News

ANTHRAX AND FOOD POISONS STILL MAJOR THREATS IN U.S.

25 September (Reuters Health [Maggie Fox])—Anthrax is still the main biological threat facing the United States, and poisons put into the food supply run a very close second, officials said.

They said the United States remains vulnerable to a range of attacks but is moving to patch many holes.

“I still believe that anthrax is the greatest threat agent that we have,” said Jerome Hauer, an assistant secretary for Health and Emergency Response at the US Department of Health and Human Services.

“We don’t have enough vaccine against anthrax at this time,” he told a conference on weapons of mass destruction organized by consulting firm E. J. Krause & Associates.

The United States is in the process of vaccinating up to 1 million troops and health and emergency workers against smallpox, but Hauer said the window of opportunity for treating anthrax victims is smaller than for smallpox.

“With anthrax, the detectors are humans,” he added.

Safer, more acceptable vaccines are needed against anthrax and smallpox, Hauer said. Better detector systems are also needed.

Progress to protect against a smallpox attack is also going slowly, Hauer said. He said 38,700 health care and emergency workers have been vaccinated against smallpox in the latest campaign—compared to a target of more than 400,000.

US Food and Drug Administration deputy commissioner Lester Crawford said every food contamination incident is now treated as a terrorist attack or a rehearsal for one. New legislation that will go into effect in December will add to the agency’s power to protect the US food supply, he said.

“We are going to be a much safer country as a result,” Crawford said. “For the first time…we can actually detain food products at the border.”

The FDA has added 655 new employees to watch for an attack on the food supply. Foods that Americans eat most, such as eggs and milk, are the most closely watched, he said.

Hauer said the biggest concern is in the lack of capacity in already stretched US hospitals, which would be overwhelmed by any large attack or epidemic.

Doctors and nurses will have to be brought out of retirement and provided with malpractice and liability coverage. “Because we simply don’t have enough people to go around in case of one of these events,” he said.

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Editor’s comment. As the collective memory of the dangers of a potential biological attack tends to fade as time passes after September 11 and the subsequent anthrax attacks, it is important to periodically emphasize the need to be on guard. This news item makes 2 points of particular interest. First, it states that anthrax is the greatest threat (now that we have large supplies of vaccine against smallpox) and that the detectors are humans. This means high reliance on early detection and reporting of initial cases by physicians. Second, it stresses our lack of adequate hospital facilities, physicians, and nurses to respond to a major attack. In light of this concern, we should just remember the SARS outbreak in Toronto, which overwhelmed the local infectious diseases physician community and required the importation of physicians from elsewhere in Canada and from the United States.

HLA HAPLOTYPE MAY EXPLAIN GEOGRAPHIC VARIATION IN SARS VIRULENCE

1 October (Reuters Health)—A particular HLA antigen may explain why SARS raged last year in southeast Asia and nowhere else in the world outside of Toronto, Taiwanese researchers reported this week.

The genetic variant is common in people of southern Chinese descent, the team at Mackay Memorial Hospital in Taipei reports in an online journal, BMC Medical Genetics.

“After the outbreak of SARS coronavirus infection in the Guangdong Province of China, it was surprising to observe that the spreading of the disease was mostly confined among southern Asian populations (the Hong Kong people, Vietnamese, Singaporeans and Taiwanese),” they write.

Marie Lin, Chun-Hsiung Huang, and colleagues examined the HLA haplotypes of 37 cases of probable SARS, 28 fever patients excluded later as probable SARS, and 101 noninfected health care workers who were exposed or possibly exposed to SARS coronavirus. “An additional control set of 190 normal healthy unrelated Taiwanese was also used in the analysis,” they write in their report.

They found that patients with severe cases of SARS were likely to carry HLA-B 4601.

They noted that no indigenous Taiwanese, who make up about 1.5% of the population, ever developed SARS. HLA-B 4601 is not seen among indigenous Taiwanese, they note.

“Interestingly,” they add, HLA-B 4601 is also seldom seen in European populations.

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Editor’s comment. The results of this report, which need to be confirmed in additional studies, are fascinating in that they give a potential explanation for the
epidemiology of severe SARS observed earlier this year. The significance level in
the article was \( P < .0001 \). (The report
was released online on 12 September 2003 at http://www.biomedcentral.com/
1471-2350/4/9/abstract.)

**HONG KONG TO USE HIV DRUG TO TREAT SARS PATIENTS**

25 September (Reuters Health)—Hong Kong hospitals will use the HIV drug Ka-
letra, together with ribavirin, to treat SARS patients if the territory is hit by a second
wave of the deadly disease, its hospital chief said.

Experts have warned that the disease could return during the winter months,
and countries in the region are arming themselves with drugs and elaborate con-
tingency plans for what may be another onslaught of the disease.

Hospital Authority chief William Ho said an analysis of the treatments given to
all SARS patients in Hong Kong showed that a small group given both Kaletra and
ribavirin had a significantly lower death rate than those given only ribavirin.

Those who were administered both drugs also needed lower dosages of ster-
oi ds, he added.

“Only ribavirin may not be useful, but both ribavirin and Kaletra look more
promising,” Ho told a news conference.

“If SARS comes, all hospitals will co-
operate and use what’s believed to be the
best treatment protocol.”

Hong Kong used a combination of the
drug ribavirin and steroids to treat the
bulk of its nearly 1800 SARS patients ear-
lier this year, but experts elsewhere have repeatedly questioned the use of ribavirin,
saying it was ineffective.

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**Editor’s comment.** Although these observations are not based on controlled
studies, this information is from an area
with a large amount of experience in
treating SARS, and it would deserve
serious consideration, should SARS
emerge in the United States. An article by
Knowles et al. published in the 15 October
2003 issue of Clinical Infectious Diseases
discussed complications of ribavirin treat-
ment in Canadian cases of SARS.

**CONCERNS ABOUT SEQUELAE OF SMALLPOX VACCINE, ANTHRAX CLEARED UP**

2 October (Reuters Health)—Cardiac
events that occurred after smallpox vacci-
nation earlier this year are probably not
related to the vaccine, investigators report
in the Morbidity and Mortality Weekly Re-
port for 3 October.

After 3 cardiac deaths and 13 other
ischemic events occurred following vacci-
nation with the New York City Board of
Health (NYCBOH) vaccinia strain, the
Centers for Disease Control and Preven-
tion recommended that individuals with
potential heart disease forego smallpox
vaccination.

However, there was no clear evidence
that the cardiac events were associated
with the vaccine.

To investigate further, Dr. T. Frieden, of
the New York City Department of Health
and Mental Hygiene, and colleagues ex-
amined data related to a 1947 vaccination
campaign during which more than 6 mil-
lion residents were vaccinated with the
same NYCBOH strain. New York City
death certificates filed during the postvac-
cination period in 1947 were compared
with the same periods in 1946 and 1948.

“The difference in the rate of cardiac
deaths was not statistically significant dur-
ing the 2-week risk period compared with
other periods among persons aged 50 to
64 years…or among all adults,” the au-
thors note. Findings were similar when
comparing the 4-week risk period with
other periods.

Source: MMWR CDC Surveill Summ
2003; 52:933–8.

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**SOURCE OF INFECTION NOT IDENTIFIED IN MALARIA OUTBREAK IN FLORIDA**

25 September (Reuters Health)—An out-
break of malaria in Florida this past sum-
mer is the first with extended transmission
in the United States since 1986. According
to a report in the Morbidity and Mortality
Weekly Report for 26 September, the index
case had no risk factors for malaria.

While most cases of malaria in the
United States are imported, locally ac-
quired cases continue to occur, the authors
note.

Dr. Malecki, of Palm Beach County
Health Department, and colleagues de-
scribe 7 patients diagnosed with Plasmo-
dium vivax malaria after hospital admis-
sion between 24 July and 26 August.

None had a history of malaria, recent
blood transfusion, organ transplantation,
or IV drug use. Other than the last patient
to be diagnosed, who had emigrated to
the United States from Bogota, Columbia,
in July 2001, none had ever traveled to
endemic areas.

The patients all lived within 10 miles of
Palm Beach International Airport. How-
ever, of more than 400 mosquitoes
trapped within 1 mile of patients’ homes,
none harbored the parasite.

Genotyping of \( P. \) vivax isolates revealed
that all were the same strain. According
to an editorial note, “these results support
the hypothesis that this cluster of cases was
the result of extended malaria transmis-

Editor’s comment. The report from
Morbidity and Mortality Weekly Report
referred to ischemic cardiac events only.
Myocarditis/pericarditis after smallpox
vaccination has been described previously
and was observed in both civilians and
military personnel vaccinated during the
2003 campaign.

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