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1. A new threat from an old enemy: Re-emergence of coronavirus (Review)

Authors Docea A.O.; Tsatsakis A.; Tutelyan V.A.; Onischenko G.G.; Aschner M.; Albulescu D.; Cristea O.; Zlatian O.; Vinceti M.; Moschos S.A.; Tsoukalas D.; Goumenou M.; Drakoulis N.; Dumanov1 J.M.; Spandidos D.A.; Calina D.
Source International Journal of Molecular Medicine; 2020; vol. 45 (no. 6); p. 1631-1643
Publication Date 2020
Publication Type(s) Review
PubMedID 32236624
Database EMBASE
Available at International journal of molecular medicine from ProQuest (Health Research Premium) - NHS Version
Available at International journal of molecular medicine from Unpaywall
Abstract The new outbreak of coronavirus from December 2019 has brought attention to an old viral enemy and has raised concerns as to the ability of current protection measures and the healthcare system to handle such a threat. It has been known since the 1960s that coronaviruses can cause respiratory infections in humans; however, their epidemic potential was understood only during the past two decades.

2. Emergent strategies for the next phase of covid-19

Authors Huh K.; Peck K.R.; Shin H.-S.
Source Infection and Chemotherapy; 2020; vol. 52 (no. 1); p. 105-109
Publication Date 2020
Publication Type(s) Review
Database EMBASE
Available at Infection & chemotherapy from Europe PubMed Central - Open Access
Available at Infection & chemotherapy from Unpaywall

3. What we know so far: COVID-19 current clinical knowledge and research

Authors Lake M.A.
Source Clinical Medicine, Journal of the Royal College of Physicians of London; 2020; vol. 20 (no. 2); p. 124-127
Publication Date 2020
Publication Type(s) Review
Database EMBASE
Available at Clinical medicine (London, England) from ProQuest (Health Research Premium) - NHS Version
Available at Clinical medicine (London, England) from Request from Barts Health - Newham University Hospital Local Full Text Collection [location] : Request from Barts Health - Newham University Hospital. [title_notes] : Donated title.
Available at Clinical medicine (London, England) from Unpaywall
Abstract In December 2019, health authorities in Wuhan, China, identifi ed a cluster of pneumonia cases of unknown aetiology linked to the city's South China Seafood Market. Subsequent investigations revealed a novel coronavirus, SARS-CoV-2, as the causative agent now at the heart of a major outbreak. The rising case numbers have been accompanied by unprecedented public health action, including the wholesale isolation of Wuhan. Alongside this has been a robust scientifi c response, including early publication of the pathogen genome, and rapid development of highly specifi c diagnostics. This article will review the new knowledge of SARS-CoV-2 COVID-19 acute respiratory disease, and summarise its clinical features.

4. COVID-19 pandemic: Lessons learned and future directions.

Authors Khanna, Rohit C; Cicinelli, Maria Vittoria; Gilbert, Suzanne S; Honavar, Santosh G; Murthy, Gudlavalleti S V
Source Indian journal of ophthalmology; May 2020; vol. 68 (no. 5); p. 703-710
Publication Date May 2020
Publication Type(s) Journal Article Review
PubMedID 32317432
Database Medline
Available at Indian journal of ophthalmology from Europe PubMed Central - Open Access
Available at Indian journal of ophthalmology from ProQuest (Health Research Premium) - NHS Version
Available at Indian journal of ophthalmology from Unpaywall

Abstract Emerging pandemics show that humans are not infallible and communities need to be prepared. Coronavirus outbreak was first reported towards the end of 2019 and has now been declared a pandemic by the World Health Organization. Worldwide countries are responding differently to the virus outbreak. A delay in detection and response has been recorded in China, as well as in other major countries, which led to an overburdening of the local health systems. On the other hand, some other nations have put in place effective strategies to contain the infection and have recorded a very low number of cases since the beginning of the pandemics. Restrictive measures like social distancing, lockdown, case detection, isolation, contact tracing, and quarantine of exposed had revealed the most efficient actions to control the disease spreading. This review will help the readers to understand the difference in response by different countries and their outcomes. Based on the experience of these countries, India responded to the pandemic accordingly. Only time will tell how well India has faced the outbreak. We also suggest the future directions that the global community should take to manage and mitigate the emergency.

5. COVID-19 outbreak: current scenario of Pakistan

Authors Waris A.; Ali M.; Atta U.K.; Asmat A.; Baset A.
Source New Microbes and New Infections; May 2020; vol. 35
Publication Date May 2020
Publication Type(s) Review
Database EMBASE
Available at New microbes and new infections from ScienceDirect
Available at New microbes and new infections from ClinicalKey
Available at New microbes and new infections from Europe PubMed Central - Open Access
Available at New microbes and new infections from Unpaywall

Abstract COVID-19 outbreak was first time experienced in the Wuhan City of China at the end of December 2019. Which spread rapidly in China and then worldwide in 209 countries of America, Europe, Australia and Asia including Pakistan. There are more than fifty thousand mortalities and one million plus people have been affected worldwide, while figure increases rapidly. Different steps have been taken worldwide for the control of COVID-19. Even with less resources Pakistan also taken rigorous measures like designed special hospitals, Laboratories for testing, quarantine facilities, awareness campaign and lock down to control the spread of virus. We highlighted the efforts of government to combat this deadly pneumonia.

6. COVID-19 Outbreak: An Overview.

Authors Ciotti, Marco; Angeletti, Silvia; Minieri, Marilena; Giovannetti, Marta; Benvenuto, Domenico; Pascarella, Stefano; Sagnelli, Caterina; Bianchi, Martina; Bernardini, Sergio; Ciccozzi, Massimo
Source Chemotherapy; Apr 2020 ; p. 1-9
Publication Date Apr 2020
Publication Type(s) Journal Article Review
PubMedID 32259829
Database Medline
Available at Chemotherapy from Unpaywall

Abstract BACKGROUNDIn late December 2019, Chinese health authorities reported an outbreak of pneumonia of unknown origin in Wuhan, Hubei Province.SUMMARYA few days later, the genome of a novel coronavirus was released (http://viro-logical.org/t/novel-2019-coronavirus-genome/319; Wuhan-Hu-1, GenBank accession No. MN908947) and made publicly available to the scientific community. This novel coronavirus was provisionally named 2019-nCoV, now SARS-CoV-2 according to the Coronavirus Study Group of the International Committee on Taxonomy of Viruses. SARS-CoV-2 belongs to the Coronaviridae family, Betacoronavirus genus, subgenus Sarbecovirus. Since its discovery, the virus has spread globally, causing thousands of deaths and having an enormous impact on our health systems and economies. In this review, we summarize the current knowledge about the epidemiology, phylogenesis, homology modeling, and molecular diagnostics of SARS-CoV-2. Key Messages: Phylogenetic analysis is essential to understand viral evolution, whereas homology modeling is important for vaccine strategies and therapies. Highly sensitive and specific diagnostic assays are key to case identification, contact tracing, identification of the animal source, and implementation of control measures.

7. COVID-19 Mobile Positioning Data Contact Tracing and Patient Privacy Regulations: Exploratory Search of Global Response Strategies and the Use of Digital Tools in Nigeria.

Authors Ekong, Iniobong; Chukwu, Emeka; Chukwu, Martha
Source JMIR mHealth and uHealth; Apr 2020; vol. 8 (no. 4); p. e19139
Publication Date Apr 2020
Publication Type(s) Journal Article
PubMedID 32310817
Database Medline

Available at JMIR mHealth and uHealth from Europe PubMed Central - Open Access
Available at JMIR mHealth and uHealth from Unpaywall

Abstract BACKGROUNDThe coronavirus disease (COVID-19) pandemic is the biggest global economic and health challenge of the century. Its effect and impact are still evolving, with deaths estimated to reach 40 million if unchecked. One effective and complementary strategy to slow the spread and reduce the impact is to trace the primary and secondary contacts of confirmed COVID-19 cases using contact tracing technology.OBJECTIVEThe objective of this paper is to survey strategies for digital contact tracing for the COVID-19 pandemic and to present how using mobile positioning data conforms with Nigeria's data privacy regulations.METHODSWe conducted an exploratory review of current measures for COVID-19 contact tracing implemented around the world. We then analyzed how countries are using mobile positioning data technology to reduce the spread of COVID-19. We made recommendations on how Nigeria can adopt this approach while adhering to the guidelines provided by the National Data Protection Regulation (NDPR).RESULTSDespite the potential of digital contact tracing, it always conflicts with patient data privacy regulations. We found that Nigeria's response complies with the NDPR, and that it is possible to leverage call detail records to complement current strategies within the NDPR.CONCLUSIONSOur study shows that mobile position data contact tracing is important for epidemic control as long as it conforms to relevant data privacy regulations. Implementation guidelines will limit data misuse.

8. Clinical characteristics and diagnostic challenges of pediatric COVID-19: A systematic review and meta-analysis.

Authors Chang, Tu-Hsuan; Wu, Jhong-Lin; Chang, Luan-Yin
Source Journal of the Formosan Medical Association = Taiwan yi zhi; Apr 2020
Publication Date Apr 2020
Publication Type(s) Journal Article
PubMedID 32307322
Database Medline
Available at Journal of the Formosan Medical Association = Taiwan yi zhi from ScienceDirect
Available at Journal of the Formosan Medical Association = Taiwan yi zhi from ClinicalKey
Available at Journal of the Formosan Medical Association = Taiwan yi zhi from Unpaywall

Abstract BACKGROUND/PURPOSECurrent studies on pediatric coronavirus disease 2019 (COVID-19) are rare. The clinical characteristics and spectrum are still unknown. Facing this unknown and emerging pathogen, we aimed to collect current evidence about COVID-19 in children.METHODSWe performed a systematic review in PubMed and Embase to find relevant case series. Because some reports were published in Chinese journals, the journals and publications of the Chinese Medical Association related to COVID-19 were completely reviewed. A random effects model was used to pool clinical data in the meta-analysis.RESULTSNine case series were included. In the pooled data, most of patients (75%) had a household contact history. The disease severity was mainly mild to moderate (98%). Only 2 children (2%) received intensive care. Fever occurred in 59% of the patients, while cough in 46%. Gastrointestinal symptoms (12%) were uncommon. There are 26% children are asymptomatic. The most common radiographic finding was ground glass opacities (48%). Currently, there is no evidence of vertical transmission to neonates born to mothers with COVID-19. Compared with the most relevant virus, SARS-CoV, SARS-CoV-2 causes less severe disease.CONCLUSIONCOVID-19 has distinct features in children. The disease severity is mild. Current diagnosis is based mainly on typical ground glass opacities on chest CT, epidemiological suspicion and contact tracing.

9. Covid-19: UK pledges to reintroduce contact tracing to fight virus

Authors Iacobucci, Gareth
Source BMJ : British Medical Journal (Online); Apr 2020; vol. 369
Publication Date Apr 2020
Publication Type(s) News
Database BNI
Available at BMJ (Clinical research ed.) from BMJ Journals
Available at BMJ (Clinical research ed.) from Request from Barts Health - Whipps Cross University Hospital Local Print Collection [location] : Request from Barts Health - Whipps Cross University Hospital.
Available at BMJ (Clinical research ed.) from Request from Barts Health - Newham University Hospital Local Print Collection [location] : Request from Barts Health - Newham University Hospital.
Available at BMJ (Clinical research ed.) from Unpaywall

Abstract [...]San Francisco has asked public health professionals to conduct voluntary phone interviews with covid-19 patients, and they then call anyone that the patient has been in contact with and ask them to quarantine themselves for 14 days.1 There are also question marks over how effective digital technology is for contact tracing, with a rapid evidence review from an independent research institute published last week warning that there was currently no evidence to support the immediate national deployment of contact tracing apps in the NHS.2 It said, "The significant technical limitations, and deep social risks, of digital contact tracing outweigh the value offered to the crisis response." Anthony Costello, head of the Institute for Global Health at University College London and a former WHO director, also appearing at the select committee hearing, said that the UK needed to adopt a traditional public health approach to contact tracing, and he suggested that retired clinicians could help with contacting people by phone. [...]at the Downing Street press conference on 19 April England's deputy chief medical officer, Jenny Harries, defended the government's approach and questioned the link between low death rates and comprehensive contact tracing.

10. Epidemiology, causes, clinical manifestation and diagnosis, prevention and control of coronavirus disease (COVID-19) during the early outbreak period: a scoping review.

Authors Adhikari, Sasmita Poudel; Meng, Sha; Wu, Yu-Ju; Mao, Yu-Ping; Ye, Rui-Xue; Wang, Qing-Zhi; Sun, Chang; Sylvia, Sean; Rozelle, Scott; Raat, Hein; Zhou, Huan
Source Infectious diseases of poverty; Mar 2020; vol. 9 (no. 1); p. 29
Publication Date Mar 2020
Publication Type(s) Journal Article Review
PubMedID 32183901
Database Medline
Available at Infectious diseases of poverty from BioMed Central
Available at Infectious diseases of poverty from Europe PubMed Central - Open Access
Available at Infectious diseases of poverty from ProQuest (Health Research Premium) - NHS Version
Available at Infectious diseases of poverty from Unpaywall

Abstract BACKGROUNDThe coronavirus disease (COVID-19) has been identified as the cause of an outbreak of respiratory illness in Wuhan, Hubei Province, China beginning in December 2019. As of 31 January 2020, this epidemic had spread to 19 countries with 11 791 confirmed cases, including 213 deaths. The World Health Organization has declared it a Public Health Emergency of International Concern.METHODSA scoping review was conducted following the methodological framework suggested by Arksey and O'Malley. In this scoping review, 65 research articles published before 31 January 2020 were analyzed and discussed to better understand the epidemiology, causes, clinical diagnosis, prevention and control of this virus. The research domains, dates of publication, journal language, authors' affiliations, and methodological characteristics were included in the analysis. All the findings and statements in this review regarding the outbreak are based on published information as listed in the references.RESULTSMost of the publications were written using the English language (89.2%). The largest proportion of published articles were related to causes (38.5%) and a majority (67.7%) were published by Chinese scholars. Research articles initially focused on causes, but over time there was an increase of the articles related to prevention and control. Studies thus far have shown that the virus' origination is in connection to a seafood market in Wuhan, but specific animal associations have not been confirmed. Reported symptoms include fever, cough, fatigue, pneumonia, headache, diarrhea, hemoptysis, and dyspnea. Preventive measures such as masks, hand hygiene practices, avoidance of public contact, case detection, contact tracing, and quarantines have been discussed as ways to reduce transmission. To date, no specific antiviral treatment has proven effective; hence, infected people primarily rely on symptomatic treatment and supportive care.CONCLUSIONSThere has been a rapid surge in research in response to the outbreak of COVID-19. During this early period, published research primarily explored the epidemiology, causes, clinical manifestation and diagnosis, as well as prevention and control of the novel coronavirus. Although these studies are relevant to control the current public emergency, more high-quality research is needed to provide valid and reliable ways to manage this kind of public health emergency in both the short- and long-term.

11. Rapid establishment of laboratory diagnostics for the novel coronavirus SARS-CoV-2 in Bavaria, Germany, February 2020

Authors Konrad R.; Dangel A.; Berger A.; Bengs K.; Sing A.; Eberle U.; Treis B.; Fingerle V.; Ackermann N.; Liebl B.
Source Eurosurveillance; Mar 2020; vol. 25 (no. 9)
Publication Date Mar 2020
Publication Type(s) Review
PubMedID 32156330
Database EMBASE
Available at Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin from Europe PubMed Central - Open Access
Available at Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin from Unpaywall

Abstract The need for timely establishment of diagnostic assays arose when Germany was confronted with the first travel-associated outbreak of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in Europe. We describe our laboratory experiences during a large contact tracing investigation, comparing previously published real-time RT-PCR assays in different PCR systems and a commercial kit. We found that assay performance using the same primers and probes with different PCR systems varied and the commercial kit performed well.

12. First cases of coronavirus disease 2019 (COVID-19) in France: Surveillance, investigations and control measures, January 2020

Authors Stoecklin S.B.; Mailles A.; Campese C.; Georges S.; Coignard B.; Levy-Bruhl D.; Rolland P.; Silue Y.; Bassi C.; Simondon A.; Yamani E.; Mechain M.; Nguyen M.; Meurice L.; Behillil S.; Enouf V.; Ismael S.; Lescure F.X.; Nguyen D.; Malvy D.; Lazarus C.; Tabai A.; Stempfelet M.
Source Eurosurveillance; Feb 2020; vol. 25 (no. 6)
Publication Date Feb 2020
Publication Type(s) Review
PubMedID 32070465
Database EMBASE
Available at Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin from Europe PubMed Central - Open Access
Available at Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin from Unpaywall
Abstract A novel coronavirus (severe acute respiratory syndrome coronavirus 2, SARS-CoV-2) causing a cluster of respiratory infections (coronavirus disease 2019, COVID-19) in Wuhan, China, was identified on 7 January 2020. The epidemic quickly disseminated from Wuhan and as at 12 February 2020, 45,179 cases have been confirmed in 25 countries, including 1,116 deaths. Strengthened surveillance was implemented in France on 10 January 2020 in order to identify imported cases early and prevent secondary transmission. Three categories of risk exposure and follow-up procedure were defined for contacts. Three cases of COVID-19 were confirmed on 24 January, the first cases in Europe. Contact tracing was immediately initiated. Five contacts were evaluated as at low risk of exposure and 18 at moderate/high risk. As at 12 February 2020, two cases have been discharged and the third one remains symptomatic with a persistent cough, and no secondary transmission has been identified. Effective collaboration between all parties involved in the surveillance and response to emerging threats is required to detect imported cases early and to implement adequate control measures.

13. Real-time tentative assessment of the epidemiological characteristics of novel coronavirus infections in Wuhan, China, as at 22 January 2020

Authors Wu P.; Hao X.; Lau E.H.Y.; Wong J.Y.; Leung K.S.M.; Wu J.T.; Cowling B.J.; Leung G.M.
Source Eurosurveillance; Jan 2020; vol. 25 (no. 3)
Publication Date Jan 2020
Publication Type(s) Review
PubMedID 31992388
Database EMBASE
Available at Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin from Europe PubMed Central - Open Access
Available at Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin from Unpaywall
Abstract A novel coronavirus (2019-nCoV) causing severe acute respiratory disease emerged recently in Wuhan, China. Information on reported cases strongly indicates human-to-human spread, and the most recent information is increasingly indicative of sustained human-tohuman transmission. While the overall severity profile among cases may change as more mild cases are identified, we estimate a risk of fatality among hospitalised cases at 14% (95% confidence interval: 3.9 32%).

14. Epidemic Models of Contact Tracing: Systematic Review of Transmission Studies of Severe Acute Respiratory Syndrome and Middle East Respiratory Syndrome.

Authors Kwok, Kin On; Tang, Arthur; Wei, Vivian W I; Park, Woo Hyun; Yeoh, Eng Kiong; Riley, Steven
Source Computational and structural biotechnology journal; 2019; vol. 17 ; p. 186-194
Publication Date 2019
Publication Type(s) Journal Article Review
PubMedID 30809323
Database Medline
Available at Computational and structural biotechnology journal from ScienceDirect

Available at Computational and structural biotechnology journal from Europe PubMed Central - Open Access
Available at Computational and structural biotechnology journal from Unpaywall

Abstract The emergence and reemergence of coronavirus epidemics sparked renewed concerns from global epidemiology researchers and public health administrators. Mathematical models that represented how contact tracing and follow-up may control Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS) transmissions were developed for evaluating different infection control interventions, estimating likely number of infections as well as facilitating understanding of their likely epidemiology. We reviewed mathematical models for contact tracing and follow-up control measures of SARS and MERS transmission. Model characteristics, epidemiological parameters and intervention parameters used in the mathematical models from seven studies were summarized. A major concern identified in future epidemics is whether public health administrators can collect all the required data for building epidemiological models in a short period of time during the early phase of an outbreak. Also, currently available models do not explicitly model constrained resources. We urge for closed-loop communication between public health administrators and modelling researchers to come up with guidelines to delineate the collection of the required data in the midst of an outbreak and the inclusion of additional logistical details in future similar models.

15. Exit and Entry Screening Practices for Infectious Diseases among Travelers at Points of Entry: Looking for Evidence on Public Health Impact.

Authors Mouchtouri, Varvara A; Christoforidou, Eleni P; An der Heiden, Maria; Menel Lemos, Cinthia; Fanos, Margherita; Rexroth, Ute; Grote, Ulrike; Belfroid, Evelien; Swaan, Corien; Hadjichristodoulou, Christos
Source International journal of environmental research and public health; Nov 2019; vol. 16 (no. 23)
Publication Date Nov 2019
Publication Type(s) Research Support, Non-u.s. Gov't Journal Article Systematic Review
PubMedID 31766548
Database Medline
Available at International journal of environmental research and public health from Europe PubMed Central - Open Access
Available at International journal of environmental research and public health from ProQuest (Health Research Premium) - NHS Version
Available at International journal of environmental research and public health from Unpaywall

Abstract A scoping search and a systematic literature review were conducted to give an insight on entry and exit screening referring to travelers at points of entry, by analyzing published evidence on practices, guidelines, and experiences in the past 15 years worldwide. Grey literature, PubMed. and Scopus were searched using specific terms. Most of the available data identified through the systematic literature review concerned entry screening measures at airports. Little evidence is available about entry and exit screening measure implementation and effectiveness at ports and ground crossings. Exit screening was part of the World Health Organisation's (WHO) temporary recommendations for implementation in certain points of entry, for specific time periods. Exit screening measures for Ebola Virus Disease (EVD) in the three most affected West African countries did not identify any cases and showed zero sensitivity and very low specificity. The percentages of confirmed cases identified out of the total numbers of travelers that passed through entry screening measures in various countries worldwide for Influenza Pandemic (H1N1) and EVD in West Africa were zero or extremely low. Entry screening measures for Severe Acute Respiratory Syndrome (SARS) did not detect any confirmed SARS cases in Australia, Canada, and Singapore. Despite the ineffectiveness of entry and exit screening measures, authors reported several important concomitant positive effects that their impact is difficult to assess, including discouraging travel of ill persons, raising awareness, and educating the traveling public and maintaining operation of flights from/to the affected areas. Exit screening measures in affected areas are important and should be applied jointly with other measures including information strategies, epidemiological investigation, contact tracing, vaccination, and quarantine to achieve a comprehensive outbreak management response. Based on review results, an algorithm about decision-making for entry/exit screening was developed.

16. Call to action for improved case definition and contact tracing for MERS-CoV

Authors Memish Z.A.
Source Journal of Travel Medicine; Jul 2019; vol. 26 (no. 5)
Publication Date Jul 2019
Publication Type(s) Review
PubMedID 30649438
Database EMBASE
Available at Journal of travel medicine from Unpaywall

17. Signs and symptoms in adult patients with acute dyspnea: a systematic review and meta-analysis.

Authors Renier, Walter; Winckelmann, Karin Hoogma-von; Verbakel, Jan Y; Aertgeerts, Bert; Buntinx, Frank
Source European journal of emergency medicine : official journal of the European Society for Emergency Medicine; Feb 2018; vol. 25 (no. 1); p. 3-11

Publication Date Feb 2018
Publication Type(s) Journal Article Review Systematic Review
PubMedID 29252938
Database Medline
Abstract INTRODUCTIONRapid and accurate diagnosis of patients with a new episode of acute dyspnea is a common challenge for Primary Care or Emergency Physicians.OBJECTIVETo determine the diagnostic accuracy of signs and symptoms in adult patients with a new episode of acute dyspnea presenting to a GP or an Emergency Physician (EP).PATIENTS AND METHODSThis was a diagnostic systematic review. Using MEDLINE, Cumulative Index to Nursing and Allied Health Literature, EMBASE, tracing references, and by contacting experts, studies were identified on the diagnostic accuracy of additional signs and symptoms in adult patients with acute or suddenly worsening dyspnea, presenting to a GP or an EP. Study quality was assessed using QUADAS and results were pooled using a random-effects model. Sensitivity, specificity, positive and negative likelihood ratio (NLR), and positive and negative predictive values for a diagnosis of heart failure (HF) were calculated for the combination of acute dyspnea and each additional sign or symptom in the selected studies.RESULTSEight of the 24 identified studies were carried out in the ED and provided us with all the required data, including 4737 patients. All publications reported HF; two studies additionally investigated pulmonary embolism, acute exacerbations of chronic obstructive pulmonary disease or asthma, acute pulmonary infectious diseases, or acute coronary syndrome. The prevalence of HF in patients with acute dyspnea ranged from 25 to 59%. Heterogeneity was present in all analyses.Comparing signs and symptoms, sensitivity was very poor for the presence of fever (0.05) and sputum production (0.06), and poor for fatigue (0.36-0.76), orthopnea (0.2-0.76), paroxysmal nocturnal dyspnea (0.23-0.70), elevated jugular venous pressure (0.19-0.70), rales (0.32-0.88), and peripheral edema (0.29-0.77). Specificity was poor for fatigue (0.28-0.69), moderate for the presence of fever (0.76-0.88), sputum production (0.73-0.89), orthopnea (0.49-0.92), paroxysmal nocturnal dyspnea (0.52-0.93), and rales (0.31-0.98), and good for elevated jugular venous pressure (0.75-0.97) and peripheral edema (0.67-0.89).For all other signs and symptoms, sensitivities varied between 0.20 and 0.43; specificities for symptoms varied widely between 0.37 and 0.91 and those of signs between 0.20 and 1.0.The pooled sensitivities, however, remained poor: below 0.55. Pooled specificity of most signs ranged between 0.69 and 0.88. The positive likelihood ratio was between 0.64 and 4.11 and the NLR was between 0.59 and 1.29 with one outlier: rales (pooled NLR=0.35).CONCLUSIONThis systematic review, which only included patients from ED settings, did not identify any single sign or symptom that had acceptable sensitivity to be useful in ruling out a diagnosis of HF, chronic obstructive pulmonary disease, asthma, or pulmonary embolism. Elevated jugular venous pressure (0.88, pooled odds ratio: 7), added third heart sound (0.97), and lung crepitations (0.77, pooled odds ratio: 11) are useful in ruling in HF.

18. Communicating risk with relatives in a familial hypercholesterolemia cascade screening program: a summary of the evidence.

Authors Allison, Melanie
Source The Journal of cardiovascular nursing; 2015; vol. 30 (no. 4); p. E1
Publication Date 2015
Publication Type(s) Journal Article Review
PubMedID 24831729
Database Medline
Abstract BACKGROUNDFamilial hypercholesterolemia (FH) is the most common inherited, potentially deadly disease, affecting an estimated 600 000 people in the United States. When FH is undiagnosed and untreated, it is linked with early coronary heart disease in more than 50% of men by age 50 years and 30% of women by age 60 years. Cascade screening is the most cost effective method available to identify family members with this disease; however, cascade screening guidelines do not specify best methods to use when contacting relatives. Therefore, I conducted an exhaustive search of the literature to find the most successful communication methods used in contact tracing and cascade screening.PURPOSEThe purpose of this summary of the evidence was to identify the communication method with greatest impact in having at-risk populations present to a provider for disease screening. These findings will inform clinicians of the most successful methods to implement when cascade screening relatives of known FH patients.CONCLUSIONSMost studies support direct contact of relatives via letter, mailed from the provider. Provider-initiated communication more often resulted in relatives being tested when compared with other methods of communication.CLINICAL IMPLICATIONSOn the basis of the literature, family members of current FH patients will be more likely to present to a provider for cascade screening if they receive written communication from the provider.

19. Communicating Risk With Relatives in a Familial Hypercholesterolemia Cascade Screening Program.

Authors Allison, Melanie
Source Journal of Cardiovascular Nursing; Jul 2015; vol. 30 (no. 4)
Publication Date Jul 2015
Publication Type(s) Academic Journal
Database CINAHL

Abstract Background: Familial hypercholesterolemia (FH) is the most common inherited, potentially deadly disease, affecting an estimated 600 000 people in the United States. When FH is undiagnosed and untreated, it is linked with early coronary heart disease in more than 50% of men by age 50 years and 30% of women by age 60 years. Cascade screening is the most cost effective method available to identify family members with this disease; however, cascade screening guidelines do not specify best methods to use when contacting relatives. Therefore, I conducted an exhaustive search of the literature to find the most successful communication methods used in contact tracing and cascade screening. Purpose: The purpose of this summary of the evidence was to identify the communication method with greatest impact in having at-risk populations present to a provider for disease screening. These findings will inform clinicians of the most successful methods to implement when cascade screening relatives of known FH patients. Conclusions: Most studies support direct contact of relatives via letter, mailed from the provider. Provider-initiated communication more often resulted in relatives being tested when compared with other methods of communication. Clinical Implications: On the basis of the literature, family members of current FH patients will be more likely to present to a provider for cascade screening if they receive written communication from the provider.

20. Middle East Respiratory Syndrome Coronavirus "MERS-CoV": Current Knowledge Gaps

Authors Banik G.R.; Khandaker G.; Rashid H.
Source Paediatric Respiratory Reviews; Jun 2015; vol. 16 (no. 3); p. 197-202
Publication Date Jun 2015
Publication Type(s) Review
Database EMBASE
Available at Paediatric respiratory reviews from ClinicalKey
Available at Paediatric respiratory reviews from Unpaywall
Abstract The Middle East respiratory syndrome coronavirus (MERS-CoV) that causes a severe lower respiratory tract infection in humans is now considered a pandemic threat to the Gulf region. Since its discovery in 2012, MERS-CoV has reached 23 countries affecting about 1100 people, including a dozen children, and claiming over 400 lives. Compared to SARS (severe acute respiratory syndrome), MERS-CoV appears to kill more people (40% versus 10%), more quickly, and is especially more severe in those with pre-existing medical conditions. Most MERS-CoV cases (>85%) reported thus far have a history of residence in, or travel to the Middle East. The current epidemiology is characterised by slow and sustained transmission with occasional sparks. The dromedary camel is the intermediate host of MERS-CoV, but the transmission cycle is not fully understood. In this current review, we have briefly summarised the latest information on the epidemiology, clinical features, diagnosis, treatment and prevention of MERS-CoV especially highlighting the knowledge gaps in its transmission dynamics, diagnosis and preventive strategy.

21. The 2009 influenza pandemic and the Ebola crisis: What are the lessons learnt?

Authors Yin M.; Tambyah P.A.
Source Future Virology; Apr 2015; vol. 10 (no. 4); p. 335-339
Publication Date Apr 2015
Publication Type(s) Review
Database EMBASE
Available at Future Virology from ProQuest (Health Research Premium) - NHS Version

22. MERS coronavirus: data gaps for laboratory preparedness.

Authors de Sousa, Rita; Reusken, Chantal; Koopmans, Marion
Source Journal of clinical virology : the official publication of the Pan American Society for Clinical Virology; Jan 2014; vol. 59 (no. 1); p. 4-11
Publication Date Jan 2014
Publication Type(s) Research Support, Non-u.s. Gov't Journal Article Review
PubMedID 24286807
Database Medline
Available at Journal of clinical virology : the official publication of the Pan American Society for Clinical Virology from ClinicalKey
Available at Journal of clinical virology : the official publication of the Pan American Society for Clinical Virology from Unpaywall

Abstract Since the emergence of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in 2012, many questions remain on modes of transmission and sources of virus. In outbreak situations, especially with emerging organisms causing severe human disease, it is important to understand the full spectrum of disease, and shedding kinetics in relation to infectivity and the ability to transmit the microorganism. Laboratory response capacity during the early stages of an outbreak focuses on development of virological and immunological methods for patient diagnosis, for contact tracing, and for epidemiological studies into sources, modes of transmission, identification of risk groups, and animal reservoirs. However, optimal use of this core public health laboratory capacity requires a fundamental understanding of kinetics of viral shedding and antibody response, of assay validation and of interpretation of test outcomes. We reviewed available data from MERS-CoV case reports, and compared this with data on kinetics of shedding and immune response from published literature on other human coronaviruses (hCoVs). We identify and discuss important data gaps, and biases that limit the laboratory preparedness to this novel disease. Public health management will benefit from standardised reporting of methods used, details of test outcomes by sample type, sampling date, in relation to symptoms and risk factors, along with the currently reported demographic, clinical and epidemiological findings.

23. Lessons from the history of quarantine, from plague to influenza A

Authors Tognotti E.
Source Emerging Infectious Diseases; Feb 2013; vol. 19 (no. 2); p. 254-259
Publication Date Feb 2013
Publication Type(s) Review
PubMedID 23343512
Database EMBASE
Available at Emerging infectious diseases from Europe PubMed Central - Open Access
Available at Emerging infectious diseases from Unpaywall
Abstract In the new millennium, the centuries-old strategy of quarantine is becoming a powerful component of the public health response to emerging and reemerging infectious diseases. During the 2003 pandemic of severe acute respiratory syndrome, the use of quarantine, border controls, contact tracing, and surveillance proved effective in containing the global threat in just over 3 months. For centuries, these practices have been the cornerstone of organized responses to infectious disease outbreaks. However, the use of quarantine and other measures for controlling epidemic diseases has always been controversial because such strategies raise political, ethical, and socioeconomic issues and require a careful balance between public interest and individual rights. In a globalized world that is becoming ever more vulnerable to communicable diseases, a historical perspective can help clarify the use and implications of a still-valid public health strategy.

24. Evidence for airborne infectious disease transmission in public ground transport - A literature review

Authors Mohr O.; Askar M.; Schink S.; Eckmanns T.; Krause G.; Poggensee G.
Source Eurosurveillance; 2012; vol. 17 (no. 35)
Publication Date 2012
Publication Type(s) Review
PubMedID 22958608
Database EMBASE
Abstract While guidelines on contact tracing (CT) after exposure to certain infectious pathogens during air travel exist, no guidance documents are available on CT in response to potential exposure on public ground transport. We reviewed scientific and non-scientific literature on transmission of airborne pathogens in public ground transport and on factors potentially influencing transmission. We identified 32 relevant publications (15 scientific and 17 non-scientific). Most of the selected studies dealt with transmission of tuberculosis. However, the relation between travel duration, proximity to the index case and environmental factors, such as ventilation, on disease transmission in public ground transport is poorly understood. Considering the difficulty and probably limited effectiveness of CT in ground transport, our results suggest that only exceptional circumstances would justify CT. This contrasts with the high level of attention CT in air travel seems to receive in international regulations and recommendations. We question whether the indication for CT should be revisited after a risk-benefit assessment that takes into account exposure in both ground and air transport.

25. European risk assessment guidance for infectious diseases transmitted on aircraft--the RAGIDA project.

Authors Leitmeyer, K
Source Euro surveillance : bulletin Europeen sur les maladies transmissibles = European communicable disease bulletin; Apr 2011; vol. 16 (no. 16)
Publication Date Apr 2011
Publication Type(s) Journal Article Review Systematic Review
PubMedID 21527131
Database Medline

Abstract In order to assist national public health authorities in the European Union to assess the risks associated with the transmission of infectious agents on board aircrafts, the European Centre for Disease Prevention and Control initiated in 2007 the RAGIDA project (Risk Assessment Guidance for Infectious Diseases transmitted on Aircraft). RAGIDA consists of two parts: the production of a systematic review and a series of disease-specific guidance documents. The systematic review covered over 3,700 peer-reviewed articles and grey literature for the following diseases: tuberculosis, influenza, severe acute respiratory syndrome (SARS), invasive meningococcal disease, measles, rubella, diphtheria, Ebola and Marburg haemorrhagic fevers, Lassa fever, smallpox and anthrax. In addition, general guidelines on risk assessment and management from international aviation boards and national and international public health agencies were systematically searched. Experts were interviewed on case-based events by standardised questionnaires. Disease-specific guidance documents on tuberculosis, SARS, meningococcal infections, measles, rubella, Ebola and Marburg haemorrhagic fevers, Lassa fever, smallpox and anthrax were the result of consultations of disease-specific expert panels. Factors that influence the risk assessment of infectious disease transmission on board aircrafts and decision making for contact tracing are outlined.

26. Influenza a (H1N1-2009) pandemic in Singapore - public health control measures implemented and lessons learnt

Authors Tay J.; Cutter J.; James L.; Ng Y.F.
Source Annals of the Academy of Medicine Singapore; Apr 2010; vol. 39 (no. 4); p. 313-324
Publication Date Apr 2010
Publication Type(s) Review
PubMedID 20473458
Database EMBASE
Abstract We describe the public health control measures implemented in Singapore to limit the spread of influenza A (H1N1-2009) and mitigate its social effects. We also discuss the key learning points from this experience. Singapore's public health control measures were broadly divided into 2 phases: containment and mitigation. Containment strategies included the triage of febrile patients at frontline healthcare settings, admission and isolation of confirmed cases, mandatory Quarantine Orders (QO) for close contacts, and temperature screening at border entry points. After sustained community transmission became established, containment shifted to mitigation. Hospitals only admitted H1N1-2009 cases based on clinical indications, not for isolation. Mild cases were managed in the community. Contact tracing and QOs tapered off, and border temperature screening ended. The 5 key lessons learnt were: (1) Be prepared, but retain flexibility in implementing control measures; (2) Surveillance, good scientific information and operational research can increase a system's ability to manage risk during a public health crisis; (3) Integrated systems-level responses are essential for a coherent public health response; (4) Effective handling of manpower surges requires creative strategies; and (5) Communication must be strategic, timely, concise and clear. Singapore's effective response to the H1N1-2009 pandemic, founded on experience in managing the 2003 SARS epidemic, was a whole-of-government approach towards pandemic preparedness planning. Documenting the measures taken and lessons learnt provides a learning opportunity for both doctors and policy makers, and can help fortify Singapore's ability to respond to future major disease outbreaks.

27. Preparing for an influenza pandemic in Singapore.

Authors Cutter, Jeffery
Source Annals of the Academy of Medicine, Singapore; Jun 2008; vol. 37 (no. 6); p. 497-503
Publication Date Jun 2008
Publication Type(s) Journal Article Review
PubMedID 18618062
Database Medline
Abstract The national strategy against pandemic influenza essentially consists of 3 prongs: (i) effective surveillance, (ii) mitigation of the pandemic's impact, and (iii) render the population immune through vaccination. When the pandemic hits Singapore, the response plan aims to achieve the following 3 outcomes: (i) maintenance of essential services to limit social and economic disruption, (ii) reduction of morbidity and mortality through antiviral treatment, and (iii) slow and limit the spread of influenza to reduce the surge on healthcare services. The biggest challenge will come from managing the surge of demand on healthcare services. A high level of preparedness will help healthcare services better cope with the surge.

28. Signs and symptoms in diagnosing acute myocardial infarction and acute coronary syndrome: a diagnostic meta-analysis.

Authors Bruyninckx, Rudi; Aertgeerts, Bert; Bruyninckx, Pieter; Buntinx, Frank
Source The British journal of general practice : the journal of the Royal College of General Practitioners; Feb 2008; vol. 58 (no. 547); p. 105-111
Publication Date Feb 2008
Publication Type(s) Meta-analysis Journal Article Review Systematic Review
PubMedID 18307844
Database Medline

Available at British Journal of General Practice from Europe PubMed Central - Open Access
Available at British Journal of General Practice from HighWire - Free Full Text
Available at British Journal of General Practice from Request from Barts Health - Whipps Cross University Hospital Local Print Collection [location] : Request from Barts Health - Whipps Cross University Hospital.
Available at British Journal of General Practice from Unpaywall

Abstract BACKGROUNDPrompt diagnosis of acute myocardial infarction or acute coronary syndrome is very important.AIMA systematic review was conducted to determine the accuracy of 10 important signs and symptoms in selected and non-selected patients.DESIGN OF STUDYDiagnostic meta-analysis.METHODUsing MEDLINE, CINAHL, EMBASE, tracing references, and by contacting experts, studies were sought out that described one of the 10 signs and symptoms on one or both conditions. Studies were excluded if they were not based on original data. Validity was assessed using QUADAS and all data were pooled using a random effects model.RESULTSSixteen of the 28 included studies were about patients who were non-selected. In this group, absence of chest-wall tenderness on palpation had a pooled sensitivity of 92% (95% confidence interval [CI] = 86 to 96) for acute myocardial infarction and 94% (95% CI = 91 to 96) for acute coronary syndrome. Oppressive pain followed with a pooled sensitivity of 60% (95% CI = 55 to 66) for acute myocardial infarction. Sweating had the highest pooled positive likelihood ratio (LR+), namely 2.92 (95% CI = 1.97 to 4.23) for acute myocardial infarction. The other pooled LR+ fluctuated between 1.05 and 1.49. Negative LRs (LR-) varied between 0.98 and 0.23. Absence of chest-wall tenderness on palpation had a LR- of 0.23 (95% CI = 0.18 to 0.29).CONCLUSIONSBased on this meta-analysis it was not possible to define an important role for signs and symptoms in the diagnosis of acute myocardial infarction or acute coronary syndrome. Only chest-wall tenderness on palpation largely ruled out acute myocardial infarction or acute coronary syndrome in low-prevalence settings.

29. Respiratory hygiene in the emergency department...reprinted from Annals of Emergency Medicine, 48, Rothman RE, Irvin CB, Moran GJ, Sauer L, Bradshaw YS, Fry RB Jr., et al. Respiratory hygiene in the emergency department, 570-82. Copyright 2006 with permission from the American College of Emergency Physicians

Authors Rothman RE; Irvin CB; Moran GJ; Sauer L; Bradshaw YS; Fry RB Jr; Josephine EB; Ledyard HK; Hirshon JM
Source JEN: Journal of Emergency Nursing; Apr 2007; vol. 33 (no. 2); p. 119-134
Publication Date Apr 2007
Publication Type(s) Academic Journal
PubMedID NLM17379028
Database CINAHL
Available at Journal of Emergency Nursing from doi.org
Available at Journal of Emergency Nursing from PubMed
Available at Journal of Emergency Nursing from PubMed Central
Available at Journal of Emergency Nursing from Unpaywall

Abstract The emergency department (ED) is an essential component of the public health response plan for control of acute respiratory infectious threats. Effective respiratory hygiene in the ED is imperative to limit the spread of dangerous respiratory pathogens, including influenza, severe acute respiratory syndrome, avian influenza, and bioterrorism agents, particularly given that these agents may not be immediately identifiable. Sustaining effective respiratory control measures is especially challenging in the ED because of patient crowding, inadequate staffing and resources, and ever-increasing numbers of immunocompromised patients. Threat of contagion exists not only for ED patients but also for visitors, health care workers, and inpatient populations. Potential physical sites for respiratory disease transmission extend from out-of-hospital care, to triage, waiting room, ED treatment area, and the hospital at large. This article presents a summary of the most current information available in the literature about respiratory hygiene in the ED, including administrative, patient, and legal issues. Wherever possible, specific recommendations and references to practical information from the Centers for Disease Control and Prevention are provided. The 'Administrative Issues' section describes coordination with public health departments, procedures for effective facility planning, and measures for health care worker protection (education, staffing optimization, and vaccination). The patient care section addresses the potentially infected ED patient, including emergency medical services concerns, triage planning, and patient transport. 'Legal Issues' discusses the interplay between public safety and patient privacy. Emergency physicians play a critical role in early identification, treatment, and containment of potentially lethal respiratory pathogens. This brief synopsis should help clinicians and administrators understand, develop, and implement appropriate policies and procedures to address respiratory hygiene in the ED.

30. The severe acute respiratory syndrome: impact on travel and tourism.

Authors Wilder-Smith, Annelies
Source Travel medicine and infectious disease; Mar 2006; vol. 4 (no. 2); p. 53-60
Publication Date Mar 2006
Publication Type(s) Journal Article Review
PubMedID 16887725
Database Medline

Available at Travel medicine and infectious disease from ProQuest (Health Research Premium) - NHS Version
Available at Travel medicine and infectious disease from PubMed
Available at Travel medicine and infectious disease from doi.org
Available at Travel medicine and infectious disease from PubMed Central

Abstract SARS and travel are intricately interlinked. Travelers belonged to those primarily affected in the early stages of the outbreak, travelers became vectors of the disease, and finally, travel and tourism themselves became the victims. The outbreak of SARS created international anxiety because of its novelty, its ease of transmission in certain settings, and the speed of its spread through jet travel, combined with extensive media coverage. The psychological impacts of SARS, coupled with travel restrictions imposed by various national and international authorities, have diminished international travel in 2003, far beyond the limitations to truly SARS hit areas. Governments and press, especially in non SARS affected areas, have been slow to strike the right balance between timely and frequent risk communication and placing risk in the proper context. Screening at airport entry points is costly, has a low yield and is not sufficient in itself. The low yield in detecting SARS is most likely due to a combination of factors, such as travel advisories which resulted in reduced travel to and from SARS affected areas, implementation of effective pre-departure screening at airports in SARS-hit countries, and a rapid decline in new cases at the time when screening was finally introduced. Rather than investing in airport screening measures to detect rare infectious diseases, investments should be used to strengthen screening and infection control capacities at points of entry into the healthcare system. If SARS reoccurs, the subsequent outbreak will be smaller and more easily contained if the lessons learnt from the recent epidemic are applied. Lessons learnt during the outbreak in relation to international travel will be discussed.

31. Avian influenza: risk, preparedness and the roles of public health nurses in Hong Kong.

Authors Ho, Georgina; Parker, Judith
Source Nursing inquiry; Mar 2006; vol. 13 (no. 1); p. 2-6
Publication Date Mar 2006
Publication Type(s) Journal Article Review
PubMedID 16494661
Database Medline
Available at Nursing inquiry from Wiley Online Library Medicine and Nursing Collection 2019 - NHS

Abstract This paper provides an overview of the Hong Kong government's influenza preparedness plan and the key roles of public health nurses in that plan. The part played by Hong Kong public health nurses in the management of the avian influenza outbreak in Hong Kong in 1997 and the sudden acute respiratory syndrome outbreak in 2003, together with the capacity-building work they are now undertaking in preparing for an influenza pandemic, highlight their crucial role in public health. Recent strengthening of public health infrastructure in Hong Kong and heightened public awareness of public health issues have facilitated more proactive and effective public health nursing activities.

32. Strategies adopted and lessons learnt during the severe acute respiratory syndrome crisis in Singapore.

Authors SARS Investigation Team from DMERI; SGH
Source Reviews in medical virology; 2005; vol. 15 (no. 1); p. 57-70
Publication Date 2005
Publication Type(s) Research Support, Non-u.s. Gov't Journal Article Review
PubMedID 15565739
Database Medline
Available at Reviews in medical virology from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Reviews in medical virology from ProQuest (Health Research Premium) - NHS Version

Abstract In Singapore, the military was actively involved in the containment of the outbreak of severe acute respiratory syndrome (SARS) last year. The outbreak started in February 2003 with three Singapore travellers to Hong Kong. At that time, nothing was known about the aetiological agent of the atypical pneumonia that was termed SARS. Unfortunately one of the travellers was a super-spreader, defined as a person with high efficiency for virus transmission, and was responsible for the expansion of the national outbreak. Not only was the Singapore military involved in contact tracing of personnel and enforcement of home quarantine, military-affiliated research institutes were also involved in providing diagnostic support. This review reconstructs the events that took place during the SARS outbreak, focusing on the special support arising from complementing the military-affiliated laboratory with the public health laboratory. A description of the diagnostic findings is provided in chronological order. The review ends with lessons Singapore learnt from the SARS crisis, stressing the importance of national preparedness for future outbreaks.

33. New approaches to quantifying the spread of infection.

Authors Matthews, Louise; Woolhouse, Mark
Source Nature reviews. Microbiology; Jul 2005; vol. 3 (no. 7); p. 529-536
Publication Date Jul 2005

Publication Type(s) Research Support, Non-u.s. Gov't Journal Article Review
PubMedID 15995653
Database Medline
Available at Nature reviews. Microbiology from ProQuest (Health Research Premium) - NHS Version
Available at Nature reviews. Microbiology from PubMed
Available at Nature reviews. Microbiology from PubMed Central
Available at Nature reviews. Microbiology from doi.org
Available at Nature reviews. Microbiology from Unpaywall
Abstract Recent major disease outbreaks, such as severe acute respiratory syndrome and foot-and-mouth disease in the UK, coupled with fears of emergence of human-to-human transmissible variants of avian influenza, have highlighted the importance of accurate quantification of disease threat when relatively few cases have occurred. Traditional approaches to mathematical modelling of infectious diseases deal most effectively with large outbreaks in large populations. The desire to elucidate the highly variable dynamics of disease spread amongst small numbers of individuals has fuelled the development of models that depend more directly on surveillance and contact-tracing data. This signals a move towards a closer interplay between epidemiological modelling, surveillance and disease-management strategies.

34. Severe acute respiratory syndrome epidemic in Taiwan, 2003.

Authors Hsueh, Po Ren; Yang, Pan Chyr
Source Journal of microbiology, immunology, and infection = Wei mian yu gan ran za zhi; Apr 2005; vol. 38 (no. 2); p. 82-88
Publication Date Apr 2005
Publication Type(s) Journal Article Review
PubMedID 15843851
Database Medline
Abstract In Taiwan, since the first case of severe acute respiratory syndrome (SARS) was identified on February 25, 2003, a total of 3032 cases of suspected or probable SARS were reported prior to July 5, 2003. Among these cases, 664 cases were classified as probable SARS based on the clinical case definitions and 346 had a positive result for the SARS-associated coronavirus (SARS-CoV). The epidemic in Taiwan could be divided into 2 distinct stages. In stage I (late-February to mid-April) patients had traceable contact with infected patients or travel histories to known affected areas of SARS. By contrast, patients in stage II (mid-April to June) acquired infection via intra-hospital or inter-hospital transmission. The mortality rate directly attributable to SARS during the 2 stages of the outbreak in Taiwan was 11% (37 patients). Phylogenetic analysis of sequences of SARS-CoV strains in Taiwan and other countries showed that Taiwanese strains were closely related to those isolated from patients in Hong Kong and Guangdong. The nonspecific initial symptoms and signs of the illness, the absence of reliable diagnostic tests, as well as the initial lack of strict infection control measures in hospitals and effective national control policies contributed to the island-wide spread of the SARS epidemic in Taiwan. Development of an effective strategy to prepare for future outbreaks will require the implementation of an active coordinated clinical reporting system, international collaboration to identify cases in the early stage, development of laboratory tools for early diagnosis, a robust system of prepared isolation, and adequate quarantine facilities.

35. Risk of respiratory infections in health care workers: lessons on infection control emerge from the SARS outbreak.

Authors Wilder-Smith, Annelies; Low, Jenny Guek Hong
Source The Southeast Asian journal of tropical medicine and public health; Mar 2005; vol. 36 (no. 2); p. 481-488
Publication Date Mar 2005
Publication Type(s) Journal Article Review
PubMedID 15916060
Database Medline
Available at The Southeast Asian journal of tropical medicine and public health from ProQuest (Health Research Premium) - NHS Version

Abstract Close proximity of persons together with handling of human secretions (eg respiratory secretions) make health care workers (HCW) particularly vulnerable to transmission of droplet-transmitted respiratory infections. This was tragically highlighted during the international outbreak of severe acute respiratory syndrome (SARS) in 2003 with attack rates of more than 50% in HCW. The purpose of this article is to review common airborne and droplet-transmitted bacterial and viral respiratory tract infections with regard to their impact on health care workers. Lessons need to be learned from the SARS epidemic. The three main strategies to prevent or control occupationally acquired infections are relatively simple and cost-effective-droplet and contact precautions and for some pathogens also vaccination. Enforced implementation of stringent droplet precautions during the SARS crisis should be maintained; and this will most likely have a major additional impact on other nosocomial infections. Employee health services should proactively and creatively devise delivery systems that enhance compliance with vaccination programs for all health care workers. Hospital surveillance should be expanded to all respiratory diseases to facilitate early detection of nosocomial outbreaks, and this should also include surveillance of all HCW. Integrated syndromic and virological surveillance systems set up during the SARS epidemic will also further our understanding of other respiratory infections in the hospital setting. Even if pursuing early diagnosis for unspecific respiratory illnesses is expensive, identification of the causative organism may reduce unnecessary isolation, contact tracing and anxiety, in particular during an outbreak situation. We have a duty to protect our health care workers.

36. SARS in Taiwan: An overview and lessons learned

Authors Chen K.-T.; Chang H.-L.; Wu Y.-C.; Chen C.-T.; Twu S.-J.; Lin T.-H.; Olsen S.J.; Dowell S.F.; Su I.-J.
Source International Journal of Infectious Diseases; Mar 2005; vol. 9 (no. 2); p. 77-85
Publication Date Mar 2005
Publication Type(s) Review
PubMedID 15708322
Database EMBASE
Available at International journal of infectious diseases : IJID : official publication of the International Society for Infectious Diseases from ScienceDirect
Available at International journal of infectious diseases : IJID : official publication of the International Society for Infectious Diseases from Unpaywall
Abstract Objectives: This report aims to describe the epidemiology of severe acute respiratory syndrome (SARS) in Taiwan between March and July 2003, and to examine the public health response.
Method(s): Surveillance for SARS was initiated on 14 March 2003. Response activities are described for the isolation of patients; contact tracing; quarantine of contact persons; fever screening for inbound and outbound passengers at the airport; and hospital infection control as assessed by mobile SARS containment teams.
Result(s): Between 14 March and 30 July 2003 a total of 668 probable cases of SARS were reported. Of the 668 cases, 181 (27%) were fatal. Compared to the survivors, fatal cases were more likely to be older ($p < 0.001$), male ($p < 0.05$), exposed through hospital contact ($p < 0.001$), and have a coexisting medical disorder ($p < 0.001$). Between 28 March and 30 July a total of 151,270 persons were quarantined. Among them, 46 (3.0/10,000) were subsequently classified as being probable SARS cases. At the time of the mobile team assessments, 46 (53%) hospitals had implemented WHO infection control recommendations.
Conclusion(s): In this outbreak, an emergency plan consisted of patient isolation and strict hospital infection control.

37. SARS: the new challenge to international health and travel medicine.

Authors Venkatesh, S; Memish, Z A
Source Eastern Mediterranean health journal = La revue de sante de la Mediterranee orientale = al-Majallah al-sihhiyah li-sharq al-mutawassit; 2004; vol. 10 (no. 4-5); p. 655-662
Publication Date 2004
Publication Type(s) Journal Article Review
PubMedID 16335659
Database Medline
Abstract Severe acute respiratory syndrome (SARS), the first severe new infectious disease of this millennium, caused widespread public disruption. By July 2003, 8427 probable SARS cases had been reported from 29 countries with a case fatality rate of 9.6%. The new febrile respiratory illness spread around the world along the routes of international air travel, with outbreaks concentrated in transportation hubs or densely populated areas. The etiologic agent was identified as a novel coronavirus, SARS-CoV. The disease is transmissible person-to-person through direct contact, large droplet contact and indirect contact from fomites and unwashed hands. Saudi Arabia successfully prevented the entry of the disease by imposing travel restrictions, special entry requirements, screening procedures at airports, including temperature checks, and quarantine. Ongoing efforts are aimed at developing case investigation, case management and surveillance protocols for SARS.

38. Severe acute respiratory syndrome and sport: Facts and fallacies

Authors So R.C.H.; Yuan Y.W.Y.; Ko J.; Lam J.J.; Louie L.

Source Sports Medicine; 2004; vol. 34 (no. 15); p. 1023-1033
Publication Date 2004
Publication Type(s) Review
PubMedID 15575793
Database EMBASE
Available at Sports Medicine from Unpaywall
Abstract Severe Acute Respiratory Syndrome (SARS) not only paralysed economic activities in SARS-affected cities, it also affected sporting activities, SARS was identified in Hong Kong in late February 2003 and the WHO issued a global alert on 12 March, 2003. The incubation period of SARS is usually 4-6 days and patients commonly present with high fever (temperature >38degreeC), dry cough, chills and rigor, dyspnoea and diarrhoea. Although a specific antiviral agent and vaccines for SARS are not available at the time of writing, a standard treatment protocol for SARS has been developed. The average mortality rate is about 16% in Hong Kong. The coronavirus is a common pathogen for upper respiratory tract infection and is the most probable pathogen for SARS. Transmission methods may, therefore, be similar for both these infections. Transmission is possible when aerosolised viral particles come into contact with the susceptible host's mucous membrane, most commonly the nose, but also the mouth and eyes. With appropriate preventive measures to avoid contact with virus, the probability of infection is minimal. Isolation of those who have had close contact with confirmed or suspected SARS patients and/or who have persistent fever will be the most effective and practical method of avoiding contact. Maintaining personal hygiene and frequent hand washing can also reduce the risk of infection. Using diluted bleach (1 part bleach in 99 parts water) to cleanse training areas and equipment is also recommended. With proper event planning to conform with quarantine measures, special travel arrangements, facility sterilisation and use of venues with good ventilation and filtering systems, sport competition can still proceed.

39. Severe acute respiratory syndrome: Did quarantine help?

Authors Schabas R.
Source Canadian Journal of Infectious Diseases; 2004; vol. 15 (no. 4); p. 204
Publication Date 2004
Publication Type(s) Review
Database EMBASE
Abstract Quarantine was a prominent control strategy used in the recent severe acute respiratory syndrome (SARS) outbreaks. The present commentary identifies useful measures of disease control that warrant an infectious outbreak for quarantine and concludes that SARS did not warrant the use of quarantine. In fact, the Toronto quarantine was clearly ineffective in identifying potential SARS patients and evidence shows that SARS is not infectious during the preclinical phase and does not become significantly infectious until the symptomatic illness is well-established. The author states that SARS was an ill-suited infectious disease for quarantine and discusses the use of quarantine and recommendations for controlling outbreaks.

40. Epidemiology of severe acute respiratory syndrome (SARS): adults and children.

Authors Zhong, Nan-Shan; Wong, Gary W K
Source Paediatric respiratory reviews; Dec 2004; vol. 5 (no. 4); p. 270-274
Publication Date Dec 2004
Publication Type(s) Journal Article Review
PubMedID 15531250
Database Medline
Available at Paediatric respiratory reviews from PubMed
Available at Paediatric respiratory reviews from doi.org
Available at Paediatric respiratory reviews from PubMed Central
Abstract Severe acute respiratory syndrome (SARS) is a newly described respiratory infection with pandemic potential. The causative agent is a new strain of coronavirus most likely originating from wild animals. This disease first emerged in November 2002 in Guangdong Province, China. Early in the outbreak the infection had been transmitted primarily via household contacts and healthcare settings. In late February 2003 the infection was transmitted to Hong Kong when an infected doctor from the mainland visited there. During his stay in Hong Kong at least 17 guests and visitors were infected at the hotel at which he stayed. By modern day air travel, the infection was rapidly spread to other countries including Vietnam, Singapore and Canada by these infected guests. With the implementation of effective control strategies including early isolation of suspected cases, strict infection control measures in the hospital setting, meticulous contact tracing and quarantine, the outbreak was finally brought under control by July 2003. In addition, there were another two events of SARS in China between the end of December 2003 and January 2004 and from March to May 2004; both were readily controlled without significant patient spread.

41. What are the most appropriate methods of surveillance for monitoring an emerging respiratory infection such as SARS?

Authors Greaves, Felix
Source Journal of public health (Oxford, England); Sep 2004; vol. 26 (no. 3); p. 288-292

Publication Date Sep 2004
Publication Type(s) Evaluation Study Journal Article Review
PubMedID 15454599
Database Medline
Available at Journal of Public Health from HighWire - Free Full Text
Available at Journal of Public Health from PubMed
Available at Journal of Public Health from doi.org
Available at Journal of Public Health from PubMed Central
Available at Journal of Public Health from Unpaywall
Abstract Effective surveillance is necessary for the successful management of emerging infection. It allows public health protection measures such as contact tracing and isolation to be put in place. This study aimed to find the most appropriate surveillance method for a disease like SARS. Existing surveillance methods were evaluated against a set of new criteria in a qualitative manner. Influenza and tuberculosis (TB) surveillance were used as models. A literature search was undertaken to find relevant evidence. The results show that TB surveillance is more appropriate than influenza surveillance as a model because it is more complete in its reporting. Clinician-based reporting is better than laboratory-based because it is more timely. The results suggest a clinician-based notification system would be the most appropriate form of surveillance for a disease like SARS for public health purposes.

42. Smallpox and bioterrorism.

Authors Pennington, Hugh
Source Bulletin of the World Health Organization; 2003; vol. 81 (no. 10); p. 762-767
Publication Date 2003
Publication Type(s) Journal Article Review
PubMedID 14758439
Database Medline
Available at Bulletin of the World Health Organization from EBSCO (Health Business FullTEXT Elite)
Available at Bulletin of the World Health Organization from ProQuest (Health Research Premium) - NHS Version
Available at Bulletin of the World Health Organization from PubMed
Available at Bulletin of the World Health Organization from PubMed Central
Abstract Smallpox was declared to be eradicated on 8 May 1980, during the Thirty-third World Health Assembly. However, concerns about the possible use of the virus as a weapon of bioterrorism have increased in recent years. Governments have responded by initiating selective vaccination programmes and other public health measures. This review uses historical data from 20th century outbreaks to assess the risks to current populations (which have declining immunity) from a deliberate release of virus. The data presented supports the conclusion of a previous reviewer (Mack) that "smallpox cannot be said to live up to its reputation. Far from being a quick-footed menace, it has appeared as a plodding nuisance with more bark than bite." Its R value (the average number of secondary cases infected by a primary case) is lower than that for measles, human parvovirus, chickenpox, mumps, rubella, and poliomyelitis; only the value for severe acute respiratory syndrome (SARS) is lower. Like SARS, close person-to-person contact is required for effective spread of the disease, and exposure to the virus in hospitals has played an important role in transmission for both viruses. In the present paper the dangers of mass vaccination are emphasized, along with the importance of case isolation, contact tracing, and quarantine of close contacts for outbreak control. The need for rapid diagnosis and the continued importance of maintaining a network of electron microscopes for this purpose are also highlighted.

43. Severe acute respiratory syndrome (SARS) in children: Epidemiology, presentation and management

Authors Leung T.F.; Wong G.W.K.; Hon K.L.E.; Fok T.F.
Source Paediatric Respiratory Reviews; 2003; vol. 4 (no. 4); p. 334-339
Publication Date 2003
Publication Type(s) Review
PubMedID 14629957
Database EMBASE
Available at Paediatric Respiratory Reviews from Unpaywall

Abstract Severe acute respiratory syndrome (SARS) is a newly recognised and highly contagious respiratory infection caused by a new strain of coronavirus. The disease can result in progressive respiratory failure in adults and the mortality rate has been reported to be 8-15%. This infection spreads by droplet transmission and children appear to acquire SARS through close household contact exposure to infected adults. Disease severity is, however, much milder in the paediatric age group. The common laboratory findings in infected children and adolescents include lymphopaenia and elevated levels of lactate dehydrogenase and creatinine phosphokinase. Air space consolidation is commonly seen during the course of the illness although chest radiographs are normal on presentation in half of the cases. The pathophysiology of SARS appears to be related to immunological dysregulation in response to the coronavirus infection. The optimal treatment of SARS in children remains to be determined. No case fatality in infected children has been reported. The early and proper isolation of infected adults, meticulous infection control measures in the hospital setting, exhaustive contact tracing and quarantine measures are important steps in preventing the spread of the disease among health care workers and into the community. The development of a sensitive and rapid test for early diagnosis is underway. Further controlled trials are necessary to define the optimal treatment of this infection in children.

44. Severe acute respiratory syndrome (SARS) - an emerging infection of the 21st century.

Authors Hsueh, Po-Ren; Yang, Pan-Chyr
Source Journal of the Formosan Medical Association = Taiwan yi zhi; Dec 2003; vol. 102 (no. 12); p. 825-839
Publication Date Dec 2003
Publication Type(s) Journal Article Review
PubMedID 14976561
Database Medline
Abstract Severe acute respiratory syndrome (SARS) is an emerging infection caused by a novel coronavirus known as SARS-CoV. The disease has a high propensity to spread to household members and healthcare workers and may be associated with transmission and outbreaks in the community. Severe illness in immunocompromised patients, sophisticated hospital facilities and treatment procedures, particularly those that generate aerosols, and lack of adequate isolation and control measures, can amplify transmission and contribute to so-called "super-spreading" events. The presence of non-specific clinical manifestations at presentation and a lack of validated early diagnostic methods and effective management pose great difficulty for frontline physicians in the containment of this disease. The mortality of SARS is in the region of 10 to 15%; the presence of underlying disease, high initial C-reactive protein levels, and positive SARS-CoV in nasopharyngeal aspirate samples are associated with a higher risk of respiratory failure and mortality. Despite the disappearance of SARS cases worldwide, the potential evolution of SARS-CoV in animals suggests the disease may re-emerge in the future. Heightened levels of clinical suspicion, rapid case detection and isolation, and contact tracing are essential to effective management of future outbreaks. Further ongoing requirements for successful management include research on the immunopathogenesis of SARS and the development of timely and reliable diagnostic tests, effective antiviral and immunomodulatory agents, and vaccines for the disease.

45. Severe acute respiratory syndrome.

Authors Chan-Yeung, M; Ooi, G C; Hui, D S; Ho, P L; Tsang, K W
Source The international journal of tuberculosis and lung disease : the official journal of the International Union against Tuberculosis and Lung Disease; Dec 2003; vol. 7 (no. 12); p. 1117-1130
Publication Date Dec 2003
Publication Type(s) Journal Article Review
PubMedID 14677886
Database Medline
Available at The international journal of tuberculosis and lung disease : the official journal of the International Union against Tuberculosis and Lung Disease from IngentaConnect - Open Access
Available at The international journal of tuberculosis and lung disease : the official journal of the International Union against Tuberculosis and Lung Disease from IngentaConnect

Abstract Severe acute respiratory syndrome (SARS) is a new disease that poses a threat to international health. The SARS epidemic earlier this year affected more than 30 countries and regions, with a cumulative global total of 8098 cases. It is caused by a novel coronavirus, probably of animal origin. The mean incubation period is 6.4 days (range 2-11 days). Patients usually present with high fever, chills, myalgia and dry cough, with or without chest X-ray evidence of pneumonia at the onset of disease. A history of contact with or travel to an area with local transmission is common. Diagnosis is based on clinical criteria, as a valid rapid diagnostic test is not yet available. There is no specific antiviral therapy for this disease, and no controlled clinical trial for any treatment modality has been conducted. In several retrospective studies steroids have been shown to be useful in a proportion of patients who deteriorated despite antibiotics and supportive treatment. SARS has a high morbidity (about 25% required intensive care) and fatality (9.6%). A high index of suspicion for the disease, isolation of patients, strict observation of infection control practices and compliance with use of personal protective equipment are necessary to prevent nosocomial infection. Contact tracing and quarantine are essential measures to prevent community spread of disease. Prevention of future outbreaks requires strengthening of infection control practices in hospitals, development of a rapid diagnostic test and a vaccine, and removal of any animal reservoir and environmental conditions that led to the spread of the disease.

46. The severe acute respiratory syndrome.

Authors Peiris, Joseph S M; Yuen, Kwok Y; Osterhaus, Albert D M E; Stöhr, Klaus
Source The New England journal of medicine; Dec 2003; vol. 349 (no. 25); p. 2431-2441
Publication Date Dec 2003
Publication Type(s) Journal Article Review
PubMedID 14681510
Database Medline
Available at The New England journal of medicine from Massachusetts Medical Society
Available at The New England journal of medicine from ProQuest (Health Research Premium) - NHS Version
Available at The New England journal of medicine from PubMed
Available at The New England journal of medicine from doi.org
Available at The New England journal of medicine from handle.net
Available at The New England journal of medicine from Unpaywall

47. Current concepts: the severe acute respiratory syndrome.

Authors Peiris JSM; Yuen KY; Osterhaus ADM; Stöhr K
Source New England Journal of Medicine; Dec 2003; vol. 349 (no. 25); p. 2431-2443
Publication Date Dec 2003
Publication Type(s) Academic Journal
PubMedID NLM14681510
Database CINAHL
Available at New England Journal of Medicine from Massachusetts Medical Society
Available at New England Journal of Medicine from ProQuest (Health Research Premium) - NHS Version
Available at New England Journal of Medicine from PubMed
Available at New England Journal of Medicine from doi.org
Available at New England Journal of Medicine from handle.net
Available at New England Journal of Medicine from Unpaywall

48. Ethical and Legal Challenges Posed by Severe Acute Respiratory Syndrome: Implications for the Control of Severe Infectious Disease Threats

Authors Gostin L.O.; Bayer R.; Fairchild A.L.
Source Journal of the American Medical Association; Dec 2003; vol. 290 (no. 24); p. 3229-3237
Publication Date Dec 2003
Publication Type(s) Review
PubMedID 14693876
Database EMBASE

Abstract The appearance and spread of severe acute respiratory syndrome (SARS) on a global level raised vital legal and ethical issues. National and international responses to SARS have profound implications for 3 important ethical values: privacy, liberty, and the duty to protect the public's health. This article examines, through legal and ethical lenses, various methods that countries used in reaction to the SARS outbreak: surveillance and contact tracing, isolation and quarantine, and travel restrictions. These responses, at least in some combination, succeeded in bringing the outbreak to an end. The article articulates a set of legal and ethical recommendations for responding to infectious disease threats, seeking to reconcile the tension between the public's health and individual rights to privacy, liberty, and freedom of movement. The ethical values that inform the recommendations include the precautionary principle, the least restrictive/intrusive alternative, justice, and transparency. Development of a set of legal and ethical recommendations becomes even more essential when, as was true with SARS and will undoubtedly be the case with future epidemics, scientific uncertainty is pervasive and urgent public health action is required.

49. Overview on SARS in Asia and the world.

Authors Lam, W K; Zhong, N S; Tan, W C
Source Respirology (Carlton, Vic.); Nov 2003; vol. 8
Publication Date Nov 2003
Publication Type(s) Journal Article Review
PubMedID 15018125
Database Medline
Available at Respirology (Carlton, Vic.) from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Available at Respirology (Carlton, Vic.) from Unpaywall

Abstract Severe Acute Respiratory Syndrome (SARS) is the first major novel infectious disease to hit the international community in the 21st century. It originated in southern China in November 2002, reached Hong Kong in February 2003 and spread rapidly thereafter to 29 countries/regions on five continents. At the end of the epidemic, the global cumulative total was 8098 with 774 deaths. Seven Asian countries/regions were among the top ten on the list. Mainland China and Hong Kong, SAR, accounted for 87% of all cases and 84% of all deaths. Severe acute respiratory syndrome is caused by a novel coronavirus. It has alarmed the world with its infectivity and significant morbidity and mortality, its lack of a rapid, reliable diagnostic test and lack of effective specific treatment and vaccination. The adverse impact on travel and business around the world, particularly in Asia, has been enormous. Some lessons learnt from this epidemic included: (1) any outbreak of infectious disease can rapidly spread around the world by air travel; (2) early reporting of the outbreak to neighbouring countries/regions and the World Health Organization is essential to prevent international spread; and (3) infection control, tracing and quarantine of contacts are essential to control the epidemic. Many questions remain unanswered, including the origin and pathogenesis of the novel coronavirus, the natural history and the best specific treatment of the disease. The SARS-CoV has probably jumped from an animal host to humans. There is an urgent need to evaluate the human-animal habitat in southern China and to remove animal reservoirs if found.

50. SARS: epidemiology.

Authors Chan-Yeung, Moira; Xu, Rui-Heng
Source Respirology (Carlton, Vic.); Nov 2003; vol. 8
Publication Date Nov 2003
Publication Type(s) Journal Article Review
PubMedID 15018127
Database Medline
Available at Respirology (Carlton, Vic.) from Wiley Online Library Medicine and Nursing Collection 2019 - NHS

Abstract Severe acute respiratory syndrome (SARS) originated in Southern China in November 2002, and was brought to Hong Kong in February 2003. From Hong Kong, the disease spread rapidly worldwide but mostly to Asian countries. At the end of the epidemic in June, the global cumulative total was 8422 cases with 916 deaths (case fatality rate of 11%). People of all ages were affected, but predominantly females. Health care workers were at high risk and accounted for one-fifth of all cases. Risk factors for death included old age and comorbid illnesses, especially diabetes. The disease is caused by a novel coronavirus and is transmitted by droplets or direct inoculation from contact with infected surfaces. Contaminated sewage was found to be responsible for the outbreak in a housing estate in Hong Kong affecting over 300 residents. The mean incubation period was 6.4 days (range 2-10). The duration between onset of symptoms and hospitalisation was from 3 to 5 days. The relatively prolonged incubation period allowed asymptomatic air travellers to spread the disease globally. The number of individuals infected by each case has been estimated to be 2.7. Effective control of nosocomial transmission included early detection of disease, strict isolation of patients, practice of droplet and contact precautions and compliance with the use of personal protective equipment. Effective control of disease spread in the community included tracing and quarantine of contacts. Development of a validated diagnostic test and an effective vaccine as well as elimination of possible animal reservoirs are measures needed to prevent another epidemic.

51. SARS: Public health measures in Hong Kong

Authors Tsang T.; Lam Th.
Source Respirology; Nov 2003; vol. 8
Publication Date Nov 2003
Publication Type(s) Review
PubMedID 15018134
Database EMBASE
Available at Respirology (Carlton, Vic.) from Wiley Online Library Medicine and Nursing Collection 2019 - NHS
Abstract As there are no validated and rapid diagnostic tests nor specific treatment for severe acute respiratory syndrome (SARS) at the initial stage of the outbreak, public health measures are vital for the control of the disease. These included an enhanced disease surveillance system, expanded laboratory diagnostic capacity, heightened infection control in hospitals and residential institutions for the elderly, intensive contact tracing coupled with medical surveillance at designated medical centres, quarantine of close contacts by way of home confinement, formation of multidisciplinary investigation and response teams, and public education and communication. The above measures were implemented in many countries during the outbreak. To prevent spread in the region and beyond, port health measures targeted at both entry and exit health screenings were also carried out together with regional and international liaison.

52. Our strategies for fighting severe acute respiratory syndrome (SARS).

Authors Zhong, Nan Shan; Zeng, Guang Qiao
Source American journal of respiratory and critical care medicine; Jul 2003; vol. 168 (no. 1); p. 7-9
Publication Date Jul 2003
Publication Type(s) Case Reports Journal Article Review
PubMedID 12773318
Database Medline
Available at American journal of respiratory and critical care medicine from ProQuest (Health Research Premium) - NHS Version

53. SARS: an emerging global disease with a local impact.

Authors Hill, Jennifer
Source The Kansas nurse; May 2003; vol. 78 (no. 5); p. 10-11
Publication Date May 2003
Publication Type(s) Journal Article Review
PubMedID 12830677
Database Medline
Available at The Kansas nurse from ProQuest (Health Research Premium) - NHS Version

54. SARS: Severe acute respiratory syndromeSARS (severe acute respiratory syndrome)

Authors Gerstoft J.; Skinho P.
Source Ugeskrift for Laeger; May 2003; vol. 165 (no. 19); p. 1967-1970
Publication Date May 2003
Publication Type(s) Review
Database EMBASE
Abstract Since November 2002 an epidemic of a new severe respiratory infection has taken place primarily in South-East Asia. Severe Acute Respiratory Syndrome (SARS) is assumed caused by a recently identified corona virus, which seems to be a new pathogen in the human population. The infection is assumed transferred primarily with droplets and is highly contagious within healthcare settings and families. Respiratory and barrier precautions are necessary to contain the virus, as it is contact tracing.

Strategy 844344

#	Database	Search term	Results
1	AMED, BNI, CINAHL, EMBASE, EMCARE, HMIC, Medline, PsycINFO, PubMed	((COVID* OR corona* OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome") AND (contact* ADJ3 trac*)).ti	37
2	Medline	(COVID* OR corona* OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS).ti,ab	452099
3	Medline	exp CORONAVIRUS/	12495
5	Medline	exp "CORONAVIRUS INFECTIONS"/	10964
6	Medline	(2 OR 3 OR 5)	456958
7	Medline	(contact* ADJ3 trac*).ti,ab	2601
8	Medline	exp "CONTACT TRACING"/	4249
9	Medline	(7 OR 8)	6124
10	Medline	(6 AND 9)	271
11	Medline	(6 AND 9) [Document type Meta-analysis OR Review]	28
12	Medline	"SYSTEMATIC REVIEW"/	0
13	Medline	(systematic* ADJ3 (overview* OR review*)).ti,ab	181081
14	Medline	(evidence ADJ3 (overview* OR review*)).ti,ab	66797
15	Medline	(rapid* ADJ3 review*).ti,ab	2528
16	Medline	(scoping ADJ3 review*).ti,ab	5597
17	Medline	(Pubmed OR medline OR embase).ti,ab	199347
18	Medline	(search* strateg* OR search* criteria OR systematic* search*).ti,ab	179450
19	Medline	(study selection OR selection of studies OR (data ADJ3 extract*)).ti,ab	239520
20	Medline	exp "META-ANALYSIS"/	0
21	Medline	(meta-analys*).ti,ab	164697
22	Medline	(metaanalys*).ti,ab	105816

23	Medline	(handsearch* OR "hand-search*").ti,ab	9074
24	Medline	(PRISMA OR preferred reporting).ti,ab	15238
25	Medline	(relevant journals).ti,ab	5432
26	Medline	(reference list*).ti,ab	22885
27	Medline	(bibliograph*).ti,ab	25435
28	Medline	(12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23 OR 24 OR 25 OR 26 OR 27)	641727
29	Medline	(10 AND 28)	9
30	CINAHL	(COVID* OR corona* OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS).ti,ab	107321
31	CINAHL	exp CORONAVIRUS/	837
32	CINAHL	exp "CORONAVIRUS INFECTIONS"/	3243
33	CINAHL	(30 OR 31 OR 32)	108119
34	CINAHL	(contact* ADJ3 trac*).ti,ab	661
35	CINAHL	exp "CONTACT TRACING"/	1854
36	CINAHL	(34 OR 35)	2278
37	CINAHL	(33 AND 36)	66
38	CINAHL	(33 AND 36) [Publication types Meta Analysis OR Meta Synthesis OR Review OR Systematic Review]	5
39	CINAHL	exp "SYSTEMATIC REVIEW"/	94107
40	CINAHL	(systematic* ADJ3 (overview* OR review*)).ti,ab	105913
41	CINAHL	(evidence ADJ3 (overview* OR review*)).ti,ab	27135
42	CINAHL	(rapid* ADJ3 review*).ti,ab	922
43	CINAHL	(scoping ADJ3 review*).ti,ab	3851
44	CINAHL	(Pubmed OR medline OR embase).ti,ab	82465
45	CINAHL	(search* strateg* OR search* criteria OR systematic* search*).ti,ab	75445
46	CINAHL	(study selection OR selection of studies OR (data ADJ3 extract*)).ti,ab	59902

47	CINAHL	"META-ANALYSIS"/	0
48	CINAHL	(meta-analys*).ti,ab	70222
49	CINAHL	(metaanalys*).ti,ab	1122
50	CINAHL	(handsearch* OR "hand-search*").ti,ab	4587
51	CINAHL	(PRISMA OR preferred reporting).ti,ab	6567
52	CINAHL	(relevant journals).ti,ab	4014
53	CINAHL	(reference list*).ti,ab	10530
54	CINAHL	(bibliograph*).ti,ab	10446
55	CINAHL	(39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46 OR 47 OR 48 OR 49 OR 50 OR 51 OR 52 OR 53 OR 54)	262253
56	CINAHL	(37 AND 55)	2
57	EMBASE	(COVID* OR corona* OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS).ti,ab	627050
58	EMBASE	exp CORONAVIRINAE/	13590
59	EMBASE	exp "CORONAVIRUS INFECTION"/	12320
60	EMBASE	(57 OR 58 OR 59)	633417
61	EMBASE	(contact* ADJ3 trac*).ti,ab	2924
62	EMBASE	exp "CONTACT EXAMINATION"/	3777
63	EMBASE	(61 OR 62)	5610
64	EMBASE	(60 AND 63)	268
65	EMBASE	(60 AND 63) [Publication types Review]	34
66	EMBASE	(60 AND 63) [Evidence based medicine Meta Analysis OR Systematic Review]	4
67	EMBASE	exp "SYSTEMATIC REVIEW"/	241632
68	EMBASE	(systematic* ADJ3 (overview* OR review*)).ti,ab	227984
69	EMBASE	(evidence ADJ3 (overview* OR review*)).ti,ab	58854
70	EMBASE	(rapid* ADJ3 review*).ti,ab	2333

71	EMBASE	(scoping ADJ3 review*).ti,ab	5919
72	EMBASE	(Pubmed OR medline OR embase).ti,ab	252888
73	EMBASE	(search* strateg* OR search* criteria OR systematic* search*).ti,ab	52227
74	EMBASE	(study selection OR selection of studies OR (data ADJ3 extract*)).ti,ab	92464
75	EMBASE	exp "META-ANALYSIS"/	185593
76	EMBASE	(meta-analys*).ti,ab	215364
77	EMBASE	(metaanalys*).ti,ab	9515
78	EMBASE	(handsearch* OR "hand-search*").ti,ab	11039
79	EMBASE	(PRISMA OR preferred reporting).ti,ab	17059
80	EMBASE	(relevant journals).ti,ab	1388
81	EMBASE	(reference list*).ti,ab	20746
82	EMBASE	(bibliograph*).ti,ab	28839
83	EMBASE	(67 OR 68 OR 69 OR 70 OR 71 OR 72 OR 73 OR 74 OR 75 OR 76 OR 77 OR 78 OR 79 OR 80 OR 81 OR 82)	619745
84	EMBASE	(64 AND 83)	5
85	EMCARE	(COVID* OR corona* OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS).ti,ab	133214
86	EMCARE	exp CORONAVIRINAE/	1921
87	EMCARE	exp "CORONAVIRUS INFECTION"/	3776
88	EMCARE	(85 OR 86 OR 87)	134706
89	EMCARE	(contact* ADJ3 trac*).ti,ab	709
90	EMCARE	exp "CONTACT EXAMINATION"/	1000
91	EMCARE	(89 OR 90)	1343
92	EMCARE	(88 AND 91)	85
93	EMCARE	(88 AND 91) [Publication types Review]	9
94	EMCARE	(88 AND 91) [Evidence based medicine Meta Analysis OR Systematic Review]	1

95	EMCARE	exp "SYSTEMATIC REVIEW"/	116097
96	EMCARE	(systematic* ADJ3 (overview* OR review*)).ti,ab	96701
97	EMCARE	(evidence ADJ3 (overview* OR review*)).ti,ab	22002
98	EMCARE	(rapid* ADJ3 review*).ti,ab	845
99	EMCARE	(scoping ADJ3 review*).ti,ab	4397
100	EMCARE	(Pubmed OR medline OR embase).ti,ab	96505
101	EMCARE	(search* strateg* OR search* criteria OR systematic* search*).ti,ab	21081
102	EMCARE	(study selection OR selection of studies OR (data ADJ3 extract*)).ti,ab	35206
103	EMCARE	exp "META-ANALYSIS"/	61076
104	EMCARE	(meta-analys*).ti,ab	72340
105	EMCARE	(metaanalys*).ti,ab	2186
106	EMCARE	(handsearch* OR "hand-search*").ti,ab	4870
107	EMCARE	(PRISMA OR preferred reporting).ti,ab	6976
108	EMCARE	(relevant journals).ti,ab	588
109	EMCARE	(reference list*).ti,ab	8726
110	EMCARE	(bibliograph*).ti,ab	9555
111	EMCARE	(95 OR 96 OR 97 OR 98 OR 99 OR 100 OR 101 OR 102 OR 103 OR 104 OR 105 OR 106 OR 107 OR 108 OR 109 OR 110)	224881
112	EMCARE	(92 AND 111)	1
113	BNI	(COVID* OR corona* OR "2019-nCoV" OR "SARS-CoV" OR "MERS-CoV" OR "Severe Acute Respiratory Syndrome" OR "Middle East Respiratory Syndrome" OR SARS OR MERS).ti,ab	10049
114	BNI	"COVID-19"/	401
115	BNI	(113 OR 114)	10099
116	BNI	(contact* ADJ3 trac*).ti,ab	155
117	BNI	(115 AND 116)	23
118	BNI	(115 AND 116) [Document type Literature Review OR Review]	1

119	BNI	"SYSTEMATIC REVIEW"/	4479
120	BNI	(systematic* ADJ3 (overview* OR review*)).ti,ab	12864
121	BNI	(evidence ADJ3 (overview* OR review*)).ti,ab	4610
122	BNI	(rapid* ADJ3 review*).ti,ab	171
123	BNI	(scoping ADJ3 review*).ti,ab	750
124	BNI	(Pubmed OR medline OR embase).ti,ab	8670
125	BNI	(search* strateg* OR search* criteria OR systematic* search*).ti,ab	8798
126	BNI	(study selection OR selection of studies OR (data ADJ3 extract*)).ti,ab	5176
127	BNI	"META-ANALYSIS"/	1926
128	BNI	(meta-analys*).ti,ab	6069
129	BNI	(metaanalys*).ti,ab	3202
130	BNI	(handsearch* OR "hand-search*").ti,ab	656
131	BNI	(PRISMA OR preferred reporting).ti,ab	808
132	BNI	(relevant journals).ti,ab	353
133	BNI	(reference list*).ti,ab	1309
134	BNI	(bibliograph*).ti,ab	750
135	BNI	(119 OR 120 OR 121 OR 122 OR 123 OR 124 OR 125 OR 126 OR 127 OR 128 OR 129 OR 130 OR 131 OR 132 OR 133 OR 134)	29160
136	BNI	(117 AND 135)	1