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A Novel Coronavirus and SARS

TO THE EDITOR: Ksiazek et al. (May 15 issue)[1] report that there is antibody cross-reactivity between serum from a patient with severe acute respiratory distress syndrome (SARS) and antibodies that are reactive with group I coronaviruses. This finding raises the possibility of using existing vaccines against these heterologous coronaviruses for protection against SARS. Unfortunately, the study did not show any virus-neutralization activity. Nevertheless, the close similarity between the SARS open reading frame 1b and other human and animal coronaviruses lends support to the idea of using heterologous coronaviral strains, which are harmless to humans, as vaccines. There are several historical examples of successful heterologous vaccination, such as cowpox virus for smallpox in humans and bacille Calmette–Guérin derived from mycobacterium in cattle for tuberculosis in humans. Furthermore, it has been shown that pathogens cause diseases primarily through their ability to evade immune control and through mimicry of host proteins.[2] "Fuzzy" antigenic recognition might enable T-cell clones to recognize a spectrum of antigens, even antigens that are not closely similar to one another. Thus, the use of altered heterologous antigens, which are structurally different from self-antigens, may improve immunity against the orthologous pathogens.[3]

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Pseudo-SARS

TO THE EDITOR: We evaluated a possible case of severe acute respiratory syndrome (SARS) that involved issues of hospital admission, an inconsistent travel history, and possible enforced isolation. Some of the problems were similar to those described in a recent account in New York.[1]

On May 12, 2003, a 36-year-old white man (accompanied by his Asian wife) was evaluated in our emergency room for fever and cough. He stated that they had arrived in the United States five days earlier from Taiwan, where he worked as an English teacher for physicians. His symptoms began two days after their arrival in the United States. Emergency room personnel placed masks on the couple and isolated them from other patients. This event coincided with the start of the Top Officials 2 (TOPOFF 2) bioterrorism-response exercise at our hospital. When consulted at 1 a.m., we initially questioned whether this patient might be part of the drill. The drill scenario involved an outbreak of pneumonic plague but was also to include some surprises. The patient had no respiratory distress, and a chest radiograph and the oxygen saturation were normal, but the couple had no local residence. Therefore, the patient was admitted to a negative-pressure isolation room and placed under contact and respiratory-isolation precautions in accordance with the recommendations of the Centers for Disease Control and Prevention.[2]

The following day, the patient's diagnosis was reassessed, because he had no fever and he repeatedly requested narcotics for chest pain. That evening, he