease of 7.9 (95% CI 1.5–43.2); among those who had not smoked or smoked for <10 years but used compost, the OR was 4.6 (95% CI 1.2–17.2). Although these CIs overlap, these results suggest an increased effect of compost use on the risk for Legionnaires’ disease in persons who have smoked long-term. The OR for compost users who had smoked for ≥10 years compared with those with neither risk factor was 14.7 (95% CI 3.7–58.4).

In multivariable regression, including compost use and each of the aerosolization variables separately, the model risk factor was 14.7 (95% CI 3.7–58.4).

Discussion

Forty years since the first identification of Legionnaires’ disease, we still do not have a thorough understanding of how to prevent disease caused by the species L. longbeachae. Risk factors for Legionnaires’ disease include host characteristics and modifiable behavioral or environmental factors. Most published data have focused on the risk factors for L. pneumophila Legionnaires’ disease: smoking, older age, chronic

Table 2. Univariate analyses of the associations between health conditions or smoking and Legionella longbeachae Legionnaires’ disease, New Zealand, October 1–March 31, 2013–2014 and 2014–2015*

<table>
<thead>
<tr>
<th>Health conditions</th>
<th>Case-patients, no. (%)</th>
<th>Controls, no. (%)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preexisting health conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac disease</td>
<td>8 (26)</td>
<td>35 (20)</td>
<td>1.2 (0.47–3.0)</td>
</tr>
<tr>
<td>Respiratory disease</td>
<td>10 (32)</td>
<td>35 (20)</td>
<td>2.1 (0.87–4.9)</td>
</tr>
<tr>
<td>Asthma</td>
<td>8 (26)</td>
<td>28 (16)</td>
<td>1.9 (0.76–4.9)</td>
</tr>
<tr>
<td>COPD</td>
<td>5 (16)</td>
<td>9 (5)</td>
<td>4.2 (1.2–14.7)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5 (16)</td>
<td>12 (7)</td>
<td>2.8 (0.88–8.0)</td>
</tr>
<tr>
<td>Immunosuppression</td>
<td>6 (19)</td>
<td>16 (9)</td>
<td>2.7 (0.91–7.9)</td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker</td>
<td>4 (13)</td>
<td>9 (5)</td>
<td>2.4 (0.66–8.5)</td>
</tr>
<tr>
<td>Never smoked</td>
<td>12 (39)</td>
<td>109 (65)</td>
<td>1.0</td>
</tr>
<tr>
<td>Smoked &lt;20 y</td>
<td>5 (16)</td>
<td>26 (16)</td>
<td>1.6 (0.5–5.1)</td>
</tr>
<tr>
<td>Smoked 20 y to &lt;40 y</td>
<td>4 (13)</td>
<td>17 (10)</td>
<td>2.3 (0.6–8.0)</td>
</tr>
<tr>
<td>Smoked &gt;40 y</td>
<td>10 (32)</td>
<td>15 (9)</td>
<td>5.6 (2.0–16.0)</td>
</tr>
</tbody>
</table>

*OR, odds ratio.
†Length of time smoking could not be determined for 5 control respondents. Percentages are given for those in which length of time smoking was known.

Table 3. Univariate analyses of the associations between garden type, garden exposures, or pets and Legionella longbeachae Legionnaires’ disease, New Zealand, October 1–March 31, 2013–2014 and 2014–2015*

<table>
<thead>
<tr>
<th>Environmental factors</th>
<th>Case-patients, no. (%)</th>
<th>Controls, no. (%)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garden type</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outdoor garden on property</td>
<td>31 (100)</td>
<td>168 (98)</td>
<td>3.0 (1.3–7.1)</td>
</tr>
<tr>
<td>Enclosed garden on property†</td>
<td>11 (36)</td>
<td>29 (17)</td>
<td></td>
</tr>
<tr>
<td>Hanging pots or baskets on property</td>
<td>10 (32)</td>
<td>53 (31)</td>
<td>0.95 (0.41–2.2)</td>
</tr>
<tr>
<td>Garden exposures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Near dripping, hanging pots or baskets</td>
<td>4 (13)</td>
<td>37 (22)</td>
<td>0.55 (0.18–1.7)</td>
</tr>
<tr>
<td>Gardened in the past 3 weeks</td>
<td>29 (94)</td>
<td>151 (88)</td>
<td>1.9 (0.42–8.7)</td>
</tr>
<tr>
<td>Spent any time gardening outdoors</td>
<td>28 (90)</td>
<td>150 (87)</td>
<td>1.3 (0.36–4.7)</td>
</tr>
<tr>
<td>Spent any time gardening indoors‡</td>
<td>10 (32)</td>
<td>54 (31)</td>
<td>1.0 (0.45–2.4)</td>
</tr>
<tr>
<td>Used purchased compost</td>
<td>26 (84)</td>
<td>84 (49)</td>
<td>6.2 (2.2–17.3)</td>
</tr>
<tr>
<td>Used homemade compost§</td>
<td>7 (23)</td>
<td>40 (22)</td>
<td>1.0 (0.40–2.6)</td>
</tr>
<tr>
<td>Pets</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Own dog(s)</td>
<td>7 (23)</td>
<td>40 (23)</td>
<td>0.97 (0.36–2.6)</td>
</tr>
<tr>
<td>Own cat(s)</td>
<td>19 (61)</td>
<td>63 (37)</td>
<td>3.0 (1.3–6.8)</td>
</tr>
<tr>
<td>Own bird(s)</td>
<td>4 (13)</td>
<td>12 (7)</td>
<td>1.9 (0.55–6.5)</td>
</tr>
</tbody>
</table>

*OR, odds ratio.
†Including tending to potted plants.
‡Including glasshouse, tunnel house, hydroponics, or conservatory.
§Irrespective of use of purchased compost.
Risk Factors for Legionnaires' Disease

Table 4. Univariate analyses of the associations between gardening behaviors and Legionella longbeachae Legionnaires’ disease, New Zealand, October 1–March 31, 2013–2014 and 2014–2015*

<table>
<thead>
<tr>
<th>Activities performed around the time of gardening</th>
<th>Case-patients, no. (%)</th>
<th>Controls, no. (%)</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand to face after using compost and before washing hands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ate or drank</td>
<td>7 (23)</td>
<td>13 (8)</td>
<td>4.1 (1.4–11.8)</td>
</tr>
<tr>
<td>Touched face</td>
<td>12 (39)</td>
<td>31 (18)</td>
<td>3.6 (1.5–8.6)</td>
</tr>
<tr>
<td>Smoked</td>
<td>2 (7)</td>
<td>5 (3)</td>
<td>2.2 (0.39–12.0)</td>
</tr>
<tr>
<td>Any opportunity for getting hands near face (smoking, eating or drinking, or touching face) before washing hands</td>
<td>16 (52)</td>
<td>36 (21)</td>
<td>4.8 (2.1–11.1)</td>
</tr>
<tr>
<td>Possible compost aerosolization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opened compost</td>
<td>21 (68)</td>
<td>55 (32)</td>
<td>5.2 (2.2–12.1)</td>
</tr>
<tr>
<td>Used compost indoors</td>
<td>7 (23)</td>
<td>9 (5)</td>
<td>6.6 (2.1–20.7)</td>
</tr>
<tr>
<td>Tipped or troweled compost</td>
<td>24 (77)</td>
<td>60 (35)</td>
<td>8.3 (3.2–21.5)</td>
</tr>
<tr>
<td>Moved compost with hands</td>
<td>15 (48)</td>
<td>52 (30)</td>
<td>2.6 (1.1–5.8)</td>
</tr>
<tr>
<td>Purchased compost or moved potting mix around (with hands or by tipping/troweling)</td>
<td>26 (84)</td>
<td>70 (41)</td>
<td>9.9 (3.4–28.3)</td>
</tr>
<tr>
<td>Possible protective factors†</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wore a mask while using compost</td>
<td>5 (19)</td>
<td>12 (14)</td>
<td>1.5 (0.46–4.8)</td>
</tr>
<tr>
<td>Wore gloves while handling compost</td>
<td>17 (65)</td>
<td>50 (60)</td>
<td>1.2 (0.49–3.1)</td>
</tr>
<tr>
<td>Wet compost down before use</td>
<td>4 (13)</td>
<td>18 (11)</td>
<td>1.6 (0.48–5.4)</td>
</tr>
</tbody>
</table>

*OR, odds ratio.
†Among only those who had used compost in previous 3 weeks.

cardiovascular or respiratory disease, immunosuppression, and exposure to water aerosols (I). Data on the risk factors for L. longbeachae disease are lacking, beyond the presumed association with compost exposure. Our study highlights some similarities and differences with risk factors for Legionnaires’ disease caused by L. pneumophila. We found that COPD and smoking are host risk factors for L. longbeachae disease. Those who had ever smoked were twice as likely to get L. longbeachae disease as those who had never smoked, and the risk was higher for those who had smoked longer. Having COPD, although uncommon (16% of case-patients and 5% of controls), increased disease risk 4-fold.

Use of purchased compost products during the reference period was the strongest exposure risk factor for L. longbeachae disease in univariate analysis, and those who had smoked for ≥10 years were more likely than nonsmokers to get Legionnaires’ disease after using purchased compost products. The mechanisms by which compost use increases the risk for disease appear to include the activities that increase the likelihood of its aerosolization and activities that could lead to compost being transferred to the face or mouth, presumably leading to inhalation of particles contaminated with Legionella bacteria. Our findings suggest that the biggest reduction in L. longbeachae disease could be made by eliminating activities that aerosolize compost (population attributable fraction 65%). We also found that hand hygiene might be a useful measure for preventing L. longbeachae disease, with the potential to reduce disease by 35%. However, we did not demonstrate a benefit from wearing gloves or masks while gardening.

Our findings are similar to those from the previous studies conducted in South Australia (10,11) in identifying that having ever smoked, having a history of long-term smoking, recently using compost, and eating or drinking after using compost products before washing hands are risk factors for L. longbeachae disease. However, our study did not confirm that preexisting cardiac illness or being near dripping hanging pots or baskets were associated with L. longbeachae disease.

We found a previously unidentified association between cat ownership and L. longbeachae infection. The association was unaffected by including smoking or use of compost products in the multivariable model (data not shown). However, given the relatively small sample size and potential for a false-positive finding, further investigation of this association is required before any definitive conclusions can be made.

The small sample size was a limitation of this study. Having low numbers of cases resulted in wide CIs for ORs and the limited ability to perform more detailed multivariable analyses. Assessing the effect of different compost handling methods and different compost product exposures on disease risk was not possible. Another limitation was the poor response rate among controls. It is possible that respondents differed from the general population (e.g., a selection for gardeners probably occurred). Because information about the nature of the study provided to participants noted that L. longbeachae is found in soil, nongardeners might have perceived that the study investigators were only interested in interviewing gardeners and declined to participate. The lack of nongardeners in the study could cause an underestimation of the effect of gardening-related behaviors on disease risk. On the other hand, recall bias, in which

Table 5. Multivariable analyses of the direct and intermediate effects of types of compost use on Legionella longbeachae Legionnaires’ disease, New Zealand, October 1–March 31, 2013–2014 and 2014–2015*

<table>
<thead>
<tr>
<th>Compost use risk factor</th>
<th>OR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of compost in previous 3 weeks</td>
<td>0.97 (0.16–5.9)</td>
</tr>
<tr>
<td>Tip or trowel compost</td>
<td>6.1 (1.3–29.4)</td>
</tr>
<tr>
<td>Hand to face before handwashing</td>
<td>2.3 (0.88–6.1)</td>
</tr>
</tbody>
</table>

*OR, odds ratio.
case-patients overestimate their risk to exposed risks, could
cause overestimation of the effect. The precision of this
study did not warrant formal quantitative bias analysis (20).

Although we demonstrated no protective effect with use of
gloves or masks while gardening, we are reluctant to ad-
vise against these practices on the basis of this study alone,
especially given the increased disease risk associated with
activities that lead to the aerosolization of compost and activi-
ties that can lead to the transfer of compost from the hand to
the face. Those using face masks and gloves while handling
purchased compost products should use single-use disposable
masks and wash hands thoroughly after removing gloves but
before removing and disposing of the mask; not washing
hands before mask removal might be a potential exposure to
the face. Smokers (both current smokers and those with a long-
term history of smoking) should be made aware that they are
at increased risk for Legionnaires’ disease and advised to be
particularly careful when using purchased compost products.

Transmission of *L. longbeachae* bacteria to humans is
still not fully understood, and it is not possible to use
compost without moving it around. However, public health
messages should encourage persons handling purchased
compost products and potting mix to minimize aerosola-
(especially given the increased disease risk associated with
activities that lead to the aerosolization of compost and activi-
ties). People using face masks and gloves while handling
potting mix to minimize the risk of exposure to respirable
parts of compost, and to keep hands away from the face until they have been
thoroughly washed. Larger studies to assess the risk associ-
ated with particular compost-associated behaviors more
fully could better inform prevention strategies.

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