

since early January 2020, and COVID-19 remains uncontrollable problem. The Thai Ministry of Public Health tried several methods to counteract the disease outbreak. As a legal control, COVID-19 is included on the national list of infectious diseases under surveillance. The law requires that when a medical center detects this disease, an official reports it to the governmental center for disease control (CDC) within 3 hours. Violation of this legal control should result in a punitive consequence.

The exact advantage of this legal regulation regarding COVID-19 control is an interesting issue. In Thailand, not only governmental hospitals but also some private hospitals have the ability to conduct laboratory diagnosis of COVID-19. Among 82 cases of COVID-19 in Thailand overall (as of March 15, 2020), in 1 interesting case the patient self-declared infection via Instagram but no official report had been filed with the local CDC. This patient had received a positive laboratory result from a private hospital. This case was finally confirmed as a case of COVID-19, but it appears that the private hospital may have neglected to report it, violating the legal requirement for disease reporting. This example represents a big challenge faced by

hospitals in infection control. Good data collection is important to obtaining high-quality surveillance data, which is imperative for infectious disease control.² At times, poor, unethical, private hospitals do not follow the disease control guidelines. In a disease outbreak, collaboration from hospitals is required, and strict legal regulation of the disease control system should be undertaken. In cases of violation, the poor role model should be punished.

Acknowledgments.

Financial support. No financial support was provided relevant to this article.

Conflicts of interest. All authors report no conflicts of interest relevant to this article.

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Harmonizing the COVID-19 cacophony: People need guidance

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To the Editor—The COVID-19 pandemic caused by a novel coronavirus (SARS-CoV-2) has sounded danger alarms across the globe. According to a report by the World Health Organization (WHO), >292,142 confirmed cases had been identified worldwide as of March 21, 2020.¹ Although some differences in the real-world mortality rate and the mortality rate were reported in a few published clinical series, a total of 1,772 deaths with an average mortality rate of 2.5% was reported by the Chinese Center for Disease Control and Prevention on February 16, 2020.² With the rise in global anxiety, the WHO declared COVID-19 the sixth international public health emergency on January 30, 2020. This pandemic could have devastating outcomes across the world if the viral spread is not controlled by public health efforts.

The origin of coronavirus, a single-stranded enveloped RNA virus, dates back in 1960s. The first coronaviruses discovered caused infectious bronchitis in chickens. Two other viruses obtained from nasal secretions of human patients with common colds were named human coronavirus 229E and human coronavirus OC43. Subsequently, other members of this family have been identified, including SARS-CoV in 2003, HCoV NL63 in 2004, HKU1 in 2005, MERS-CoV in 2012, and SARS-CoV-2 (formerly named 2019-nCoV) in 2019.³ Most of these virus species cause severe respiratory infections in humans.

Overall, the clinical features of COVID-19, caused by SARS-CoV-2, correspond to common influenza. The clinical

manifestations of COVID-19 pneumonia, as demonstrated by some studies, have varied among cases. Fever is the predominant symptom followed by cough, dyspnea, myalgia, headache, and diarrhea.¹ An effective cure of COVID-19 by antiviral therapy and vaccination is currently being developed. However, considering previous management plans for MERS and SARS infections, the WHO has recommended preventive measures to inhibit the transmission of acute respiratory infections. These interventions include (1) avoiding close contact with people suffering from common cold; (2) frequent cleaning of hands with running water or alcohol sanitizers; (3) avoiding excessive touching of eyes, nose, and mouth; and (4) avoiding unprotected contact with animals. In addition, people with acute respiratory infections should practice respiratory hygiene regularly, which includes maintaining a distance of 1 m from healthy people to avoid spread of airborne droplets, covering coughs and sneezes with clothing or disposable tissues, and frequent hand washing.¹

Since the emergence of SARS-CoV-2, various international bodies have debated the use of N95 respirators and surgical masks. In their review on the use of masks and respirators for prevention of influenza transmission, Reza et al⁴ reported that effectiveness of masks is likely linked to their early, regular, and correct use; most studies have reported a reduced risk of upper respiratory infections with masks and respirators. Similarly, Jefferson et al⁵ reviewed the clinical effectiveness N95 respirators (95%) and masks (68%) in reducing the spread of respiratory viruses. In a debate organized by the Singapore Infection Control Association, Dr Lin proposed the adequacy of surgical masks for prevention of MERS-CoV transmission in addition to personal and environmental hygiene.

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Cite this article: Arif TB and Ali A. (2020). Harmonizing the COVID-19 cacophony: People need guidance. *Infection Control & Hospital Epidemiology*, 41: 876–877, <https://doi.org/10.1017/ice.2020.105>

Moreover, during SARS outbreak, N95 respirators were perceived to be difficult to tolerate by healthcare workers due to their association with impaired mental performance and headache. According to Professor Seto, the WHO has recommended the use of surgical masks for people living with infected patients and N95 respirators for aerosol-generating procedures. In 2009, the US CDC recommended the use of N95 respirators in all circumstances; however, with evolution of coronavirus pandemics, the guidelines were revised in 2010 and N95 respirators were recommended only for aerosol-generating procedures.⁶ With increasing global apprehension concerning the spread of coronaviruses, people are rushing to Amazon and local pharmacies to buy surgical masks and N95 respirators, resulting in a shortage. Different social media celebrities are also promoting a dangerous myth by unnecessarily using these masks. Considering that N95 respirators filter out 95% of small particles, medical professionals need to wear these masks during close contact with patients. However, they are of no use for general public because these heavy particles can be transmitted through surfaces and, to a limited extent, through air. In a recent press conferences, Alex Azar issued a statement that the United States needs ~300 million N95 respirators for healthcare workers due to the rapid increase in prevalence of this infection.⁷ The paucity of masks and respirators has led to significant price escalation. Some businesses in United States are completely sold out of masks despite evidence that healthy people do not need to wear them.⁸

According to the Centers for Disease Control and Prevention, frequent hand washing with running water and soap for at least 20 seconds, using hand sanitizer, avoiding large gatherings and crowds, and disinfecting fomites may primarily protect others from the virus. However, the eminent global shortage and high prices of masks cannot be overstated. The respective authorities and governments need to develop and implement the proper guidelines and preventative strategies and make sure that the general public is adhering to the proposed protocols. Governments should also provide accurate information and should clarify misinformation spread by social media to help the public face this pandemic.

Acknowledgments. None.

Financial support. No financial support was provided relevant to this article.

Conflicts of interest. All authors report no conflicts of interest relevant to this article.

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COVID-19 among medical personnel in the operating room

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To the Editor—Surgical infection is an important issue in hospital infection control; infection can occur in a patient receiving an operation. With the new coronavirus infection, COVID-19, there is a risk of nosocomial infection. Glauser¹ proposed a protocol to keep COVID-19 out of hospitals. However, the infection might be carried by medical personnel. The issue of COVID-19 among

medical personnel working in the operating room has not been well clarified.

Here, we provide reports from Thailand, a country with the second-most COVID-19 infections at one point in the worldwide outbreak timeline.² As of March 27, 2020, there were 1,136 patients with COVID-19 in Thailand, and 2 of these were medical personnel working in operating rooms. These cases occurred in 2 different rural hospitals. The first case was an anesthesiologist and the second case was an internist working as a surgeon. These 2 patients had regular work rotations in operating rooms during the

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Cite this article: Sookaromdee P and Wiwanitkit V. (2020). COVID-19 among medical personnel in the operating room. *Infection Control & Hospital Epidemiology*, 41: 877–878, <https://doi.org/10.1017/ice.2020.106>

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