

**MEETING NOTES CDC – ACI TELEPHONE CONFERENCE
APRIL 3, 2003**

**TO: ACI-NA Marketing and Communications Committee
ACI-NA Facilitation Group**

FROM: Brad Hull, Senior Manager, Policy and Public Affairs, ACI-NA

RE: ACI-NA/CDC SARS Conference Call - Summary Report

DATE: April 3, 2003

Pam Shepherd, Senior Manager of Public Affairs and Policy of ACI-NA, and Llewelyn Grant, Senior Press Officer of CDC, welcomed everyone and introduced the speakers.

Dr. Steve Ostroff, Deputy Director, CDC's National Center for Infectious Diseases

Thanks for the cooperation with airports. This situation is continuing to evolve and doesn't look like it's going away anytime soon.

The central problem is that this is an emerging infectious disease that epitomizes what we see in 21st century: the problem of transmission being amplified by the way that we live/travel and the way we take care of patients. This disease originated in the southern part of China then to Hong Kong and out to a variety of areas around world partly because of the way we travel. One person came through south China and spread to numerous people in the same hotel in Hong Kong and then these individuals came home to a number of places around the world. They started chains of transmission that continue today.

A tremendous effort has been made within the international health community to address this problem. A phenomenal amount of information has been accumulated, much of which has been in trying to determine what exact agent causes the illness. More recent information says that the agent that looks like its responsible is a virus known as corona. The type of this virus as found in humans has been mild up to this point. It has not heretofore been a family of viruses that is typically associated with the severity of SARS. This strain of the corona virus, presents itself differently from past strains of the virus, as such we may be dealing with a previously unidentified pathogen.

Transmission has occurred in several settings: hospital health care workers have been infected in large numbers; airline flights; and family members and others that come into direct close contacts in home settings.

Information suggests that it is transmitted through close direct contact, unlike other respiratory infections that can be passed by casual contacts. Most seem to be respiratory droplet transmission, but we must take into account other types like casual contact as a possibility at this stage since information is still lacking.

Numbers: 2140 cases outside US. Identified as probable cases of SARS, largest in China then Hong Kong, these 2 account for 85% of identified cases. Next largest Singapore, then Hanoi, Vietnam, and then Canada.

In the U.S., we have taken a different approach. Any case is being counted that 1) meets loosely some symptoms in an individual that traveled to those areas or 2) who has some symptoms and came in contact with someone who traveled to those areas. Thus numbers are growing at a faster rate here. Most cases have had relatively mild illness; much more milder than elsewhere and most of those will probably turn out to NOT have that disease.

Dr. Marty Cetron, Deputy Director, CDC's Division of Global Migration and Quarantine

Surveillance and containment is the strategy. There is no known treatment after exposure so must seek early containment. Other countries have more strict methods like placing exposed persons under quarantine or those who have come in contact with someone even before symptoms appear.

So our strategy in aviation is to help people understand symptoms and report the occurrence of them as early as possible. Some don't get sick until in the US but some do while in transport in the airline/airport environment. We have yellow health alert cards that are being distributed in all the international points of entry that have flights from SARS infected areas or with flights within one connecting flight and that has 10 people on board from SARS infected area. This means about 100 flights a day. Also doing disembarkation points at ports, etc.

Protocol is to hear about and manage suspected SARS cases while in transit. We are working with DOT (Department of Transportation), FAA (Federal Aviation Administration), ATA (Air Transport Association) and IATA (International Air Transport Association). Still working on that. We are working toward: knowing about a flight that has a person with symptoms, meeting it, screening the person, and providing info to other travelers and collecting contact info from them if needed in the future.

Vicki Freimuth, Director, CDC's Office of Communication

We have conducted a series of press conferences, about 7 so far and are available to you all for participation. Also we always have full transcripts up on the website after each conference. Our website also has FAQs. We operate an emergency hotline. Its traffic in the past week demonstrates great increase in interest in SARS. We are now at 1600 calls per day about SARS. There are also some guidance documents which relate to airline travel.

Q and A

Q: From Ft Lauderdale: we have a flight that comes in from Toronto, will you meet them?

A: No, transmission is not like that. Canadian expert doesn't feel that there is a general community alert necessary since there has been no community transmission there. If there were community transmission in Toronto identified then we would take the same steps with those areas of CA but not the situation now.

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Q: From Portland, OR: Please discuss the quarantining procedures and how the decision is made?

A: Two words: isolation and quarantine. We can isolate sick people who can transmit, or we can restrict people who are in an incubation period. The latter is called quarantine. From legal perspective, there are fed and state and local quarantine laws. Most quarantine situations occur on a voluntary basis (people in hospital for instance). But some can be ordered to be quarantined if deemed necessary. San Jose was a "temporary detention to assess" and not the same as quarantine. Right now what we are doing is that we meet the plane, mask the potential case, separate them, do an interview, then provide info to the other passengers and get info from them for future contact if necessary. We have done this more than a dozen times in the last 2 weeks. If we need to isolate the person, they will go through control procedures to a health care facility. The other passengers are let go. From a public health perspective therefore there has been no quarantines at all during this situation.

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Q: From Portland, OR: Are there similar info campaigns to people boarding?

A: Yes.

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Q: From LAX: Are you advising passengers to where masks?

A: No. We are suggesting that if an ill passenger is identified, airlines should make available masks for people close to that person and/or seating as far away as possible. However, large numbers of travelers are choosing to wear masks of their own volition.

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Q: Are these masks effective?

A: Well would be against droplets. Currently, people are trying to do transmission risk assessments on airplanes and there are handfuls of incidences that there are effective transmissions on airplanes but information to judge the degree of effectiveness for masks is lacking.

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Q: From Detroit: Would you speak about the coordination between WHO and CDC? There have been conflicting reports about travel restrictions/advisory? Who should we use for information and direct other to?

A: Direct people to both. CDC is a US agency and WHO is UN therefore we won't always agree. Recently WHO did revise its original and issued a travel advisory. They have never before issued a travel restriction. Additionally, each sovereign nation has its own counterparts.

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With no more questions, the call was ended. ACI-NA and CDC anticipates regular conference calls with airports on this critical subject. You will receive pertinent information as it becomes available. In the meantime, if you have questions, please contact Pam Shepherd at ACI-NA (pas@aci-na.org; 202-293-8500).