of plasma cytokines, which suggests an immunopathological process caused by a cytokine storm[60,86,87] . In this cohort of patient, around 2.3% people died within a median time of 16 days from disease onset[9,86]. Men older than 68 years had a higher risk of respiratory failure, acute cardiac injury and heart failure that led to death, regardless of a history of cardiovascular disease[86] (FIG. 4). Most patients recovered enough to be released from hospital in 2 weeks[9,80] (FIG. 4).

Early transmission of SARS-CoV-2 in Wuhan in December 2019 was initially linked to the Huanan Seafood Wholesale Market, and it was suggested as the source of the outbreak[9,22, 60]. However, community transmission might have happened before that[88]. Later, ongoing human-to-human transmission propagated the outbreak[9,22,60]. It is generally accepted that SARS-CoV-2 is more transmissible than SARS-CoV and MERS-CoV; however, determination of an accurate reproduction number (R0) for COVID-19 is not possible yet, as many asymptomatic infections cannot be accurately accounted for at this stage[89]. An estimated R0 of 2.5 (ranging from 1.8 to 3.6) has been proposed for SARS-CoV-2 recently, compared with 2.0–3.0 for SARS-CoV[90]. Notably, most of the SARS-CoV-2 human-to-human transmission in China occurred in family clusters, and in other countries large outbreaks also happened in other settings, such as migrant worker communities, slaughterhouses and meat packing plants, indicating the necessity of isolating infected people[9,12,91-93]. Nosocomial transmission was the main source of transmission in China during the initial pandemic timeline of infection in hospital settings[9]. By contrast, no such risk of nosocomial transmission was reported in some other