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Bulletin No. 32 November 5, 2003

<http://www.akepi.org>

SARS: Will It Return?

Background

The World Health Organization (WHO) reported 8,098 cases of severe acute respiratory syndrome (SARS) and 774 deaths from 30 countries between November 1, 2002 and July 31, 2003. The United States reported 164 cases, including one imported suspect case in Alaska.¹ A single case in a Singapore laboratory worker in September 2003 was attributed to occupational exposure to blood. The WHO currently considers SARS contained. However, because the SARS-associated coronavirus (SARS-CoV) has been identified in several animal species, questions about whether SARS will re-emerge in the future remain unanswered.

How should clinicians respond to influenza-like illnesses and atypical pneumonias when there is no evidence of SARS activity anywhere in the world? A draft document from the Centers for Disease Control and Prevention addresses this issue and makes recommendations for clinical assessment of possible SARS cases.²

Important Issues

- Clinical features of SARS are non-specific. Most febrile respiratory illnesses are not SARS, even during times when SARS-CoV is known to be circulating.
- Laboratory tests do not reliably detect SARS-CoV early in the course of the illness.
- False positive tests for SARS-CoV are more likely to occur when the disease is not present anywhere in the world. False positive tests are costly when they result in unnecessary isolation procedures, stigmatize groups or individuals, or disrupt travel and commerce.
- Worldwide, more than half of SARS cases occurred in health care workers. The first sign that SARS has returned may be illness in health care workers exposed to unrecognized cases.

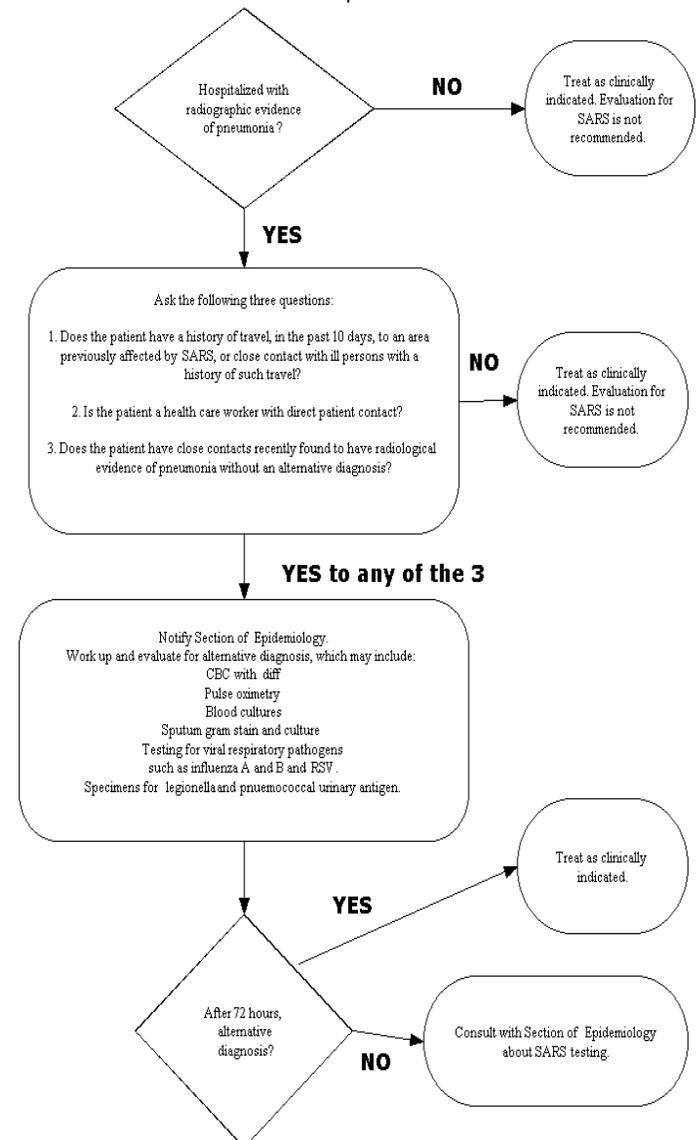
Surveillance

In the absence of a documented case of SARS, it is not necessary to consider SARS in the differential diagnosis of every person with a febrile respiratory illness or atypical pneumonia. SARS should be considered, however, when there is a cluster of cases of atypical pneumonia, especially if health care workers or international travelers are involved.

The following algorithm is adapted from the Centers for Disease Control and Prevention *Draft SARS Public Health Guidance*. It should be used to evaluate hospitalized patients with radiographic evidence of pneumonia during periods when SARS is not known to be circulating anywhere in the world.

<http://www.cdc.gov/ncidod/sars/sarsprepplan.htm>

Algorithm for evaluation of hospitalized patients with pneumonia in the absence of known SARS activity worldwide



Recommendations

1. Report clusters of atypical pneumonia or cases of atypical pneumonia in health care workers without an alternative diagnosis to the Section of Epidemiology at 269-8000.
2. Epidemiology staff is available for consultation 24 hours a day/7 days a week at 1-800-478-0084.

References:

1. Suspect Case of Severe Acute Respiratory Syndrome in Anchorage – May 2003. *Bulletin* No. 13. June 3, 2003. Section of Epidemiology, Division of Public Health, Department of Health and Social Services, Anchorage AK.
2. Centers for Disease Control and Prevention. Public health guidance for community level preparedness and response to severe acute respiratory syndrome (SARS). Draft – October, 2003.