

For information
on 12 June 2003

LegCo Panel on Health Services
Prevention of the Spread of Severe Acute Respiratory Syndrome

Further to the paper issued for the meeting on 5 June 2003, this paper updates Members on the latest development in Severe Acute Respiratory Syndrome (SARS).

Summary of cases

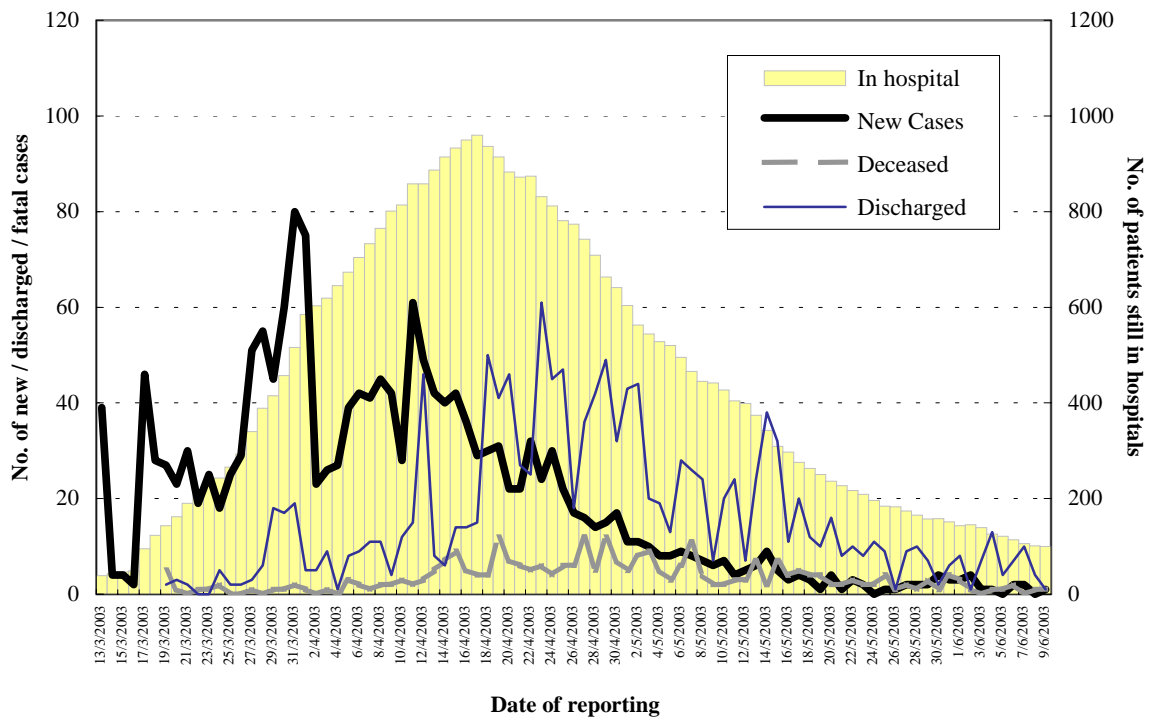
2. As at 11 June, a total of 1,755 patients have been admitted to public hospitals with SARS, among whom 386 were health care workers or medical students. There was no suspected case on 11 June.

3. A total of 1,374 patients (i.e. about 78.3% of all SARS patients) have recovered from the disease and been discharged from hospitals. On 11 June, there were 90 SARS patients remaining in hospitals, of whom 30 were undergoing convalescence before discharge and 17 were receiving treatment in intensive care units. There are a total of 291 fatal cases.

Analysis of statistics

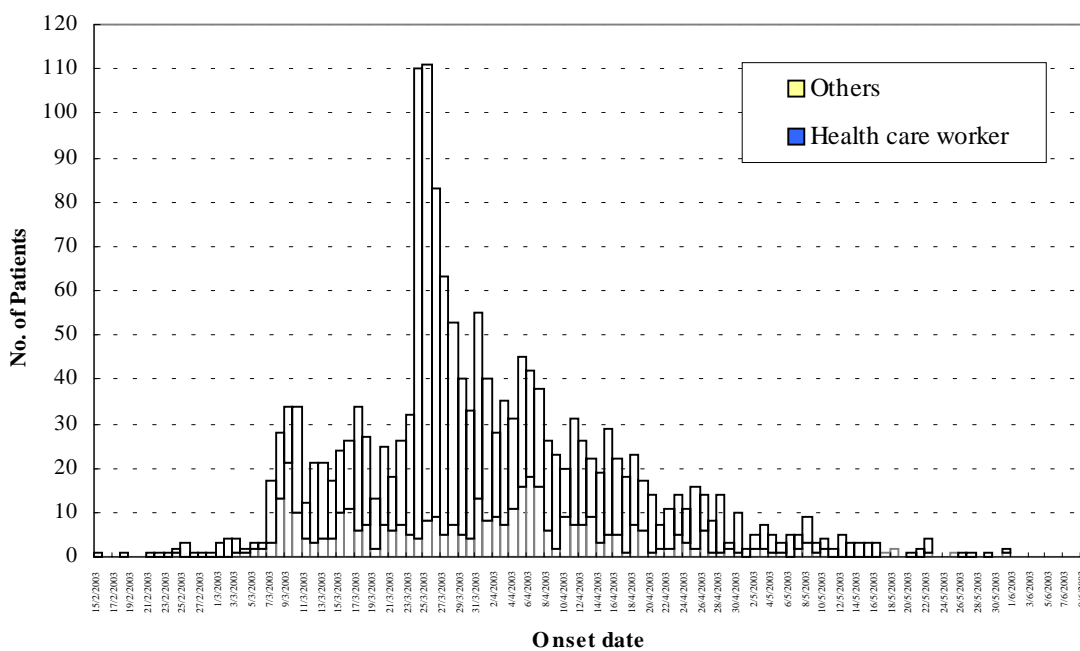
4. One patient each was confirmed to have SARS on 10 and 11 June. Since 16 May, the daily number of newly confirmed SARS cases has fallen below 5 for the 27th consecutive day, and the average number of newly confirmed cases in the past week was 1 per day. Figure 1 shows the daily number of newly confirmed cases, discharged cases and fatal cases according to the date of reporting, and the number of patients still in hospital on the corresponding date.

Figure 1



5. Figure 2 is the epidemic curve of 9 June showing the dates of onset of 1,729 patients (the dates of onset of the remaining 24 cases are to be confirmed).

Figure 2



6. As at 9 June 2003, there were 73 confirmed SARS patients whose dates of onset were on or after 4 May 2003. Fifty-five cases had history of exposure to SARS patients in hospitals during the incubation period. Seventeen of them were health care workers, 2 were visitors to the hospitals and 36 were hospital in-patients admitted for other reasons. Eighteen cases did not report a history of visit to hospitals during the incubation period, among which 13 cases were household/close contacts of known cases, 1 was a resident of a building with recent SARS cases reported, while the linkages of the remaining 4 cases are still under investigation.

7. Table 1 shows the distribution of cases by age group and gender.

Table 1

Age group	Male	Female
0-14	2%	2%
15-24	4%	6%
25-34	9%	15%
35-44	9%	12%
45-54	6%	9%
55-64	4%	4%
65-74	4%	4%
75 or above	6%	4%
Total	44%	56%

8. Information on the occupation of 1,614 patients (92.1% of all 1,753 SARS cases) has been collected and analysed. 964 of them (59.7%) belong to the working population, in which “Health Care Workers” is the largest single occupational group, representing 23.7% of all these 1,614 cases. The breakdown of the cases by the patient’s occupation is shown in Table 2.

Table 2

Working Group	Percentage	Non-working Group	Percentage
Health Care Workers	23.7%	Retired	11.7%
Domestic Helpers	1.8%	Housewives	10.5%
Food Handlers	1.7%	Students	8.2%
School Staff	1.4%	Pre-school Children	0.6%
Disciplinary Force	0.6%	Visitors/Tourists	0.2%
Others (e.g. drivers, clerical and administrative personnel)	30.5%	Others (e.g. unemployed)	9.0%
Total	59.7%	Total	40.3%

Note: Percentage may not add up to total due to rounding.

Cluster of SARS cases in the Hong Kong Baptist Hospital

9. A cluster of SARS cases occurred on the 9th Floor of the Hong Kong Baptist Hospital (HKBH) in April 2003. A total of 6 patients (1 female and 5 male) and 2 health care workers were confirmed to have SARS. Subsequent contact tracing by the Department of Health (DH) identified 5 family members of 3 of the above patients to be infected with SARS. There were 2 other sporadic cases among health care workers working on the 6th and 7th Floor.

10. The first patient was hospitalized from 20 to 21 April for kidney disease. She was referred to a public hospital on 21 April for atypical pneumonia and confirmed as SARS on 24 April. The second patient was hospitalized from 23 to 25 April for bladder disease. This patient did not have any cough or sputum. He was referred to public hospital on 25 April for management of swinging fever. He was confirmed to be suffering from SARS on 28 April. Four other patients sharing the same room with this patient during their respective period of hospitalisation i.e. 25 April, 24-27 April, 23-24 April and 19-26 April later developed symptoms after they had been discharged from the HKBH. They were confirmed to be suffering from SARS on 2, 8, 13 and 14 May respectively. Two health care workers working on the 9th Floor were admitted to public hospitals on 30 April and 1 May. They were later confirmed to be suffering from SARS on 2 and 6 May respectively.

11. In addition, the two health care workers working on the 6th and 7th floor were admitted to public hospitals on 23 April and 4 May respectively. They were confirmed as SARS patients on 24 April and 6 May respectively.

12. DH has conducted contact tracing for all these 10 SARS cases. All 99 staff who worked on the 6th, 7th and 9th floor of the HKBH were put under surveillance. Contact tracing of 214 and 130 patients discharged from the 6th, 7th and 9th floor were conducted by DH and the HKBH respectively. All household contacts were put under home confinement.

13. DH required the HKBH to submit a report on the SARS outbreak on 7 May. A report was received on 20 May and supplementary information was received on 27 May. After review, DH concluded that there were two areas of inadequacy on the part of the HKBH. The first area relates to the delay in reporting to DH using the Daily Reply Slip about the three suspected SARS cases involving health care workers. The second area relates to the withholding of information concerning the cases from other in-patients. DH sent an advisory letter to the HKBH on 31 May instructing the management to report suspected SARS cases and improve the communication with patients. The performance of the HKBH will be closely monitored and taken into account when the hospital applies for renewal of licence.

Working Group on Hospital Authority Isolation Facilities

14. The Health, Welfare and Food Bureau has set up a Working Group on Hospital Authority Isolation Facilities under the Inter-departmental Action Co-ordinating Committee on SARS to consider options on how to expand the existing infectious disease control facilities of the public hospital system, and oversee the smooth and timely implementation of feasible projects. The Working Group is chaired by the Permanent Secretary for Health, Welfare and Food. Members of the Working Group comprise representatives from the Environment, Transport and Works Bureau, Financial Services and the Treasury Bureau, Health, Welfare and Food Bureau, Hospital Authority (HA), DH, Electrical and Mechanical Services Department, Architectural Services Department and Planning Department.

15. The Working Group has met and focused its discussions on need

for extra isolation facilities to enhance support in the public hospital system. To explore additional isolation facilities for suspected SARS cases with a view to minimizing the risk of cross infection, the following factors are relevant :

- (a) the cohorting of suspected patients should best be located in the acute hospitals backed up by Intensive Care Unit facilities in view of the high level of medical and nursing dependency of patients;
- (b) the option of building fast track prefabricated construction as temporary isolation facilities is subject to various constraints.

To build a centralized temporary isolation facility would require a large site. Such an approach requires significant transport support to transport patients between the facility and the hospitals. Medical support would also be a problem if the facility is located away from any hospital. Such a facility could only take in patients with very low medical and nursing dependency. In this connection, SARS patients in convalescence can be accommodated in such a facility.

16. The Working Group agreed that as an immediate step there is the need to improve and develop the existing isolation facilities of all acute hospitals for suspected SARS cases, so that the handling of future SARS could be shared among acute hospitals. In this connection, HA proposes to adopt a staged approach to improve the hospital facilities to cater for the infection control needs of both the fever wards and the SARS wards. HA is now working on the proposed scope of improvement works for its major acute hospitals. We shall seek funding approval from the Legislative Council to carry out the improvement works once the scope of the proposed works has been determined and agreed.

17. The Working Group decided that the option of proceeding with a centralized temporary isolation facility should continue to be explored by way of active site search. At the same time, the Working Group would concurrently examine the option of building prefabricated construction in decentralized isolation facilities at various hospitals. The decentralization approach would have the advantage of adequate medical backup from the acute hospitals. This approach would, however, only be feasible provided that there

is readily available sites in the acute hospitals to accommodate the temporary facilities. HA has been asked to identify hospitals with readily available sites to take forward this option.

18. Also, action is in hand in identifying camp facilities that can be converted into temporary isolation facilities.

19. Members are invited to note the contents of this paper.

Health, Welfare and Food Bureau
12 June 2003