

CORRESPONDENCE



Managing SARS

TO THE EDITOR: With regard to the article by Wenzel and Edmond (May 15 issue),¹ the management of suspected cases of severe acute respiratory syndrome (SARS) is not harmless. Recently, we admitted a man who had returned from Saigon and had pneumonia diagnosed at the airport. His symptoms included fever, cough, interstitial lung infiltrates, lymphopenia, and elevated lactate dehydrogenase levels. No microbiologic analysis of sputum was performed because of infection-prevention measures.² Five days after empirical antibiotic therapy began, respiratory failure developed, necessitating admission to the intensive care unit. Prevention measures were then discontinued, since the patient had not been exposed to anyone with a known case of SARS, there had been no cases reported in Saigon, and polymerase-chain-reaction assays of a throat swab were negative for coronavirus.³ Finally, *Burkholderia pseudomallei* was found in the sputum.

One must remember that persons returning from Asia with pneumonia may not have SARS and that other possible diagnoses must be checked, such as melioidosis, which is the most frequent cause of pneumonia in some areas of Asia.^{4,5} A chance for a correct, early diagnosis was missed because of the limitations on examination of this patient's sputum. Infection-prevention measures are essential, but they need to be assessed daily and discontinued as soon as possible. A rapid diagnostic test would be very helpful in ruling out SARS and providing care for patients in the usual way.

Lila Bouadma, M.D.
Violaine Noël, M.D.
Frédérique Schortgen, M.D.
Hôpital Bichat
75877 Paris, France
lila.bouadma@bch.ap-hop-paris.fr

1. Wenzel RP, Edmond MB. Managing SARS amidst uncertainty. *N Engl J Med* 2003;348:1947-8.
2. Updated interim domestic infection control guidance in the health-care and community setting for patients with suspected SARS. Atlanta: Centers for Disease Control and Prevention, 2003. (Accessed July 10, 2003, at <http://www.cdc.gov/ncidod/sars/infectioncontrol.htm>.)

3. Drosten C, Günther S, Preiser W, et al. Identification of a novel coronavirus in patients with severe acute respiratory syndrome. *N Engl J Med* 2003;348:1967-76.
4. Currie BJ, Fisher DA, Howard DM, et al. Endemic melioidosis in tropical northern Australia: a 10-year prospective study and review of the literature. *Clin Infect Dis* 2000;31:981-6.
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TO THE EDITOR: Without diminishing the problem of SARS, I wonder whether this situation involves more misinformation and perceived danger than actual threat. I am not advocating that we let down our guard and ignore this disease. SARS has affected thousands of people, but I have to ask whether we really have things in perspective. The Centers for Disease Control and Prevention reports that in the United States, influenza leads to an average of 36,000 deaths and 114,000 hospitalizations each year.¹ The World Health Organization (WHO) essentially shut down Toronto, a city of almost 2.5

THIS WEEK'S LETTERS

- 707 Managing SARS
- 708 SARS in Hong Kong
- 709 A Novel Coronavirus and SARS
- 709 Pseudo-SARS
- 711 SARS and the Internet
- 712 Pneumococcal Vaccination in Older Adults
- 714 The Conjugate Vaccine and Invasive Pneumococcal Disease
- 716 Molecular Mechanism of a Frequent Genetic Form of Deafness
- 717 Hypercholesterolemic Aortic-Valve Disease

million people² where there were about 20 deaths. Not to belittle this situation, but the *Toronto Star* reported 59 murders in Toronto in 2001, and the Toronto Police Service has reported 20 murders in 2003. We should be steadfast in our determination to minimize the harm from this disease, but we must also be careful not to let hype create panic, which would lead to more harm and fear in an already tenuous world psyche.

Christian Donohue, M.D.

Summit Medical Group
Summit, NJ 07901

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2. 2001 Census of Canada. Ottawa, Ont., Canada: Statistics Canada, 2002.

THE AUTHORS REPLY: Lila and colleagues make the clinical point that not all cases of community-acquired pneumonia from a region affected by the SARS epidemic are caused by the SARS coronavirus. We agree that a detailed history, a physical examination, and a series of diagnostic tests are appropriate.

Donohue warns that the medical profession should be careful not to panic in the midst of an epidemic, especially if the number of cases pales in comparison with the number of patients with ap-

parently less threatening endemic infections. We agree that emerging infections should be managed in a data-driven way, and communications should be balanced and truthful. However, we would not necessarily find fault with the WHO, because it had to make decisions empirically in the face of limited data. Just as a physician may initially prescribe a broad spectrum of antibiotics for a patient with life-threatening sepsis of unknown cause and later narrow the antibiotic choices when the antibiogram comes back, we think that it is appropriate to take broad precautions initially when the public health is involved. Once the epidemiologic details become clear, more focused approaches may be applied. Initially, the WHO did not know where we stood on the epidemic curve, what various modes of transmission were possible, how many new cases resulted from each case (the case reproduction rate), whether the virus was carried for extended periods, or whether asymptomatic cases existed. In hindsight, some of the approaches that were taken may seem excessive, but in the context of uncertainty and risk to health, we think that they were reasonable.

Richard P. Wenzel, M.D.
Michael B. Edmond, M.D., M.P.H.

Virginia Commonwealth University
Richmond, VA 23219
rwenzel@mail2.vcu.edu

SARS in Hong Kong

TO THE EDITOR: Lee et al. (May 15 issue)¹ describe the clinical and laboratory features of 138 cases of suspected severe acute respiratory syndrome (SARS) in Hong Kong. It is striking that 44.8 percent of the patients had thrombocytopenia, 45.0 percent had elevated levels of D-dimers, and 42.8 percent had a prolonged activated partial-thromboplastin time. This combination suggests the presence of a form of disseminated intravascular coagulation² or pulmonary-induced coagulation and fibrin polymerization with consumption of platelets and clotting factors. Elevated D-dimer levels have also been reported in patients with acute lung injury and in patients with the acute respiratory distress syndrome.³ We suggest that patients with SARS who have elevated D-dimer levels might need anticoagulant therapy or fibrinolytic therapy such as plasminogen activators,⁴ activated protein C, soluble thrombomodulin, antithrombin, tissue factor–pathway

inhibitor, activated factor VII–pathway inhibitor, heparin, or low-molecular-weight heparin⁵ in order to reverse intraalveolar coagulation, microthrombi formation, and alveolar and interstitial fibrin deposition.⁶ Such reversals might improve survival.⁵

Ya Ping Wu, Ph.D.

University Medical Center
3584 CX Utrecht, the Netherlands
ywu@azu.nl

Ran Wei, M.D.

Taishan Medical College
Taian, Shandong 271000, China

Philip G. de Groot, Ph.D.

University Medical Center
3584 CX Utrecht, the Netherlands

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