NOTICE

Since 2004, there have not been any known cases of SARS reported anywhere in the world. The content in this PDF was developed for the 2003 SARS epidemic. But, some guidelines are still being used. Any new SARS updates will be posted on this Web site.

Supplement B: SARS Surveillance

VI. Plan for Surveillance of Contacts of SARS Cases

Surveillance of contacts of SARS cases is essential to control efforts. Rapid identification, evaluation, and monitoring of exposed asymptomatic contacts and prompt isolation of those who are found to be clinically ill can prevent further transmission of disease.

Infectiousness in patients with SARS-CoV disease appears to begin with the onset of clinical illness. Although the exact duration of infectiousness is not known, it is recommended that patients with SARS-CoV disease avoid contact with other persons for up to 10 days after resolution of fever and improving or absent respiratory symptoms. *Contact tracing* is the systematic identification of persons who may have been exposed to patients with suspected or confirmed SARS-CoV disease during the infectious period. In some instances, public health officials should also consider identifying persons who had contact with a SARS patient *before* the patient's onset of illness – if there is a chance that the contacts might have been exposed to the same source of infection as the case. Such situations would include those in which the SARS patient's source of infection is unclear or not previously recognized (e.g., an index case among a group of tourists).

Objective 1: Prepare to conduct surveillance of contacts by ensuring the availability of personnel and other resources**.**

Activities: State and local health departments

- Designate one person to coordinate activities related to contact tracing, interviewing, evaluation, and monitoring.
- Identify additional personnel to manage contact tracing and monitoring in different regions of the state. Personnel can be provided from state or other resources as needed. Ideally, select staff with field experience involving contact tracing (e.g., from STD, TB, or HIV control programs).
- As needed, modify and adopt sample forms provided by CDC (Appendix B3).

Additional recommendations related to preparedness planning for surveillance and management of SARS contacts, including community containment measures such as non-hospital isolation and quarantine, are provided in Supplement D.

Objective 2*:* Identify all contacts of all SARS cases.

Activities: State and local health departments

- Identify contacts of known or possible cases of SARS-CoV disease. Obtain information from the case-patient, next of kin, workplace representative, or others with appropriate knowledge of the case-patient's recent whereabouts and activities.
- Trace each contact whose name, address, and/or telephone number is provided.
- When contact information is unknown or incomplete, use a variety of resources (e.g., work and school contact numbers, telephone directories, voting lists, neighborhood interviews, site visits, visits to "hangouts") to trace contacts. If contacts cannot be found through these mechanisms,

Supplement B: SARS Surveillance
(continued from previous page)

other methods for notifying potential contacts (e.g., media announcements) may have to be considered.
- Locate and interview each contact to: 1) confirm exposure to the SARS case, 2) document the presence or absence of fever or lower respiratory symptoms,[1] and 3) identify additional contacts.
- For persons who are free of symptoms at the time of interview, initiate plans for ongoing symptom monitoring or other restrictions implemented by public health officials (see Supplement D) for 10 days after the last contact with the SARS case.

Objective 3: Prioritize contacts on the basis of estimated risk of exposure if necessary.

Contact tracing should include detailed interviews so that contacts can be prioritized on the basis of their estimated risk of SARS-CoV exposure. This process allows identification of the contacts at greatest risk and more efficient use of the resources needed for follow-up and monitoring. In some instances, however, resource limitations (e.g., limited number of skilled interviewers) or large numbers of potential contacts may preclude focused contact tracing and require follow-up and monitoring of a large number of contacts with less definite risks.

Activities: State and local health departments

- Consider establishing priorities among contacts based on the following factors:
  - Probability of SARS-CoV disease in the index case (e.g., contacts of confirmed and probable SARS-CoV cases would be highest priority)
  - Duration and spatial proximity (e.g., < 3 feet) of the contact's exposure to the case
  - History of exposure(s) known or suspected to be at higher risk for transmission (e.g., SARS patient care; participation in an aerosol-generating procedure; intimate contact)
  - Documented secondary cases resulting from exposure to the index patient
- After a review of contact priority lists and available resources, state authorities may decide to adopt different levels of contact follow-up and monitoring activities for different categories of contacts. For detailed recommendations for management of contacts, see Supplement D.

For more information, visit www.cdc.gov/ncidod/sars or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY)

[1] For persons with a high risk of exposure to SARS-CoV (e.g., persons previously identified through contact tracing or self-identified as close contacts of a laboratory-confirmed case of SARS-CoV disease; persons who are epidemiologically linked to a laboratory-confirmed case of SARS-CoV disease), clinical criteria should be expanded to include, in addition to either fever or lower respiratory symptoms, the presence of any of the early symptoms of SARS-CoV disease (i.e., chills, rigors, myalgia, headache, diarrhea, sore throat, rhinorrhea) as a potential trigger to initiate a clinical evaluation for SARS-CoV disease.