

DOE - SEVERE ACUTE RESPIRATORY SYNDROME (SARS) WEEKLY UPDATE – WEDNESDAY, JULY 02, 2003

I have been monitoring the SARS situation and provide the following information that is current as of **Thursday, July 03, 2003**, 0800 hours, EDT. Information presented is routinely taken from the Centers for Disease Control and Prevention (CDC), <http://www.cdc.gov/ncidod/sars/index.htm>, The World Health Organization (WHO), <http://www.who.int/csr/sars/en/>, the Department of Defense Global Emerging Infections Surveillance and Response System site, (DoD-GEIS)-<http://www.geis.ha.osd.mil/>, and other creditable sources. You will find the most current information in this document up-front.

WHO - Update on cases¹ and countries: As of 2 July 2003, 17:00 GMT+2, a cumulative total of 8442 probable SARS cases with 812 deaths (9.619% mortality, see charts and map, pp. 4-5) has been reported from 29 countries. **Since the last weekly update of June 25, 2003, there have been two additional cases and four new deaths.** - [Cumulative number of reported probable cases - 2 July](#).

CDC – Case Update: Information is from data reported to the World Health Organization on July 1, 2003, <http://www.cdc.gov/od/oc/media/sars/cases.htm>. In the United States, a total of 420 SARS cases have been reported from 43 states and Puerto Rico, with 347 (82.62%) cases classified as suspect SARS and 73 (17.38%) classified as probable SARS².

Recent news

WHO has today removed Toronto, Canada, from its list of areas with recent local transmission of SARS. For additional information on this topic, see the [WHO Update 92 – Chronology of travel recommendations, areas with local transmission](#), (page 2-3 of this document).

WHO Update 93 – Toronto removed from list of areas with recent local transmission

2July2003 - [Update 93 – Toronto removed from list of areas with recent local transmission - 2 July](#)

WHO has today removed Toronto, Canada, from its list of areas with recent local transmission of SARS. The last probable case was detected on 12 June and immediately isolated. When 20 days, or twice the incubation period, have passed without detection of a new case, the chain of human-to-human transmission is considered broken. “This is a great achievement for public health in what we hope is the final phase of the global emergency,” said David Heymann, the WHO Executive Director for communicable diseases. “Toronto faced an especially challenging outbreak. As we have learned, SARS is a difficult disease that produces many surprises and setbacks.” “We should all pay tribute to the health workers and others in Canada who had their lives disrupted and threatened by this disease. When the virus returned to start a second outbreak, health workers continued the fight and have now won it. We also need to remember the commitment of Canada’s scientists, who rapidly provided information about the virus and its epidemiology that has benefited public health around the world.” Toronto was among the first areas affected after the virus moved out of southern China, in late February, and began to spread internationally. WHO advised travellers to avoid all but essential travel to Toronto on 23 April. The advice was lifted a week later. On 14 May, Toronto was removed from the list of areas with recent local transmission, only to return on 26

¹ Note: The Cumulative number of cases includes number of deaths. As SARS is a diagnosis of exclusion, the status of a reported case may change over time. **This means that previously reported cases may be discarded after further investigation and follow-up.**

² **CDC.** Refer to case definition for description of suspect and probable cases and laboratory criteria for SARS-associated coronavirus (SARS-CoV) infection - <http://www.cdc.gov/ncidod/sars/casedefinition.htm>.

May after the virus surfaced in a second outbreak. All of the earliest and most severe SARS outbreaks have been traced to contact with an infected medical doctor from Guangdong Province, China, who spent a single night (21 February) on the 9th floor of the Metropole Hotel in Hong Kong. At least 16 guests and visitors to the same floor became infected. One has been identified as the source case, at the Princes of Wales Hospital, for the Hong Kong outbreak. Others, who carried the virus with them when they returned home, seeded outbreaks in Toronto, Viet Nam, and Singapore. The mechanisms by which the virus spread from one infected person to so many guests and visitors are still not fully understood. No hotel staff were infected. Another mystery is why the SARS virus spreads more efficiently in sophisticated hospital settings – another factor that may have contributed to the severity of Toronto's outbreak. Both epidemiological and anecdotal evidence suggests that certain procedures, such as difficult intubation and use of nebulizers, that are more common in sophisticated hospitals also increase the risk of infection. When the outbreak began in Toronto and, simultaneously, at the other initial sites, no one was yet aware that a new disease, capable of rapid spread within hospitals, had surfaced in China. Hospital staff, struggling to save lives, were unaware of the need to protect themselves. As a result, the SARS virus spread rapidly within hospitals and then out into the wider community as other patients, hospital visitors, and close contacts of staff became infected. After WHO issued the first global alert to SARS, on 12 March, all countries experiencing imported cases, with the notable exception of Taiwan, have been able to either prevent any further cases or keep the number of additional cases very small. With today's change in the status of Toronto, Taiwan now remains the last area in the world to have experienced recent local transmission of SARS.

WHO Update 92 – Chronology of travel recommendations, areas with local transmission

1 July 2003 - [Update 92 – Chronology of travel recommendations, areas with local transmission - 1 July](#)

If no unexpected events occur, the last two areas in the world – Toronto and Taiwan – to have experienced local transmission of SARS will be declared later this week to have broken the chain of person-to-person transmission. This achievement will mean that the SARS coronavirus is no longer thought to be circulating in the human population. From the outset, WHO's objective in combating SARS has been to seal off opportunities for the disease to become established in its new human host. Interruption of human transmission will be a milestone on the way to achieving this goal. However, scientists cannot at present guarantee that SARS has been vanquished, as questions remain about the origins of the virus and its possible seasonal occurrence. In addition, transmission may be occurring somewhere in the world at such a low level as to defy detection. In line with the WHO objective, recommendations to postpone travel to designated areas were periodically issued. Evidence that SARS was being exported from areas with local transmission was of particular concern, as this contributed to further international spread and created a heavy burden in terms of isolation and infection control, contact tracing, and quarantine. The list of areas with recent local transmission was initially developed to support the case definitions of suspect and probable cases, as both definitions depend on a history of close contact with a SARS patient. Application of the case definitions required knowledge of areas where the virus was spreading. Inclusion on the list also provided the basis for recommended exit screening of all departing passengers as a measure for preventing further international spread. The chronology below provides a record of travel recommendations issued by WHO and of changes in the status of local transmission.

Background:

12 March: WHO issues first global alert to cases of atypical pneumonia rapidly spreading among hospital staff.

15 March: WHO issues first emergency travel advisory, calling on all travellers to be aware of the main symptoms and signs of SARS. The disease appears to be spreading along the routes of international air travel.

24 March: Hong Kong officials report 9 cases of atypical pneumonia among members of a tour group that travelled together on two flights, raising the possibility of in-flight transmission.

Subsequent investigations revealed that one infected passenger, on a 15 March flight from Hong Kong to Beijing, may have infected 22 fellow passengers and 2 flight attendants.

25 March: WHO reminds travellers to remain alert, but sees no need for travel restrictions to any destinations. Most new cases are being quickly identified and immediately isolated, thus reducing opportunities for transmission outside confined areas, such as the health care setting.

27 March: WHO recommends exit screening of air passengers departing from areas where transmission is known to be occurring in local chains. No cases of suspected in-flight transmission are reported following this date.

31 March: A large cluster of almost simultaneous cases, linked to the Amoy Gardens housing estate in Hong Kong, raises the possibility of an environmental source of infection and provides strong evidence that SARS has moved out of the hospital setting and into the community at large. In addition, several areas link their first imported cases to a history of travel in Guangdong or Hong Kong. These events set the stage for the first travel recommendations.

[Travel recommendations \(postpone all but essential travel\)](#)

2 April: Issued for Hong Kong and Guangdong Province, China.

23 April: Issued for Beijing and Shanxi Province, China, and for Toronto, Canada.

30 April: Lifted for Toronto.

8 May: Issued for Tianjin and Inner Mongolia, China, and Taipei, Taiwan.

17 May: Issued for Hebei Province, China.

21 May: Issued for all of Taiwan.

23 May: Lifted for Hong Kong and Guangdong Province,

13 June: Lifted for Hebei, Inner Mongolia, Shanxi, and Tianjin provinces, China.

17 June: Lifted for Taiwan

24 June Lifted for Beijing – the last area on the list.

[Changes in the list of areas with recent local transmission](#)

22 March: Initial list includes Toronto, parts of mainland China, Hong Kong, Taiwan, Singapore, and Viet Nam.

11 April: Beijing added.

28 April: Viet Nam removed – becomes first country to contain its SARS outbreak.

1 May: Mongolia added.

7 May: Philippines added.

9 May: Mongolia removed.

14 May: Toronto removed.

20 May: Philippines removed.

26 May: Toronto added for second time.

31 May: Singapore removed.

13 June: Guangdong, Hebei, Hubei, Inner Mongolia, Jilin, Jiangsu, Shaanxi, Shanxi, and Tianjin (China) removed.

23 June: Hong Kong removed.

24 June: Beijing removed.

1 July: Only Toronto and Taiwan remain on the list.

Areas with recent local transmission of SARS

02 July 2003 - http://www.who.int/csr/sars/areas/2003_07_02/en/

This table, updated daily, is provided to public health professionals and clinicians around the world to assist with the identification and reporting of SARS cases as described in the WHO case definitions.

Country	Area	Pattern of local transmission
China	Taiwan	B

Notes: Local transmission has occurred when one or more reported probable cases of SARS have most likely acquired their infection locally regardless of the setting in which this may have occurred. If no new locally acquired cases are identified 20 days after the last reported locally acquired probable case died or was appropriately isolated, the area will be removed from this list.

Pattern A Imported probable SARS case(s) have produced only one generation of local probable cases, all of whom are direct personal contacts of the imported case(s).

Pattern B: More than one generation of local probable SARS cases, but only among persons that have been previously identified and followed-up as known contacts of probable SARS cases.

Pattern C: Local probable cases occurring among persons who have not been previously identified as known contacts of probable SARS cases.

Pattern Uncertain Insufficient information available to specify areas or extent of local transmission.

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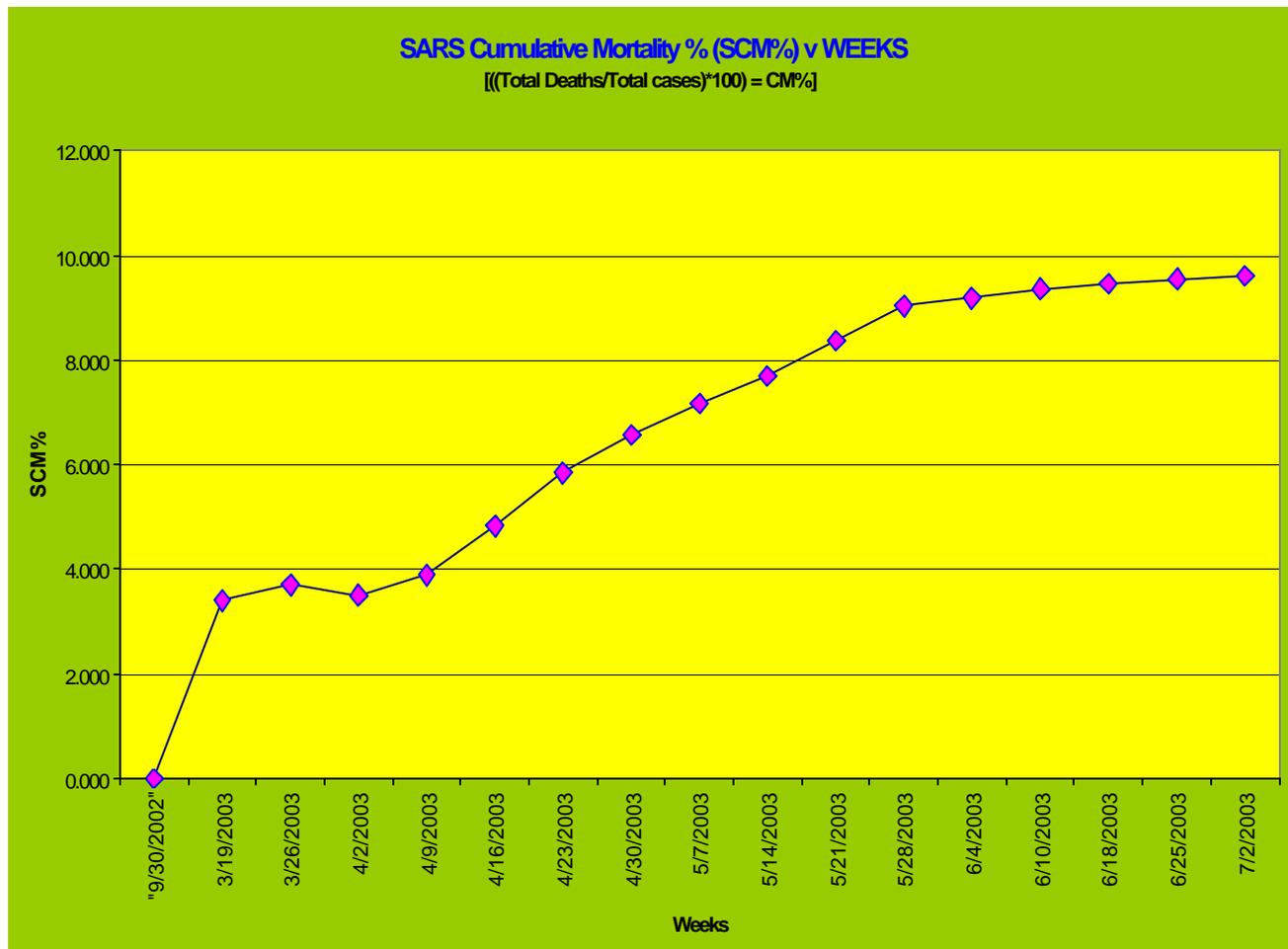
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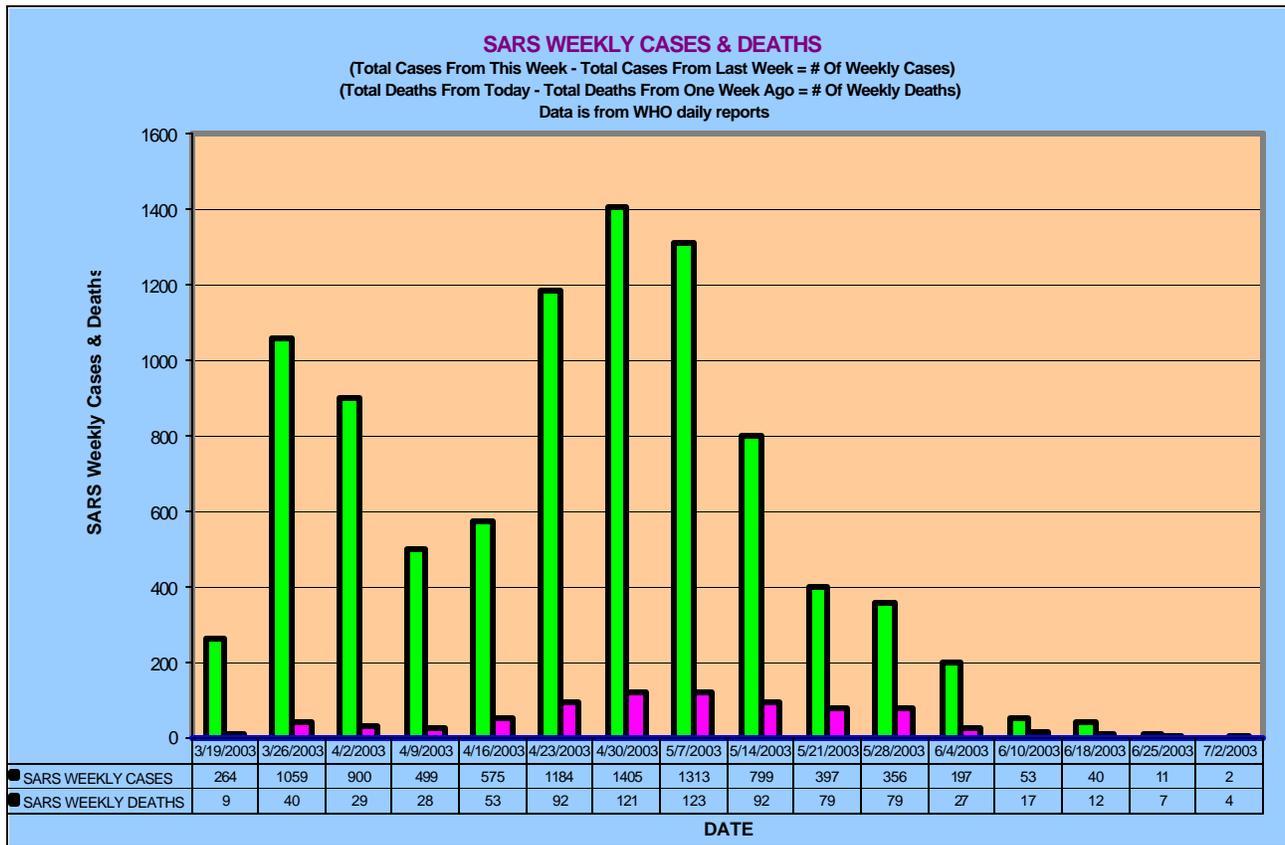
WHO - SARS Travel Recommendations Summary Table

02 July 2003 http://www.who.int/csr/sars/travel/2003_07_02/en/

This table, updated daily, indicates those areas with recent local transmission of SARS for which WHO has issued recommendations pertaining to international travel. A **travel advisory** recommends that nonessential travel be deferred; a **travel alert** does not advise against travel, but informs travelers of a health concern and provides advice about specific precautions. This table summarizes those areas of the world for which further specific measures have been recommended. [Summary of WHO measures related to international travel](#)

Country	Area	Exit screening for international travellers departing the area	Advisory - Traveller to consider postponing all but essential travel to the area
China	Taiwan	YES	NO





CDC FACT SHEET - Basic Information About SARS

June 4, 2003 - <http://www.cdc.gov/ncidod/sars/factsheet.htm>

[Español](#) | [Français](#) |

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A new disease called SARS

Severe acute respiratory syndrome (SARS) is a respiratory illness that has recently been reported in Asia, North America, and Europe. This fact sheet provides basic information about the disease and what is being done to combat its spread. To find out more about SARS, go to www.cdc.gov/ncidod/sars/ and www.who.int/csr/sars/en/. The Web sites are updated daily.

Symptoms of SARS

In general, SARS begins with a fever greater than 100.4°F [$>38.0^{\circ}\text{C}$]. Other symptoms may include headache, an overall feeling of discomfort, and body aches. Some people also experience mild respiratory symptoms. After 2 to 7 days, SARS patients may develop a dry cough and have trouble breathing.

How SARS spreads

The primary way that SARS appears to spread is by close person-to-person contact. Most cases of SARS have involved people who cared for or lived with someone with SARS, or had direct contact with infectious material (for example, respiratory secretions) from a person who has SARS. Potential ways in which SARS can be spread include touching the skin of other people or objects that are contaminated with infectious droplets and then touching your eye(s), nose, or mouth. This can happen when someone who is sick with SARS coughs or sneezes droplets onto themselves, other people, or nearby surfaces. It also is possible that SARS can be spread more broadly through the air or by other ways that are currently not known.

Who is at risk for SARS

Most of the U.S. cases of SARS have occurred among travelers returning to the United States from

other parts of the world with SARS. There have been very few cases as a result of spread to close contacts such as family members and health care workers. Currently, there is no evidence that SARS is spreading more widely in the community in the United States.

Possible cause of SARS

Scientists at CDC and other laboratories have detected a previously unrecognized coronavirus in patients with SARS. The new coronavirus is the leading hypothesis for the cause of SARS.

What CDC is doing about SARS

CDC is working closely with the World Health Organization (WHO) and other partners in a global effort to address the SARS outbreak. For its part, CDC has taken the following actions:

- * Activated its Emergency Operations Center to provide round-the-clock coordination and response.
- * Committed more than 700 medical experts and support staff to work on the SARS response.
- * Deployed medical officers, epidemiologists, and other specialists to assist with on-site investigations around the world.
- * Provided ongoing assistance to state and local health departments in investigating possible cases of SARS in the United States.
- * Conducted extensive laboratory testing of clinical specimens from SARS patients to identify the cause of the disease.
- * Initiated a system for distributing health alert notices to travelers who may have been exposed to cases of SARS.

CDC RECOMMENDATIONS

CDC has issued recommendations and guidelines for people who may be affected by this outbreak.

For individuals considering travel to areas with SARS:

CDC has issued two types of notices to travelers: advisories and alerts. A **travel advisory** recommends that nonessential travel be deferred; a **travel alert** does not advise against travel, but informs travelers of a health concern and provides advice about specific precautions. CDC updates information on its website on the travel status of other [areas with SARS](#) as the situation evolves.

For individuals who must travel to an area with SARS:

CDC advises that travelers in an area with SARS should wash their hands frequently to protect against SARS infection. In addition, CDC advises that travelers may wish to avoid close contact with large numbers of people as much as possible to minimize the possibility of infection. CDC does not recommend the routine use of masks or other personal protective equipment while in public areas.

For more information, read the Interim Guidelines about Severe Acute Respiratory Syndrome (SARS) for [Persons Traveling to Areas with SARS](#).

For individuals who think they might have SARS:

People with symptoms of SARS (fever greater than 100.4°F [$>38.0^{\circ}\text{C}$] accompanied by a cough and/or difficulty breathing) should consult a health-care provider. To help the health-care provider make a diagnosis, tell them about any recent travel to places where SARS has been reported or whether there was contact with someone who had these symptoms.

For family members caring for someone with SARS:

CDC has developed [interim infection control recommendations for patients with suspected SARS in the household](#). These basic precautions should be followed for 10 days after respiratory symptoms and fever are gone. During that time, SARS patients are asked to limit interactions outside the home (not go to work, school, or other public areas).

For health-care workers:

Transmission of SARS to health-care workers appears to have occurred after close contact with sick people before recommended infection control precautions were put into use. CDC has issued [interim infection control recommendations for health-care settings](#) as well as for the [management of exposures to SARS in health-care and other institutional settings](#).

For more information, visit [CDC's SARS Web site](#), or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY)

CDC - Frequently Asked Questions and Answers on SARS

June 10, 2003 - <http://www.cdc.gov/ncidod/sars/faq.htm>

CDC Updated Interim U.S. Case Definition of Severe Acute Respiratory Syndrome (SARS)

June 5, 2003 - [Download PDF version formatted for print](#) (344 KB/3 pages)

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

The previous CDC SARS case definition (published May 23, 2003) has been updated as follows:

- In the Epidemiologic Criteria, the last date of illness onset for inclusion as reported case for Singapore is now June 14, 2003.

Clinical Criteria

- Asymptomatic or mild respiratory illness
- Moderate respiratory illness
 - Temperature of >100.4° F (>38° C)*, and
 - One or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, or hypoxia).
- Severe respiratory illness
 - Temperature of >100.4° F (>38° C)*, and
 - One or more clinical findings of respiratory illness (e.g., cough, shortness of breath, difficulty breathing, or hypoxia), and
 - radiographic evidence of pneumonia, or
 - respiratory distress syndrome, or
 - autopsy findings consistent with pneumonia or respiratory distress syndrome without an identifiable cause.

Epidemiologic Criteria

- Travel (including transit in an airport) within 10 days of onset of symptoms to an area with current or previously documented or suspected community transmission of SARS (see Table), or
- Close contact[§] within 10 days of onset of symptoms with a person known or suspected to have SARS

Travel criteria for suspect or probable U.S. cases of SARS		
Area	First date of illness onset for inclusion as reported case†	Last date of illness onset for inclusion as reported case†
China (mainland)	November 1, 2002	Ongoing
Hong Kong	February 1, 2003	Ongoing
Hanoi, Vietnam	February 1, 2003	May 25, 2003
Singapore	February 1, 2003	June 14, 2003
Toronto, Canada	April 23, 2003	Ongoing
Taiwan	May 1, 2003	Ongoing

Laboratory Criteria

- **Confirmed**
 - Detection of antibody to SARS-CoV in specimens obtained during acute illness or >21 days after illness onset, or
 - Detection of SARS-CoV RNA by RT-PCR confirmed by a second PCR assay, by using a second aliquot of the specimen and a different set of PCR primers, or
 - Isolation of SARS-CoV.

- Negative
 - Absence of antibody to SARS-CoV in convalescent serum obtained >21 days after symptom onset.
- Undetermined
 - Laboratory testing either not performed or incomplete.

Case Classification**

- Probable case: meets the clinical criteria for severe respiratory illness of unknown etiology and epidemiologic criteria for exposure; laboratory criteria confirmed, negative, or undetermined.
- Suspect case: meets the clinical criteria for moderate respiratory illness of unknown etiology, and epidemiologic criteria for exposure; laboratory criteria confirmed, negative, or undetermined.

Exclusion Criteria

A case may be excluded as a suspect or probable SARS case if:

- An alternative diagnosis can fully explain the illness***
- The case was reported on the basis of contact with an index case that was subsequently excluded as a case of SARS (e.g., another etiology fully explains the illness) provided other possible epidemiologic exposure criteria are not present

Also see:

- [MMWR: Updated Interim Surveillance Case Definition for Severe Acute Respiratory Syndrome \(SARS\)— April 29, 2003](#)

* A measured documented temperature of >100.4° F (>38° C) is preferred. However, clinical judgment should be used when evaluating patients for whom a measured temperature of >100.4° F (>38° C) has not been documented. Factors that might be considered include patient self-report of fever, use of antipyretics, presence of immunocompromising conditions or therapies, lack of access to health care, or inability to obtain a measured temperature. Reporting authorities should consider these factors when classifying patients who do not strictly meet the clinical criteria for this case definition.

§ Close contact is defined as having cared for or lived with a person known to have SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief period of time.

‡ The WHO has specified that the surveillance period for China should begin on November 1; the first recognized cases in Hong Kong, Singapore and Hanoi (Vietnam) had onset in February 2003. The dates for Toronto and Taiwan are linked to CDC's issuance of travel recommendations.

† The last date for illness onset is 10 days (i.e., one incubation period) after removal of a CDC travel alert. The case patient's travel should have occurred on or before the last date the travel alert was in place.

¶ Assays for the laboratory diagnosis of SARS-CoV infection include enzyme-linked immunosorbent assay, indirect fluorescent-antibody assay, and reverse transcription polymerase chain reaction (RT-PCR) assays of appropriately collected clinical specimens (Source: CDC. Guidelines for collection of specimens from potential cases of SARS. Available at www.cdc.gov/ncidod/sars/specimen_collection_sars2.htm). Absence of SARS-CoV antibody from serum obtained ≤21 days after illness onset, a negative PCR test, or a negative viral culture does not exclude coronavirus infection and is not considered a definitive laboratory result. In these instances, a convalescent serum specimen obtained >21 days after illness is needed to determine infection with SARS-CoV. All SARS diagnostic assays are under evaluation.

** Asymptomatic SARS-CoV infection or clinical manifestations other than respiratory illness might be identified as more is learned about SARS-CoV infection.

*** Factors that may be considered in assigning alternate diagnoses include the strength of the epidemiologic exposure criteria for SARS, the specificity of the diagnostic test, and the compatibility of the clinical presentation and course of illness for the alternative diagnosis.

CDC - Interim Guidelines about Severe Acute Respiratory Syndrome (SARS) for Persons in the General Workplace Environment

May 8, 2003, 5:00 PM ET - <http://www.cdc.gov/ncidod/sars/workplaceguidelines.htm>

[Download PDF version formatted for print](#)  (132 KB/1 page)

The Centers for Disease Control and Prevention (CDC) is investigating the spread of a respiratory illness called severe acute respiratory syndrome (SARS). CDC has issued various levels of advice for people traveling to [areas with SARS](#). For some areas, CDC has issued travel advisories, recommending against nonessential travel. You can learn more about SARS from the [World Health Organization](#). These websites will be updated as soon as new information is learned.

SARS is an infectious illness that appears to spread primarily by close person-to-person contact, such as in situations in which persons have cared for, lived with, or had direct contact with respiratory secretions and/or body fluids of a person known to be a suspect SARS case. Potential ways in which infections can be transmitted by close contact include touching the skin of other persons or objects that become contaminated with infectious droplets and then touching your eyes, nose or mouth. Workers, who in the last 10 days have traveled to a known SARS area, or have had close contact with a co-worker or family member with suspected or probable SARS could be at increased risk of developing SARS and should be vigilant for the development of fever (greater than 100.4° F) or respiratory symptoms (e.g., cough or difficulty breathing). If these symptoms develop you should not go to work, school, or other public areas but should seek evaluation by a health-care provider and practice infection control precautions recommended for the home or residential setting; **be sure to contact your health-care provider beforehand to let them know you may have been exposed to SARS so arrangements can be made, as necessary, to prevent transmission to others in the healthcare setting.** For more information about the signs and symptoms of SARS, please visit CDC's website. More detailed guidance on management of symptomatic persons who may have been exposed to SARS, such as how long you should avoid public areas is available at the exposure management page.

As with other infectious illnesses, one of the most important and appropriate preventive practices is careful and frequent hand hygiene. Cleaning your hands often using either soap and water or waterless alcohol-based hand sanitizers removes potentially infectious materials from your skin and helps prevent disease transmission.

The routine use of personal protective equipment (PPE) such as respirators, gloves, or, using surgical masks for protection against SARS exposure is currently not recommended in the general workplace (outside the health-care setting).

WHO - First data on stability and resistance of SARS coronavirus compiled by members of WHO laboratory network

4 May 2003 - http://www.who.int/csr/sars/survival_2003_05_04/en/index.html

This information has been provided by Members of the [WHO multi-center collaborative network on SARS diagnosis](#). The major conclusions from these studies are:

Virus survival in stool and urine

- Virus is stable in faeces (and urine) at room temperature for at least **1-2 days**.
- Virus is more stable (**up to 4 days**) in stool from diarrhea patients (which has higher ph) than in normal stool where it could only be found for up to 6h.

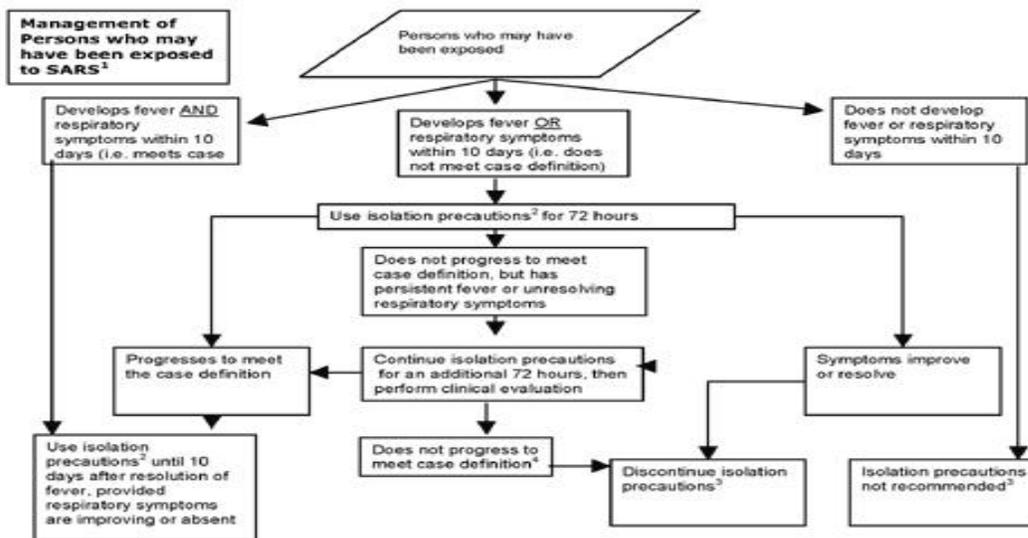
Disinfectants and fixatives (for use in laboratories)

- Virus loses infectivity after exposure to different commonly used disinfectants and fixatives.

Virus survival in cell-culture supernatant

- Only minimal reduction in virus concentration after 21 days at 4°C and -80°C.
- Reduction in virus concentration by one log only at stable room temperature for 2 days. This would indicate that the virus is more stable than the known human coronaviruses under these conditions.
- Heat at 56°C kills the SARS coronavirus at around 10000 units per 15 min (quick reduction).

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



¹Exposure includes travel from areas with documented or suspected community transmission of SARS (link to case definition) or close contact with persons who have SARS; Close contact is defined as having cared for or lived with a person known to have SARS or having a high likelihood of direct contact with respiratory secretions and/or body fluids of a patient known to have SARS. Examples of close contact include kissing or embracing, sharing eating or drinking utensils, close conversation (<3 feet), physical examination, and any other direct physical contact between persons. Close contact does not include activities such as walking by a person or sitting across a waiting room or office for a brief period of time.

²Isolation precautions include limiting patient’s interactions with others outside the home (e.g. should not go to work, school, out of home day care, church or other public areas), and following infection control guidelines for the home or residential setting (link) if not admitted to hospital for care.

³Persons need not limit interactions outside of home (e.g., need not be excluded from work, school, out of home day care, church or other public areas).

⁴Discontinuation of isolation precautions for patients who have not met the case definition 6 days following onset of symptoms, but who have persistent fever or respiratory symptoms should be done only after consultation with local public health authorities and the evaluating clinician. Factors that might be considered include the nature of the potential exposure to SARS, nature of contact with others in the residential or work setting, and evidence for an alternative diagnosis.