Summary of Important Updating of Information on Clinical Management of SARS in the Hospital Authority Intranet SARS Website

Since all the files that have ever been posted are extremely sizeable, only important documents are highlighted.

Until 1 August 03

Legend: IC : Infection Control PPE: Personal Protective Equipment

Information released on Severe Acute Respiratory Syndrome (on top of that on SCAP)

First designated SARS page launched on 19 March 03

Date of Release	Areas	Key changes introduced	Document title
19-Mar-03	Case Definition	Introduced: first case definition of SARS - differentiated into probable and suspected cases with inclusion criteria (X-ray , fever, two other symptoms) & exclusion criteria (leucocytosis, significant bronchiectasis, X-ray lobar consolidation, known pathogens)	030319 Guideline on Mgt of SARS
19-Mar-03	Treatment	Introduced: avoidance of nebuliser treatment for patient with fever and X-ray infiltrates	030319 Guideline on Mgt of SARS
24-Mar-03	Case Definition	Revised: "general malaise" replaced "shortness of breath" under inclusion criteria with "history of exposure" incorporated; "significant bronchiectasis" removed from exclusion criteria	030324 Guideline on Mgt of SARS
24-Mar-03	Infection Control	Inserted" : infection control measures for (a) SARS patients-Surgical/ N95 masks, goggles, gowns gloves; (b) other patients-surgical/ N95 masks with gowns for splashes generating procedures ; (c) staff/ contacts while at home-surgical masks; (d) visitors-access to be restricted and advised to put on protective equipment while visiting	030324 Guideline on Mgt of SARS
24-Mar-03	Treatment	Inserted : proposed treatment regimen on broad spectrum antibiotics, ribavirin & steroids; & guidelines to primary care practitioners issued by DH	030324 Guideline on Mgt of SARS
27-Mar-03	Case Definition	Revised: "known history of exposure" inserted into inclusion criteria; "Leucocytosis on admission" removed from exclusion criteria	030327 Guideline on Mgt of SARS
27-Mar-03	Discharge	Revised: Cohort patients for 3 weeks from onset or 7 days since WHO-defined convalescence	030327 Guideline on Mgt of SARS
27-Mar-03	Infection Control	Revised: visiting SARS patients disallowed; Inserted: case control study highlighting effectiveness of infection control measures	030327 Guideline on Mgt of SARS
03-Apr-03	Infection Control	Inserted: training & enforcement, environmental control, disallowing any visiting, mandatory mask wearing for all staff & patients, caution on serious-risk and high-risk procedures, waste management, post-mortem examination & measures at mortuary; PPE(For all inpatient settings: Surgical masks for all patient contact with goggles or face shield for close patient contact & gowns + gloves for contact with patient or environment; For SARS areas- Surgical/ N95 masks, protective eyewear, cap, gown, gloves)	030403 Information on Mgt of SARS
03-Apr-03	Treatment	Inserted: admission criteria, paediatric patients, pregnant patient, newborn convalescent patient plasma, prophylactic treatment, pre-emptive treatment & primary care	030403 Information on Mgt of SARS
06-Apr-03	Treatment	Revised: advice against use of BIPAP/CPAP	030406 Information on Mgt of SARS
10-Apr-03	Case Definition	Revised: a section on suspected case separately inserted; "physical signs of consolidation" deleted from inclusion criteria	030410 Information on Mgt of SARS
15-Apr-03	Case Definition	Revised : clinical judgement of likelihood to be SARS included under section on "Suspected case "	030415 Information on Mgt of SARS
17-Apr-03	Treatment	Revised: duration of cohorting convalescence cases revised to 5 days	030417 Information on Mgt of SARS
22-Apr-03	Case Definition	Revised: clause on contact history under "suspected case" deleted	030422 Information on Mgt of SARS

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Until 1 August 03

Legend: IC : Infection Control PPE: Personal Protective Equipment

25-Apr-03	Infection Control	Revised: infection control & risk management approach & patterns of breakthrough infections highlighted; cautious use of risk-stratified provisions of PPE consolidated: for most situations- surgical masks is adequate; high risk procedure- N95, goggles & face shield will provide better protection; additional PPE eg cover-all suit & air-precaution devices may be used ; Non-SARS areas – gloves & gowns for splash generating procedures	030425 Information on Mgt of SARS
29-Apr-03	Infection Control	Inserted: "Community health care workers"	030429 Information on Mgt of SARS
30-Apr-03	Treatment	Revised: precautionary measures at home for convalescent patients extended from 10 days to 14 days	030430 Information on Mgt of SARS
06-May-03	Infection Control	Inserted: measures for "Ward Contacts" & "Laboratory"	030506 Information on Mgt of SARS
06-May-03	Treatment	Revised: section on treatment for further revision based on discussions by advisory groups	030506 Information on Mgt of SARS
07-May-03	Treatment	Inserted: section on "alternative Treatment" and evidence appraisal report on Vitamin C	030507 Information o Mgt of SARS
12-May-03	Infection Control	Inserted: management by "Allied Health Professionals"	030512 Information on Mgt of SARS
15-May-03	Treatment	Revised: principle of treatment revisited based on latest evidence with publications by local authors highlighted	030515 Information on Mgt of SARS (Treatment)
15-May-03	Infection Control	Revised: recommended minimum standards of PPE; Inserted: pros and cons of different respirators	030515 Information on Mgt of SARS (Infection Control) & 030515 Respirator_information
21-May-03	Infection Control	Inserted : section on "in-Hospital Resuscitation of patients at risk of SARS"	030521 Information on Mgt of SARS (Infection Control) & 030623 SARS_resuscitation_gu
22-May-03	Infection Control	Inserted: section on "Outpatient setting"	030522 Information on Mgt of SARS (Infection Control)
22-May-03	Infection Control	Inserted: section on "Non-emergency patient transfer"	030522 Information on Mgt of SARS (Infection Control)
09-Jun-03	Treatment	Inserted: guidelines on pregnant patients issued by Hong Kong College of Obstetricians & Gynaecologists	030609_Information on Mgt of SARS (Treatment)
26-Jun-03	Treatment	Inserted: Occupational Therapy Service Guidelines for Patients with SARS in Hospitals	030626_Information on Mgt of SARS (Treatment)
28-Jun-03	Infection Control	Revised: Management of ward contacts in wards with a highly suspected or confirmed SARS case in view of closure of DMC	030628 Information on Mgt of SARS (Infection Control)

Summary of Important Updating of Information on Clinical Management of SARS in the Hospital Authority Intranet SARS Website

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Until 1 August 03

Legend: IC : Infection Control PPE: Personal Protective Equipment

30-Jun-03	Treatment	Deleted: Primary Care, Paediatric, Pregnancy & Alternative Treatment Revised: Principles of Treatment	030630_Information on Mgt of SARS (Treatment)
30-Jun-03	Convalescence	Revised: Discharge Advice for SARS patients for dissemination in view of closure of DMC	030630_Information on Mgt of SARS (Convalescence)

Remark:: information posting might sometimes have lagged behind other means of dissemination including hospital forums, emails etc so that dates of release through website may not coincide with other those through other means

090027

Print Date : 15-7-03
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Version Date : 17.3.03

Guideline on the Management of Severe Acute Respiratory Syndrome (SARS)

March 19, 2003

Surveillance Case definition:

Taking into consideration of WHO case definition and our local clinical experience, cases of SARS are defined as suspect and probable cases.

Department of Health has issued clinical protocol for general practitioners in the management pneumonia, and suspected cases would be referred to hospitals for further investigation and management when the case definition is met (see appendix 1).

In hospitals, cases of pneumonia would be screened according to HA case definition, and when the criteria are met, such cases are defined as probable SARS (see appendix 2).

Case Reporting and Specimens Collection:

- Please follow the Case Reporting mechanism and report to the Secretariat of Central Committee in Infection Control (CCIC) using the appropriate report forms and report to the "Secretariat of Central Committee in Infection Control". Please refer to the Guideline posted at the HA intranet (Under Clinical Guidelines/Infectious Disease)
- Specimens should be collected (NPA, serum samples) and sent to laboratory promptly,

What are the Infection Control Measures?

- The recommended method of isolation for cases of suspect and probable SARS is droplets precautions, in additional to Universal Precautions.
- This is based on the observation that:
    i) SARS so far are limited to healthcare workers and close household contacts which suggests spread by droplets;
    ii) nearly all hospital staff who have acquired SARS had direct exposure to index patients;
    iii) the implementation of droplets precautions has reduced the number of staff being infected significantly;

Droplet Precautions includes:

- Place patient in a room with other patient(s) having SARS (**cohorting**) maintaining separation of at least 3 feet from each other.
- Staff should have barrier apparels (gloves and gowns) when coming into contact with the patient's blood, body fluids, secretions, excretions, mucous membranes and contaminated items.
- Wear a mask when working within 3 feet of the patient.
- Wash hands after removal of gloves and before nursing another patient even when contact is only with non-contaminated items.
- Proper disinfection of the environment and equipment is required.

Precautions when attending to hospitalised patients and patients in the AED:

- When attending to patients with respiratory symptoms (such as fever, sore throat, headache, running nose, cough, myalgia, skin rash, pleuritic chest pain), put on a mask and wash hands after patient contact.
- Ask patients with respiratory symptoms to put on a surgical mask.
- Staff with respiratory symptoms should also put on a surgical mask.
- Treatment with nebuliser should be avoided in patients with fever and chest XR infiltrates.

What if we ourselves develop influenza-like illness?

- Staff feeling unwell should seek medical advice, e.g. attending the staff clinic.
- Based on severity of symptoms, sick leave would be granted on an individual basis.
- Staff with mild respiratory symptoms e.g. cough, but otherwise fit for work, they should put on a surgical mask when attending to patients.

Appendix I

Guidelines to Primary Care Physicians / Family Physicians on the management of cases of suspected Severe Acute Respiratory Syndrome (SARS)

In accordance with World Health Organization, symptoms and signs of SARS include –

- high fever (>38°C) AND
- one or more respiratory symptoms including cough, shortness of breath, difficulty breathing AND
- close contact* with a person who has been diagnosed with SARS

*close contact means having cared for, having lived with, or having had direct contact with respiratory secretions and body fluids of a person with SARS.

In addition to fever and respiratory symptoms, SARS may be associated with other symptoms including: headache, muscular stiffness, loss of appetite, malaise, confusion, rash, and diarrhea.

When to refer

Doctors are advised to refer patients with the following conditions to hospital for further management –

(I) Fever more than 38 Celsius and new onset of pulmonary infiltrate and either shortness of breath or cough and no symptomatic response to standard therapy including a beta-lactam (penicillin & cephalosporin groups) and coverage for atypical pneumonia (a fluoroquinolone, tetracyclines, or a macrolide) after 2 days of therapy in terms of fever and general well being

OR

(II) Fever more than 38 Celsius and new onset of pulmonary infiltrate and either shortness of breath or cough and patient has been exposed to patients with pneumonia in the previous 7 days

Department of Health

17 March 2003

Appendix II

Severe Acute Respiratory Syndrome (SARS) Registry, Hospital Authority

Case Definition of ARS

Inclusion:

1. Presence of new radiological infiltrates compatible with pneumonia, and
2. Fever ≥ 38°C, or history of such any time in the last 2 days, and
3. Presence of at least 2 of the following:
   a. Chills any time in the last 2 days
   b. New or increased cough
   c. New or increased shortness of breath
   d. Typical physical signs of consolidation

Exclusion (any one of the following):

1. Significant bronchiectasis
2. Leucocytosis on admission
3. CXR show lobar consolidation
4. The pathogen is already known

Reporting Procedure

A duty officer will be appointed in all hospitals which admit patients from A&E. The officer should either be a respiratory physician or infectious disease physician. He/She (or designate) shall screen admissions from the A&E on a daily basis (except Sundays). When cases satisfying the inclusion and exclusion criteria are found, the patient data shall be entered into a standard form (annex II) and sent to a receiving point by fax or email, as follows:

		Fax No.
PWH, AHNH, NDH	Dr. Louis Chan	(2636 0008)
KWH, CMC, WTSH	Dr. Melissa Ho	(2781 5427)
PMH, YCH	Ms. Adela Lai	(2990 1058)
PYNEH, RH	Dr. Raymond Yung	(2515 9657)
TMH	Dr. T L Que	(2463 2565)
UCH, HOHH, TKOH	Dr. Raymond Lai	(2772 0917)
QEH, KH	Ms. Clara Yip	(2782 6385)
QMH, GH	Ms. Patricia Ching	(2855 3805)

The collected information will be passed on to Mr Clement CHE, Secretary of Central Committee on Infection Control.

SARS

Cases that meet the inclusion and exclusion criteria, and who require assisted ventilation and/ or care in the ICU/HDU, either on admission or subsequently, must be separately reported using the existing system.

090030

Annex II

SARS Registry, Hospital Authority
(For reporting of cases fallen under the case definition for SARS)

CONFIDENTIAL

To: _____

Fax no. _____ Date: _____

(No need to enter if gum label is available)	Gum Label
HKID	
Sex Age	
Date of Admission	

History of Contact with patient with SARS:	Yes / No
History of Travel to China:	Yes / No
Healthcare Worker?	No / Doctor / Nurse / Allied Health / HCA /Lab staff / Other
Institutionalised (including OAH):	Yes / No
Underlying chronic illness:	Yes / No
Respiratory failure:	Yes / No
Condition on admission:	Good / Fair / Poor / Critical

Hospital:

090031

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Version Date : 20.3.03

Guideline on the Management of Severe Acute Respiratory Syndrome (SARS)

March 20, 2003

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What are the Infection Control Measures?

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Droplet Precautions includes:

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- Staff should have barrier apparels (gloves and gowns) when coming into contact with the patient's blood, body fluids, secretions, excretions, mucous membranes and contaminated items.
- Wear a mask when working within 3 feet of the patient.
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OR

(II) Fever more than 38 Celsius and new onset of pulmonary infiltrate and either shortness of breath or cough and patient has been exposed to patients with pneumonia in the previous 7 days

Department of Health

17 March 2003

Severe Acute Respiratory Syndrome (SARS) Registry, Hospital Authority

Case Definition of ARS

Inclusion:
1. Presence of new radiological infiltrates compatible with pneumonia, and
2. Fever ≥ 38°C, or history of such any time in the last 2 days, and
3. Presence of at least 2 of the following:
   a. Chills any time in the last 2 days
   b. New or increased cough
   c. New or increased shortness of breath
   d. Typical physical signs of consolidation

Exclusion (any one of the following):
1. Significant bronchiectasis
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3. CXR show lobar consolidation
4. The pathogen is already known

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A duty officer will be appointed in all hospitals which admit patients from A&E. The officer should either be a respiratory physician or infectious disease physician. He/She (or designate) shall screen admissions from the A&E on a daily basis (except Sundays). When cases satisfying the inclusion and exclusion criteria are found, the patient data shall be entered into a standard form (annex II) and sent to a receiving point by fax or email, as follows:

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TMH	Dr. T L Que	(2463 2565)
UCH, HOHH, TKOH	Dr. Raymond Lai	(2772 0917)
QEH, KH	Ms. Clara Yip	(2782 6385)
QMH, GH	Ms. Patricia Ching	(2855 3805)

The collected information will be passed on to Mr Clement CHE, Secretary of Central Committee on Infection Control.

SARS

Cases that meet the inclusion and exclusion criteria, and who require assisted ventilation and/ or care in the ICU/HDU, either on admission or subsequently, must be separately reported using the existing system.

090034

Annex II

SARS Registry, Hospital Authority
(For reporting of cases fallen under the case definition for SARS)

CONFIDENTIAL

To: _____

Fax no. _____ Date: _____

(No need to enter if gum label is available)	Gum Label
HKID	
Sex Age	
Date of Admission	

History of Contact with patient with SARS: Yes / No
History of Travel to China: Yes / No
Healthcare Worker? No / Doctor / Nurse / Allied Health / HCA /Lab staff / Other
Institutionalised (including OAH): Yes / No
Underlying chronic illness: Yes / No
Respiratory failure: Yes / No
Condition on admission: Good / Fair / Poor / Critical

Hospital:

Print Date : 15.7.03

090035 Send Date : 13.8.03

Upload Date : 24.3.03

Version Date : 24.3.03

HA Guideline on the Management of Severe Acute Respiratory Syndrome (SARS)

(This guideline should be read by HA staff)

Revised 24 March, 2003

1. Case definition:

1.1 In hospitals, cases of pneumonia would be screened according to HA Surveillance case definition (as below), such cases are defined as probable SARS.

Case Definition of SARS (Revised date 22/3/2003)
Inclusion: 1. Presence of new radiological infiltrates compatible with pneumonia, and 2. Fever ≥ 38°C, or history of such any time in the last 2 days, and 3. At least 2 of the following: a. Chills any time in the last 2 days b. New or increased cough c. General malaise d. Typical physical signs of consolidation If no know history of exposure, consider exclusion if presence of any one of the following: 1. Leucocytosis on admission 2. CXR show lobar consolidation 3. The pathogen is already known

1.2 Department of Health has issued clinical protocol for general practitioners in the management of pneumonia, and suspected SARS cases would be referred to hospitals for further investigation and management (Appendix I).

2. Reporting Procedure :

- A SARS Coordination Centre has been set up at HAHO with the following designation:

Telephone number: 2300 7890
Fax number: 2194 6045
HA Intranet email address: HA SARS

- The centre opens from 9:00am - 5:00pm daily until further notice.
- The detail reporting procedure is at Appendix II.

3. Infection Control Measures

3.1. For SARS patients:

- The main mode of transmission of SARS, based on epidemiological analysis and initial evidence of the virus isolated, is by droplets and direct contact with patient's secretions and subsequent inoculation into mucous membranes e.g. conjunctiva, oral mucosa etc.,
- The recommended infection control measures is, therefore, droplets precautions with emphasis on the use of barrier apparels and environmental cleaning in addition to Universal Precautions.
- Staff are also reminded of the importance of handwashing, and the strict avoidance of touching or scratching of eyes, nose and mouth with hands.
- SARS patients should be nursed in a room with other SARS patient(s) (cohorting) but maintaining separation of at least 3 feet from each other.
- Put on barrier apparels (mask, goggles, gloves and gowns) when attending to SARS patients.
- Staff should wear a surgical/N95 mask properly (see Guideline on its use) and wash hands after touching the external surface of the mask.
- Wash hands after removal of gloves and before nursing another patient.

- Proper and frequent (at least daily) disinfection of ward environment and equipment with hypochlorite solution (1000 ppm) is important.
- Visitors should be restricted. They should be advised to put on barrier apparels and avoid close contact with the patient or touching objects in the patient's near vicinity. They should be advised to wash their hands when leaving the ward.
- Staff and patients with respiratory symptoms should put on a surgical mask.
- Treatment with neubuliser should be avoided in patients with fever and chest XR infiltrates.

3.2. For all other Non- SARS patients, including those in the OPD or AED:

- Staff are also reminded of the importance of handwashing, and the strict avoidance of touching or scratching of eyes, nose and mouth with hands.
- Put on a surgical / N95 mask when attending patients.
- Wear gloves before touching blood, body fluids or secretions / excretions.
- Wear gown during procedures likely to generate splashes or sprays of blood and body fluids.
- Staff should wear a surgical/N95 mask properly (see Guideline on its use) and wash hands after touching the external surface of the mask.
- Wash hands after removal of gloves and before nursing another patient.
- Proper and frequent disinfection of ward environment and equipment with hypochlorite solution (1000 ppm) is important.
- Visitors should be restricted. They should be advised to put on a surgical mask. They should be advised to wash their hands when leaving the ward.
- Staff and patients with respiratory symptoms should put on a surgical mask.

3.3. Infection Control measures at home for all staff caring for SARS patients / contacts of SARS patients or SARS patients discharged from hospital:

- Frequent handwashing with liquid soap rather than bar soap, especially after contact with nose, mouth and respiratory secretions, e.g. after sneezing.
- Family members should practice handwashing frequently, and avoid touching the eyes, nose and mouth with their hands.
- Put on a surgical mask.
- Avoid close contact with family members (e.g. mucosal contact).
- Avoid sharing food and utensils with family members.
- Shower immediately after work.
- These precautionary measures should be adopted for 1 week from the latest contact with SARS patient, and for 3 weeks for discharged SARS patients.
- Cleanse and disinfect the facilities (including furniture and toilet facilities) regularly (at least once a day), using diluted household bleach (i.e. adding 1 part of household bleach to 99 parts of water), rinse with water and then mop dry.
- If the facilities are contaminated with vomitus, wash / wipe with diluted domestic bleach (mixing 1 part of bleach with 49 parts of water) immediately

4. Effectiveness of Wearing Mask in preventing SARS

- A case control study has just been completed to assess the effectiveness of "droplets precautions" for SARS.
- This was conducted in 5 HA hospitals where definite index patients were cared for (excluding the case with the use of nebulizers).
- A total of 12 staff were identified with SARS after contact with an index patient.
- Exposed but non-infected staff in these wards were also surveyed and used as controls.
- They were surveyed on their use of mask, gloves, gowns as recommended in "droplets precautions". A total of 160 controls have been analysed.
- The result is very clear. All three items: mask, gloves and gowns, and especially the use of mask (surgical mask or N95) show highly significant protection for staff.

5. Proposed Treatment Regimen:

- **Broad spectrum antibiotics** should be given to cover the usual pathogens of community-acquired pneumonia:

Either
- Augmentin plus (Clarithromycin or Azithromycin)

Or
- Levofloxacin alone

The intravenous route is preferable for severe cases

- **Corticosteroids:** Current experience indicates that it can control fever in one to two days and improves general well being. There is no clear observation that it can change the course of disease

Suggested regimen:
- Hydrocortisone 2mg/kg q6h iv or 4mg/kg q8h iv, tail off over one week when there is clear clinical improvement
- For severe cases consider Methylprednisolone 10mg/kg q24h iv for 2 days, then continue with hydrocortisone as above

- Ribavirin: This drug shows good in-vitro broad-spectrum antiviral activity. The use of this drug alone in a few cases of SARS was not associated with improvement. There is as yet no evidence that addition to systemic steroids confer beneficial effects on the course of disease

Suggested regimen:
- Ribavirin 8mg/kg q8h iv for 7-10 days

Notable side effects of Ribavirin are haemolytic anaemia and bone marrow suppression. It is contraindicated in pregnancy.

- **Amantadine and Oseltamivir is not recommended**

6. What if staff develop influenza-like illness?

- Staff feeling unwell should seek medical advice, e.g. attending the staff clinic.
- Based on severity of symptoms, sick leave would be granted on an individual basis.
- Staff with mild respiratory symptoms should put on a surgical mask when attending to patients.

7. Other sources of information:

7.1 PWH Guidelines:

- Interim guidelines for infection control procedures for special areas requiring upgraded droplet precautions
- Interim guideline for infection control procedures in areas which do not require upgraded droplet precautions
- Use of mask - respiratory outbreak PWH

7.2 DH guideline: Health Advice on the Prevention of Respiratory Tract Infection in Public Places.

Appendix I

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When to refer

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OR

(II) Fever more than 38° Celsius and new onset of pulmonary infiltrate and either shortness of breath or cough and patient has been exposed to patients with pneumonia in the previous 7 days

Department of Health

17 March 2003

Appendix II

Reporting Procedure for SARS Registry, HA

A duty officer is appointed in all hospitals which admit patients from A&E. The officer should either be a respiratory physician or infectious disease physician (Annex I). He/She (or designate) shall screen admissions from the A&E on a daily basis. When cases satisfying the inclusion and exclusion criteria are found, the patient data shall be entered into a standard form (annex II) and sent to a receiving point by fax or email, as follows:

		Fax No.
PWH, AHNH, NDH	Dr. Louis Chan	(2636 0008)
KWH, CMC, WTSH	Dr. Melissa Ho	(2781 5427)
PMH, YCH	Ms. Adela Lai	(2990 1058)
PYNEH, RH	Dr. Raymond Yung	(2515 9657)
TMH	Dr. T L Que	(2463 2565)
UCH, HOHH, TKOH	Dr. Raymond Lai	(2772 0917)
QEH, KH	Ms. Clara Yip	(2782 6385)
QMH, GH	Ms. Patricia Ching	(2855 3805)

The collected information will be passed on to HA SARS Coordination Section (Fax Number:2194 6045, or HA intranet email address: HA SARS)

A flow chart is at Annex III .

Reporting of severe CAP cases (requiring ICU/HDU care or mechanical ventilation) is ended with immediate effect.

Annex I of Appendix II

Reporting Procedure for SARS Registry, HA

List of Duty Chest Physician

Hospital	Name	Rank
HKW	KEN TSANG WONG POON CHU	Asso. Prof Medicine, QMH Consultant, Medicine, QMH
TMH	TAM CHEUK Yin	Consultant, Medicine, TMH
KWH	WILSON YEE	SMO(M&G)
CMC	MAUREEN WONG	SMO(M&G)
WTSH	Dr Y C CHAN	COS, TB&Chest Unit
PMH	YEUNG YIU CHEONG	MO(M&G)
YCH	KONG FOOK YIP	SMO, Medicine
QEH	JOHNLY CHAN WAI MAN	SMO
NDH	WONG KWAN KEUNG	COS, Medicine
AHNH	CHAN HOK SUM	COS, Medicine
PYNEH	CHEUNG MAN TAT	SMO, Medicine
RH	LAM CHUK WAH	Consultant, Respiratory & Medicine
UCH	CHU CHUNG MING	SMO, M&G
HHH	K S CHAN	COS, Pulmonary & Palliative Care
TKOH	P Y TSE	SMO(Medicine)
KH	THOMAS MOK YUNG WING	Consultant, Respiratory & Medicine
PWH	DAVID HUI	Asso Prof, M&T, PWH

Annex II to Appendix II

SARS Reporting Form, Hospital Authority

To be completed by chest physician, infectious disease physician or ICU physician

CONFIDENTIAL

Case Definition of SARS (Revision date: 22/3/2003)
Inclusion:
4. Presence of new radiological infiltrates compatible with pneumonia, and
5. Fever ≥38°C, or history of such any time in the last 2 days, and
6. At least 2 of the following:
   a. Chills any time in the last 2 days
   b. New or increased cough
   c. General malaise
   d. Typical physical signs of consolidation

If no known history of exposure, consider exclusion if presence of any one of:
4. Leucocytosis on admission
5. CXR show lobar consolidation
6. The pathogen is already known

How to report?
(i) Input data directly into the HA SARS Registry (for those with program installed), or
(ii) Complete this form & fax to 28815848

From: _____ Hospital Date of Report: _____
(dd/mm/yy)

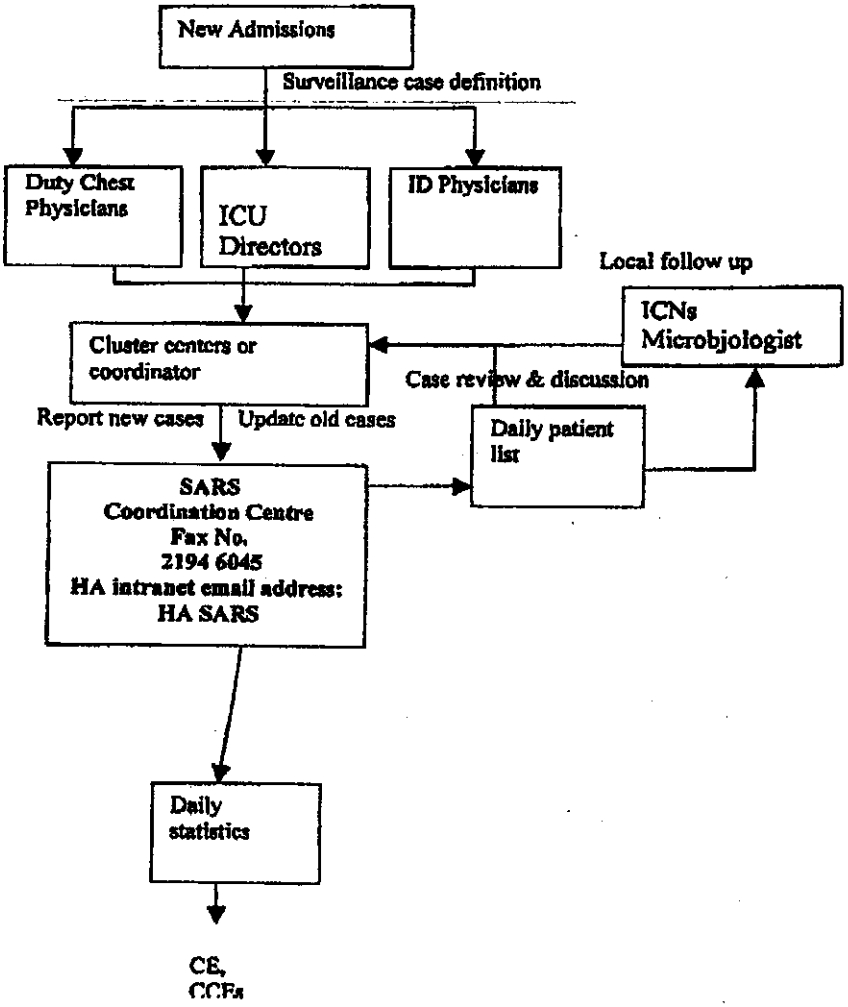
(No need to enter if gum label is available)	Affix Gum Label
HKID / Passport no.	
Sex Age	
Date of Admission	

Circle the correct choice(s), select more than one if indicated.

Date of onset:	Symptom:	Fever ≥38°C:
History of Contact with probable SARS:	Yes / No Source: _____ _____ _____ *Surname* *Full Name* *HKID (if available)* Place of contact: Exposure date: Nature of contact:	
Does any family member or close contact has symptom?	Yes / No. Specify:	
History of Travel outside HK within 30 days of onset of symptoms:	Yes / No Destination city: Date(s):	
Occupation	Healthcare worker (Doctor / Nurse / Allied Health / HCA /Lab staff / Other: _____) Non-healthcare worker:	
Daytime address (if different from home, e.g. company, school, old age home, etc.)	Institute/Building: District:	
Underlying chronic disease	Yes / No	
On admission: Overall condition	Stable / Respiratory distress / ICU	
On admission: Body temperature	℃	
On admission: CXR		
Condition on report day	Discharged / Stable / Respiratory distress / ICU / Died	
Any other relevant information		

Annex III to Appendix II

Flowchart on the Reporting of Severe Acute Respiratory Syndrome (SARS)



Interim guidelines for infection control procedures for special areas requiring upgraded droplet precautions:

A&E Dept., O Room, ICU, paediatric areas with outbreak cases & other upgraded droplet precaution areas, PWH.

(Reviewed 19th March, 2003)

1. Handwashing- wash hands promptly and thoroughly with hand antiseptic (e.g. Hibiscrub) after patient handlings, and especially after contact with blood, body fluids, secretion and excretions. Alcoholic hand-rub can be use where handwashing is not readily available..
2. Gloves - put on disposable gloves (e.g. latex gloves) for all patient contacts, and wash hands upon removal of gloves.
3. Masks - staff should properly apply N95 respirator (reusable) covering both nose and mouth (Refer to guideline on use of N95 mask), patients should wear surgical masks where situations allow.
4. Gowns and protective apparel - staff should wear gowns during the care of patients. They are removed upon leaving the ward/room area.
5. Goggles / eye protection – avoid aerosol generating procedures whenever feasible. Goggles / eye protection should be worn for aerosol generating procedures (e.g. intubation, suction), and for procedures likely to generate splashes of blood, body fluids, secretions or excretions. Disinfect with hypochlorite solution diluted 1:50 (1000 PPM) for 15 min. after use.
6. Patient care equipment - contaminated, reusable items should go through proper disinfection / sterilization procedures before recirculation for communal use.
7. Disposal of potentially infected items:
   A/ Linen/Laundry- treat all used linens as potentially infectious according to hospital guidelines.
   B/ Urinal & bedpan- urine and faeces should be carefully poured into sewage. Wash and disinfect containers using Bedpan Disinfector (80 – 85°C) or disinfect by immersing in hypochlorite solution of (1000ppm) dilution for at least 15 mins.
8. Waste handling- in addition to the hospital current clinical waste management protocol, all wastes arising from patient diagnosis and treatment, dressing & swabs, items contaminated with patients' secretions & excretions should be placed in red bags with white tag for special treatment.
9. Specimen handling- apply Universal Precautions, and follow existing practices
10. Environment- routine cleansing procedures (at least daily) by using hypochlorite solution of 1000ppm dilution.
11. Visitors- restrict visitors whenever possible, offer N95 masks, gloves and gowns to visitors who absolutely need to go into the ward/room. Discourage close contact of visitors with patients.
12. Disposal of dead bodies – treated as Category 2 (yellow label) with upgraded droplet precautions .

Interim guideline for infection control procedures in areas which do not require upgraded droplet precautions*
(Reviewed 19th March, 2003)

The following measures are recommended for the care of all patients;

- Masking
  - All staff should wear a surgical mask / N95 (reusable) mask
  - For visitors and patients requesting provision of masks in ward areas, surgical masks should be provided
- Handwashing
  - Before and after patient contact, and after removing gloves
- Wear gloves
  - Before touching blood, body fluids, secretions, excretions & contaminated items
- Wear gown
  - During procedures likely to generate splashes or sprays of blood & body fluids.
- Linen and clinical waste
  - Follow current hospital protocol
- For patients with high fever and chills, rigors or myalgia or signs and symptoms of pneumonia
  - Place patient in single isolation room or cohort patients
  - Follow the infection control guidelines for special areas requiring upgraded droplet precautions

*All PWH areas except; ICU, paediatric areas with outbreak cases, Observation Ward, A&E Department and other upgraded droplet precaution areas

Infection Control Unit, PWH. 19th March, 2003.

Use of masks – SARS outbreak PWH
(Reviewed 21st March, 2003)

- N95 masks are recommended for the screening clinic, ICU, and other SARS isolation areas
- Surgical masks are recommended for other areas of the hospital
- Each mask should be used by one person only
- Masks should not be removed from the hospital environment

For N95 masks:

- Staff should perform a fit check before each use to ensure proper sealing of face and mouth
  - Place both hands over the mask and exhale vigorously
  - If air leaks around nose, adjust the nosepiece
  - If air leaks at mask edges, reposition the straps for a better fit
  - Recheck
- Each person should store their mask e.g. in a paper bag, when not in use
- Dispose used mask when it becomes soiled or physically damaged, otherwise, no later than 30 days after first use.

Infection Control Unit, PWH. 21st March, 2003.

Health Advice on the Prevention of Respiratory Tract Infections in Public Places

Members of the public are advised to avoid frequenting crowded public places to prevent the spread of respiratory tract infections. When visiting crowded places such as cinemas and restaurants, the following precautionary measures should be taken :

- Maintain good personal hygiene. Cover nose and mouth when sneezing or coughing.
- Dispose of used tissue paper properly
- Keep hands clean. Wash hands when they are dirtied by respiratory secretions e.g. after sneezing
- Do not share towels
- Consult your doctor promptly if you develop respiratory symptoms, and follow instructions given by your doctor including the use of drugs as prescribed and adequate rest as appropriate
- Patients should put on masks to reduce the chance of spread of infection

Workers in public places should take the following precautionary measures to reduce the chance of spread of infection :

- Maintain good personal hygiene. Cover nose and mouth when sneezing or coughing
- Wash hands after sneezing, coughing or cleaning the nose
- Consult your doctor promptly if you develop respiratory symptoms
- Allow plenty of fresh air into the indoor environment
- If the facilities are mechanically ventilated, ensure frequent air exchanges and proper maintenance and cleansing of the system
- Ensure that toilet flushing apparatus is functioning properly
- Provide toilets with liquid soap and disposable tissue towels or hand dryers
- Cleanse and disinfect the facilities (including furniture and toilet facilities) regularly (at least once a day), using diluted household bleach (i.e. adding 1 part of household bleach to 99 parts of water), rinse with water and then mop dry
- If the facilities are contaminated with vomitus, wash / wipe with diluted domestic bleach (mixing 1 part of bleach with 49 parts of water) immediately

Department of Health
17 March 2003

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Version Date : 29.3.03

HA Guideline on the Management of *Severe Respiratory Syndrome (SRS)*

(Note: Name of the Syndrome has been renamed as Severe Respiratory Syndrome wef 26 March 2003)

(This guideline should be read by HA staff)

Revised *27 March, 2003 (changes are marked in Italic)*

1. Case definition:

1.1 In hospitals, cases of pneumonia would be screened according to HA Surveillance case definition (as below), such cases are defined as probable *SRS*.

Case Definition of SRS (Revised date *27/3/2003*)
Inclusion: 1. Presence of new radiological infiltrates compatible with pneumonia, and 2. Fever ≥ 38°C, or history of such any time in the last 2 days, and 3. At least 2 of the following: a. Chills any time in the last 2 days b. New or increased cough c. General malaise d. Typical physical signs of consolidation e. *Known history of exposure* If no know history of exposure, consider exclusion if presence of any one of the following: *1. XR show lobar consolidation* *2. The pathogen is already known*

1.2 Department of Health has issued clinical protocol for general practitioners in the management of pneumonia, and suspected *SRS* cases would be referred to hospitals for further investigation and management (Appendix I).

2. Reporting Procedure :

- A *SRS* Coordination Centre has been set up at HAHO with the following designation:

Telephone number: 2300 7890 Fax number: 2194 6045 HA intranet email address: HA SARS ***(for convenience sake, original name of the mailbox is retained)***

- The centre opens from 9:00am - 5:00pm daily until further notice.
- The detail reporting procedure is at Appendix II.

3. Infection Control Measures

3.1. For *SRS* patients:

- The main mode of transmission of SRS, based on epidemiological analysis and initial evidence of the virus isolated, is by droplets and direct contact with patient's secretions and subsequent inoculation into mucous membranes e.g. conjunctiva, oral mucosa etc.,
- The recommended infection control measures is, therefore, droplets precautions with emphasis on the use of barrier apparels and environmental cleaning, in addition to Universal Precautions.
- Staff are also reminded of the importance of handwashing, and the strict avoidance of touching or scratching of eyes, nose and mouth with hands.
- SRS patients should be nursed in a room with other SRS patient(s) (cohorting) but maintaining separation of at least 3 feet from each other.

- Put on barrier apparels (mask, goggles, gloves and gowns) when attending to SRS patients.
- Staff should wear a surgical/N95 mask properly (see Guideline on its use) and wash hands after touching the external surface of the mask.
- Wash hands after removal of gloves and before nursing another patient.
- Proper and frequent (at least daily) disinfection of ward environment and equipment with hypochlorite solution (1000 ppm) is important.
- Staff and patients with respiratory symptoms should put on a surgical mask.
- Treatment with neubuliser should be avoided in patients with fever and chest XR infiltrates.

- *Visit to SRS patients is not allowed. This is needed because of the risk of spreading the infection to visitors who might then subsequently spread the infection to their household members and members of the public in the community. (Notice has been disseminated to the public via the HA internet website. To download the notice, please click the desired language as appropriate (English) (Chinese). The information is also available for download from the Severe Respiratory Syndrome webpage in HA Intranet)*
- *Only under very exceptional circumstances should visit to SRS patients be allowed. Visitors should take full barrier precautions (surgical mask, gown, gloves) and hand washing / disinfection when leaving the area. The visit should also be short, preferably no longer than 15 minutes, and the details of the visitors and the timing should be documented.*
- *Use of chlorhexidine alcoholic handrub (e.g. Hexol) should be encouraged, in addition to frequent hand washing.*

3.2. For all other Non-SRS patients, including those in the OPD or AED:

- Staff are also reminded of the importance of handwashing, and the strict avoidance of touching or scratching of eyes, nose and mouth with hands.
- Put on a surgical / N95 mask when attending patients.
- Wear gloves before touching blood, body fluids or secretions / excretions.
- Wear gown during procedures likely to generate splashes or sprays of blood and body fluids.
- Staff should wear a surgical/N95 mask properly (see Guideline on its use) and wash hands after touching the external surface of the mask.
- Wash hands after removal of gloves and before nursing another patient.
- Proper and frequent disinfection of ward environment and equipment with hypochlorite solution (1000 ppm) is important.
- Visitors should be restricted. They should be advised to put on a surgical mask. They should be advised to wash their hands when leaving the ward.
- Staff and patients with respiratory symptoms should put on a surgical mask.
- Use of chlorhexidine alcoholic handrub (e.g. Hexol) should be encouraged, in addition to frequent hand washing.

3.3. Infection Control measures at home for all staff caring for *SRS* patients / contacts of *SRS* patients or *SRS* patients discharged from hospital [*To download information under this section for dissemination, please click the desired language as appropriate: (English) (Chinese)]*

- Frequent handwashing with liquid soap rather than bar soap, especially after contact with nose, mouth and respiratory secretions, e.g. after sneezing.

- Family members should practice handwashing frequently, and avoid touching the eyes, nose and mouth with their hands.
- Put on a surgical mask.
- Avoid close contact with family members (e.g. mucosal contact).
- Avoid sharing food and utensils with family members.
- *Shower immediately after work (for staff caring for patients with Severe Respiratory Syndrome).*
- *Cleanse and disinfect the facilities (including furniture and toilet facilities) regularly (at least once a day), using diluted household bleach (i.e. adding 1 part of household bleach to 99 parts of water), rinse with water and then mop dry.*
- *If the facilities are contaminated with vomitus or body secretions, wash / wipe with diluted domestic bleach (mixing 1 part of bleach with 49 parts of water) immediately.*
- *These precautionary measures should be adopted for 1 week from the latest contact with patient with Severe Respiratory Syndrome, and for 3 weeks for discharged patients with Severe Respiratory Syndrome.*

4. ***Guideline on discharge of patients recovering from SARS:***

- *According to WHO, a convalescent case who is medically fit for discharge should be:*
  - *Afebrile for 48 hours;*
  - *No cough;*
  - *White cell (lymphocyte) count returning to normal*
  - *Platelet count returning to normal*
  - *Creatinine phosphokinase returning to normal*
  - *Liver function tests returning to normal*
  - *Improving chest x-ray changes*
- *Since the potential for continued viral shedding during convalescence is still being investigated, a cautious approach is adopted in discharging SARS patients. They should be cohorted in hospital during convalescence for up to 3 weeks from onset of illness, or at least 7 days since convalescence (defined above), whichever longer.*
- *SARS patients should be asked to report to AED promptly should they experience any fever or return of symptoms after discharge.*

5. **Effectiveness of Wearing Mask in preventing *SRS***

- A case control study has just been completed to assess the effectiveness of "droplets precautions" for *SRS*.
- This was conducted in 5 HA hospitals where definite index patients were cared for (excluding the case with the use of nebulizers).
- A total of 12 staff were identified with *SRS* after contact with an index patient.
- Exposed but non-infected staff in these wards were also surveyed and used as controls.
- They were surveyed on their use of mask, gloves, gowns as recommended in "droplets precautions". A total of 160 controls have been analysed.
- The result is very clear. All three items: mask, gloves and gowns, and especially the use of mask (surgical mask or N95) show highly significant protection for staff.

6. **Proposed Treatment Regimen:**

- **Broad spectrum antibiotics** should be given to cover the usual pathogens of community-acquired pneumonia:
  Either
  - Augmentin plus (Clarithromycin or Azithromycin)
  Or
  - Levofloxacin alone
  The intravenous route is preferable for severe cases

- **Corticosteroids:** Current experience indicates that it can control fever in one to two days and improves general well being. There is no clear observation that it can change the course of disease.

  Suggested regimen:
  - Hydrocortisone 2mg/kg q6h iv or 4mg /kg q8h iv, tail off over one week when there is clear clinical improvement
  - For severe cases consider Methylprednisolone 10mg/kg q24h iv for 2 days, then continue with hydrocortisone as above

- **Ribavirin**: This drug shows good in-vitro broad-spectrum antiviral activity. The use of this drug alone in a few cases of *SRS* was not associated with improvement. There is as yet no evidence that addition to systemic steroids confer beneficial effects on the course of disease

  Suggested regimen:
  - Ribavirin 8mg/kg q8h iv for 7-10 days

  Notable side effects of Ribavirin are haemolytic anaemia and bone marrow suppression. It is contraindicated in pregnancy.

- **Amantadine and Oseltamivir is not recommended**

7. **What if staff develop influenza-like illness?**

- Staff feeling unwell should seek medical advice, e.g. attending the staff clinic.
- Based on severity of symptoms, sick leave would be granted on an individual basis.
- Staff with mild respiratory symptoms should put on a surgical mask when attending to patients.

8. **Other sources of information:**

8.1 PWH Guidelines:

- Interim guidelines for infection control procedures for special areas requiring upgraded droplet precautions
- Interim guideline for infection control procedures in areas which do not require upgraded droplet precautions
- Use of mask - respiratory outbreak PWH

8.2 DH guideline: Health Advice on the Prevention of Respiratory Tract Infection in Public Places.

Appendix I

Guidelines to Primary Care Physicians / Family Physicians on the management of cases of suspected Severe Acute Respiratory Syndrome (*SRS*)

In accordance with World Health Organization, symptoms and signs of *SRS* include –

- high fever (>38°C) AND
- one or more respiratory symptoms including cough, shortness of breath, difficulty breathing AND
- close contact* with a person who has been diagnosed with *SRS*

*close contact means having cared for, having lived with, or having had direct contact with respiratory secretions and body fluids of a person with *SRS*.

In addition to fever and respiratory symptoms, *SRS* may be associated with other symptoms including: headache, muscular stiffness, loss of appetite, malaise, confusion, rash, and diarrhea.

When to refer

Doctors are advised to refer patients with the following conditions to hospital for further management –

(I) Fever more than 38° Celsius and new onset of pulmonary infiltrate and either shortness of breath or cough and no symptomatic response to standard therapy including a beta-lactam (penicillin & cephalosporin groups) and coverage for atypical pneumonia (a fluoroquinolone, tetracyclines, or a macrolide) after 2 days of therapy in terms of fever and general well being

OR

(II) Fever more than 38° Celsius and new onset of pulmonary infiltrate and either shortness of breath or cough and patient has been exposed to patients with pneumonia in the previous 7 days

Department of Health

17 March 2003

Appendix II

Reporting Procedure for SRS Registry, HA

A duty officer is appointed in all hospitals which admit patients from A&E. The officer should either be a respiratory physician or infectious disease physician (Annex I). He/She (or designate) shall screen admissions from the A&E on a daily basis. When cases satisfying the inclusion and exclusion criteria are found, the patient data shall be entered into a standard form (Annex II) and sent to a receiving point by fax or email, as follows:

		Fax No.
PWH, AHNH, NDH	Dr. Louis Chan	(2636 0008)
KWH, CMC, WTSH	Dr. Melissa Ho	(2781 5427)
PMH, YCH	Ms. Adela Lai	(2990 1058)
PYNEH, RH	Dr. Raymond Yung	(2515 9657)
TMH	Dr. T L Que	(2463 2565)
UCH, HOHH, TKOH	Dr. Raymond Lai	(2772 0917)
QEH, KH	Ms. Clara Yip	(2782 6385)
QMH, GH	Ms. Patricia Ching	(2855 3805)

The collected information will be passed on to HA *SRS* Coordination Section (Fax Number:2194 6045, or HA intranet email address: HA *SRS*)

A flow chart is at Annex III .

Reporting of severe CAP cases (requiring ICU/HDU care or mechanical ventilation) is ended with immediate effect.

Annex I to Appendix II

Contact List of Respiratory doctors

Hospital	Name of doctors	Title
HKW	KEN TSANG WONG POON CHU	Asso. Prof Medicine, QMH Consultant, Medicine, QMH
TMH	TAM CHEUK Yin	Consultant, Medicine, TMH
KWH	WILSON YEE	SMO(M&G)
CMC	MAUREEN WONG	SMO(M&G)
WTSH	Y C CHAN	COS, TB&Chest Unit
PMH	YEUNG YIU CHEONG	MO(M&G)
YCH	KONG FOOK YIP	SMO, Medicine
QEH	JOHNLY CHAN WAI MAN	SMO, Medicine
NDH	WONG KWAN KEUNG	COS, Medicine
AHNH	CHAN HOK SUM	COS, Medicine
PYNEH	CHEUNG MAN TAT	SMO, Medicine
RH	LAM CHUK WAH	Consultant, Respiratory & Medicine
UCH	CHU CHUNG MING	SMO, M&G
HHH	K S CHAN	COS, Pulmonary & Palliative Care
TKOH	P Y TSE	SMO(Medicine)
KH	THOMAS MOK YUNG WING	Consultant, Respiratory & Medicine
PWH	DAVID HUI	Asso Prof, M&T, PWH

090054

Click here for the latest version (Revision 5 - effective 29/03/03)

Annex II to Appendix II

SRS Reporting Form, Hospital Authority (Revision 4, Effective date: 27/3/2003)

CONFIDENTIAL

To be completed by chest physician, infectious disease physician or ICU physician

Case Definition of *SRS* (Revision date: 27/3/2003)

Inclusion:

1. Presence of new radiological infiltrates compatible with pneumonia, **and**
2. Fever ≥38°C, or history of such any time in the last 2 days, **and**
3. At least 2 of the following:
   a. Chills any time in the last 2 days
   b. New or increased cough
   c. General malaise
   d. Typical physical signs of consolidation
   e. Known history of exposure

If **no known history of exposure**, consider exclusion if presence of **any one of**:

1. CXR show lobar consolidation
2. The pathogen is already known

(i) Input data directly into the HA SRS Registry (for those with program installed), or
(ii) Complete this form & fax to your cluster coordinator and to HAHO 2194 6045

From: _____ Hospital Date of Report: _____ *(dd/mm/yy)*

(No need to enter if gum label is available)	Affix **FULL** Gum Label
HKID / Passport no.	
Sex Age	
Date of Admission	

Circle the correct choice(s), select more than one if indicated.

Date of onset of symptom:		Date of onset of fever ≥38°C:
History of Contact with probable SRS:		Yes / No Source: _____ _____ *Surname* *Full Name* *HKID (if available)* Place of contact: Exposure date: Nature of contact:
Does any family member or close contact has symptom?		Yes / No. Specify:
History of Travel outside HK within 30 days of onset of symptoms:		Yes / No Destination city: Date(s):
Occupation		Healthcare worker (Doctor / Nurse / Allied Health / HCA /Lab staff / Medical student/ Other: _____) Non-healthcare worker (specify):
Home address (if not provided in gum label)		Bldg/Estate/Street: District:
Daytime address (if different from home, e.g. company, school, old age home, etc.)		Institute/Bldg/School etc: Tel: District:
Underlying chronic disease		Yes / No
Data on admission	Condition	Stable / Respiratory distress / ICU
	Body temperature	°C
	CXR (e.g. LLZ haziness)	
Condition on report day		Discharged / Stable/ Respiratory distress / ICU/ Died / Transferred to other hospital / Not SRS
Any other relevant information		

Annex III to Appendix II

Flowchart on the Reporting of
Severe Acute Respiratory Syndrome (*SRS*)