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Familiarity breeds contempt

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Avian influenza could cause a pandemic even more devastating than that of severe acute respiratory syndrome (SARS), said a radio announcer the other day. Newspapers have made the same comparison, implying that SARS in 2002–03 had been as horrendous as the Black Death in the 14th century or the flu pandemic of 1918–19.

But was SARS either pandemic or devastating? Although the causative coronavirus seemed to have the potential to be both, its impact so far has been far smaller than was forecast by the apocalyptic headlines that greeted its arrival. Rather than millions of fatalities throughout the planet, the toll has been 774 deaths in 29 countries.

And adverse economic consequences (on tourism in China, for example) have resulted as much from panic as from the actual predations of the virus.

One of the dangers in a scenario such as this, characterised by images of crowds wearing face masks to escape a “new killer virus”, is that more familiar threats will be temporarily eclipsed. Not only public but professional attention too can easily focus on a novel danger at the expense of existing ones.

Severe community-acquired pneumococcal pneumonia (CAP) is a pertinent example. Visiting Singapore last year, Martin Kelly of Altnagelvin Area Hospital, Derry, Northern Ireland, was struck by the high profile of SARS in the media, and by the public use of face masks, especially in Changi airport. By contrast, he says, “countless cases of CAP often go unnoticed and unpublicised. Indeed, these too may be severe, life-threatening, or even fatal”.

In an attempt to highlight this disparity, Kelly and colleagues have now published two case reports on CAP in young men. Their paper serves to remind clinicians of the continued impact of the condition, and of the value of the British Thoracic Society’s CURB score in early recognition of adverse physiology in critically ill patients.

The first case was a 22-year-old male welder who had had an influenza-like illness with a dry cough, anorexia, and anergia for 4 days before being admitted to hospital, plus fever and rigors over the previous day. He showed a tachycardia, tachypnoea, hypotension, and desaturation, and had dullness with coarse, inspiratory crackles at the left base.

Chest radiography revealed extensive left lower-lobe consolidation, while arterial gas measurement showed a mixed pattern of respiratory failure with acidosis. Further investigations confirmed leucopenia and acute renal failure. Day-1 blood cultures yielded a penicillin-sensitive pneumococcus.

Aggressive resuscitation corrected the hypovolaemia, with marked improvement in kidney function. Yet, despite high-flow oxygen, continuous positive airway pressure respiratory support, and antibiotics, the patient had to be admitted to intensive care. He required invasive ventilation for 25 days and eventually a tracheostomy for respiratory distress syndrome. Thereafter he recovered quickly.

The second patient was a 22-year-old alcohol abuser who had been living rough and arrived in hospital in a toxic confusional state. He had a tachycardia, tachypnoea, and type-1 respiratory failure with alkalosis. A chest radiograph showed right lower-lobe consolidation and pleural effusion with lingular and left lower-lobe consolidation.

The patient improved with antibiotics, oxygen, and other treatments, and culture of the purulent, blood-stained sputum he was expectorating yielded a penicillin-sensitive pneumococcus. But he also developed a complicated right parapneumonic effusion that failed to resolve and he was referred to thoracic surgeons for further management.

These two cases exemplify the link between higher CURB scores and poorer outcomes. The first, who had a more critical course, showed a score of 3/4 (raised urea and respiratory rate and low blood pressure), while the second rated 1/4 (confusion).

“In this time of increased alertness towards unusual respiratory pathogens, it is important that the more usual presentations of CAP are still recognised”, write Kelly and co-workers in the Journal of Medical Microbiology (2004; 53: 88). “These can cause . . . significant morbidity and mortality, yet respond well if recognized and treated promptly. Indeed, early recognition of severely ill patients and their consequent deterioration is often poor, yet objective triggers such as severity scores may be important in triggering a response.”

A timely reminder from Derry.