Suspect Case of Severe Acute Respiratory Syndrome in Anchorage—May, 2003

Background
On May 18, the Alaska Division of Public Health and the Anchorage Department of Health and Human Services received a report from the Anchorage Fire Department that a 28-year-old man (Patient A) with possible Severe Acute Respiratory Syndrome (SARS) was being transported by ambulance from a local hotel to Providence Alaska Medical Center. Patient A was the co-pilot of an air cargo plane that originated in mainland China and arrived in Anchorage on May 16. Patient A reported spending one night in Guandong Province, China on May 15.

Clinical Presentation
After arriving in Anchorage, Patient A was in good health until the evening of May 17, when he developed muscle aches and fatigue. At 2 AM on May 18, he developed a high fever and a dry cough. Five hours later, he was transported to the hospital emergency department. At presentation, Patient A was anxious with shaking chills, a dry cough, and a temperature of 104.1°F. Rapid influenza A and B, RSV and Group B Streptococcal studies were all negative. Blood cultures were obtained. The initial chest x-ray was clear and the patient’s oxygen saturation was 99% on room air.

Based upon the clinical evaluation and exposure history (Box 1), the patient met the case definition as a suspect case of SARS as defined by the U.S. Centers for Disease Control and Prevention (CDC) (1).

Patient A was admitted to the hospital under CDC-recommended contact and respiratory isolation precautions (2). On Monday, May 19, CDC-recommended SARS clinical specimens were collected (Box 2) (3). Specimens were sent to the Alaska State Virology Laboratory in Fairbanks for coronavirus culture and to CDC for SARS CoV culture, serology and polymerase chain reaction (PCR) testing.

Patient A’s white blood cell (WBC) count went from 7,800 on admission to 2,800 two days after admission. In addition, his platelet count went from 161,000 on admission to 118,000 two days after admission. Other SARS patient case-reports have shown similar trends with their WBC and platelet counts (4). Patient A’s white blood cell (WBC) count went from 7,800 on admission to 2,800 two days after admission. In addition, his platelet count went from 161,000 on admission to 118,000 two days after admission. Other SARS patient case-reports have shown similar trends with their WBC and platelet counts (4).

A follow-up chest x-ray on May 19 showed a mild infiltrate in the medial left lung base, consistent with subsegmental atelectasis and pneumonia; however, repeat chest x-rays on May 20 and 22 were clear.

Patient A was afebrile from May 21-30 and was released from hospital emergency department. At presentation, Patient A was anxious with shaking chills, a dry cough, and a temperature of 104.1°F. Rapid influenza A and B, RSV and Group B Streptococcal studies were all negative. Blood cultures were obtained. The initial chest x-ray was clear and the patient’s oxygen saturation was 99% on room air.

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Patient A was afebrile from May 21-30 and was released from isolation on May 30 as per CDC’s recommendations (5). As of June 3, all clinical samples have remained negative for the SARS CoV virus.

Close Contacts
Three additional crewmembers were on board the cargo airplane with Patient A, and all three were in close contact with him during the evening of May 17. Crewmembers were interviewed by CDC staff and were followed for symptoms of SARS. During their stay in Alaska, crewmember activities were not restricted, and all three contacts remained asymptomatic until their departure back to China on May 23.