Severe acute respiratory syndrome and Toronto

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Early detection and isolation of suspected cases is the key

It is important to see the current Canadian SARS outbreak in a wider context to appreciate the lessons it offers to others. Canada covers an extensive geographical area with a comparatively small but heavily urbanised population distribution. Of the present 33 million Canadians about 13 million live in Ontario, 9 million in the Greater Toronto area, and 3 million in the City of Toronto itself. Within Toronto about 100 000 people are Chinese or of Chinese descent. An understanding and appreciation of the demographics of populations can give the first clues as to the probable impacts of newly emerging infections and other urbanised areas with similar ethnic and social profiles to Toronto could be similarly affected in time. Opportunities can therefore be taken to target public information campaigns to population groups who are at increased risk. These include travellers to affected areas where transmission has been demonstrated and to local communities that have links with affected areas.

Sick or worried people will often present themselves to their local accident and emergency units and the key issue of whether or not local hospitals can promptly detect and isolate suspected cases is perhaps worthy of particular scrutiny.

Awareness among healthcare professionals is also important and although specific guidance needs to be given, as important is to provide support and reassurance for front line workers who are not immune to the same understandable concerns surrounding the emergence of an new infections as members of the public. Perhaps healthcare professionals need to be communicated as people first and professionals second?

We also need to be mindful of the lessons learned from communicating about other serious infections such as HIV. The assimilation of this information does not happen overnight and can be very difficult to come to terms with in the midst of an outbreak. Communication strategies should aim to pave the way now to minimise possible problems in the future by establishing links and communicating key messages early so that people have the time and opportunity to digest and accept them.

Control of infection in hospital and surveillance for infection will never be quite the same again. Focused infection control measures and public health intentions will need to be put in place using a risk assessment approach. The Hazard analysis critical control point (HACCP) approach is one well known risk assessment model widely used in industry and in food hygiene and now increasingly being used and applied to infectious diseases and public health issues. This approach has the potential to provide a useful checklist for action to guide decision makers and public health professionals, as they become “task saturated” with a multitude of diverse problems in the heat of a major communicable disease incident. Pressure points in the health and social care system can be anticipated using a HACCP approach and some early measures put in place in advance. HACCP principles are currently being applied to the development of national contingency plans for SARS by the Health Protection Agency and critical control points defined for each phase of an evolving outbreak.

Prompt detection and appropriate isolation of hospitalised cases is one critical control point and suggests that in the future that there should be more investment in syndromic surveillance. Perhaps travel associated pneumonias and nosocomial pneumonias should be early candidates for such surveillance in the post-SARS period. Most importantly we should look to constructively learn from the practical experience that others have gained from engaging to control SARS. Capturing, remembering, and learning from these experiences will enable the wider international community to be better prepared for not only SARS, but also for the next emerging infection that we will undoubtedly have to face in the future.
In this issue of the journal, Lee and Abdullah focus on the adoption of hygienic and health promotion measures in Hong Kong for controlling the spread of severe acute respiratory syndrome (SARS). One of the interesting aspects of this work is that it provides an insider’s point of view, yet these hygienic measures need to be discussed in the overall context of the outbreak, including the other public health interventions that have been performed in both Hong Kong and other heavily affected cities.

It should first be mentioned that one of the distinguishing characteristics of SARS is that for the first time in many years the entire world has perceived an outbreak as a life threatening event with a great non-discriminatory potential for diffusion, whereas this has not been the case for other epidemics of emerging infections in the era of antibiotics. For example, despite the fact that the outbreaks of Ebola and Lassa fever produced high case fatality rates in Sub-Saharan Africa, they remained for the most part confined to remote areas and were thus never truly perceived as global level threats by persons living in industrialised countries. Although the HIV/AIDS pandemic represents a true global level concern surrounding threats by persons living in industrialised countries, it can be safely said that they were effective.

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