

ers' comments about our recent article.¹ Although we concluded that the WHO case definition criteria are not accurate when applied as screening criteria in the ED, our intent not to criticize the work of the WHO, and we recognize that diagnostic criteria and public health case definitions have different purposes. Nevertheless, the WHO case definition has been advocated and used worldwide in EDs and other primary health care settings as the basis for ED screening decisions, and to guide patient disposition and management. Since the outbreak in the spring of 2003, other authors^{2,3} have also identified this concern and concluded that the use of these criteria for early screening will result in over- and under-diagnosis, which is potentially disastrous for our patients and our health care system.

We agree with Dr. Daly that public health officials play a crucial role in containing and limiting the spread of SARS, but this does not reduce the need for emergency physicians to make difficult decisions based on inadequate information. We also agree with Dr. Ovens that the WHO criteria are not appropriate for ED screening decisions and that ED physicians need to develop the right tools for the right job. In our follow-up study (see page 12),⁴ we identified clinical and laboratory parameters, present during the initial ED visit, which will help emergency physicians make better screening decisions.

Our suggestion that the WHO case definition requires revision is supported by the fact that virology testing has become the gold standard for SARS diagnosis and has been incorporated as a component of the US Centers for Disease Control and Prevention (CDC) SARS case definition since July 2003.⁵ It is particularly important to develop a rapid SARS-CoV virological assay and deploy this in EDs to facilitate early confirmation. The costs of the SARS outbreak, both in terms of lives and in

dollars, demonstrate the need to urgently upgrade the ED response and to develop comprehensive national standards as recommended in the recent Canadian Association of Emergency Physicians position statement.⁶

Finally, in response to Dr. Daly's comments, I want to clarify that only the Amoy Garden residents in Block E where the index case lived were quarantined, and only those with definite close contact were monitored daily by our colleagues in the Hong Kong Department of Health, as described in the Report of the Hong Kong SARS Expert Committee.⁷ Unlike the confined outbreaks in Canada and Singapore, SARS spread widely in our Hong Kong community, and we could not afford to apply intensive public health measures to ALL potential contacts and low-risk suspected cases. This left primary care providers and emergency physicians to make critical early disposition and management decisions that undoubtedly had a major impact on the subsequent course of the outbreak.

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Case definition versus screening tool for SARS

To the Editor: In the November issue of *CJEM*, Wong Wing Nam and colleagues published an excellent study in which they compared physician judgement to the WHO case definition and concluded that the latter is an ineffective screening tool for SARS.¹ Other researchers^{2,3} have made similar criticisms, which may be unfair. The WHO criteria were not meant to be a triage screening tool. Rather, they were intended to "describe the epidemiology of SARS and to monitor the magnitude and spread of this disease, in order to provide advice on spread and control."⁴ It may therefore be inappropriate to apply these criteria in the ED.

In a subsequent study (see page 12), which was also published as an early online release, these authors identified clinical predictors helpful in the diagnosis of SARS.⁵ Not surprisingly, chest radiography was the strongest of these. Given that emergency physicians were able to use chest radiography in their di-

agnostic decisions, and that the WHO "suspect case" definition does not include radiographic findings, it is no wonder that physician judgement was more accurate. It would have been fairer to compare physician judgement with the WHO "probable case" definition, which includes radiographic evidence.⁴

Finally, the WHO criteria had poor sensitivity for ED screening because fever and respiratory symptoms are often delayed, in some cases appearing after radiographic changes.² In the Wong Wing Nam study, a patient who presented with a fever of 37.8°C, a positive contact history and radiographic changes would most likely have been correctly admitted as a suspected SARS case according to physician judgement, but would be considered a "miss" by the WHO criteria, even if the patient later progressed to develop a higher temperature (>38°C) and respiratory symptoms. In such a case, the ED physician was accurate, and the WHO criteria fulfilled its surveillance function. It is important to recognize the distinction between "screening tool" and "case definition." Misunderstanding may lead to unnecessary discredit to the WHO.

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**Correct way to wear
respirator head harnesses**

To the Editor: The cover photo of *CJEM*'s July 2003 issue showed 3 physicians who had intubated a patient at the North York General Hospital in Toronto.

My training in occupational hygiene at Mount Royal College and with the Canadian Navy gave me familiarity with respirators, and I noticed the 3 were wearing full face respirators with the head harnesses outside the hoods of their protective suits. One worker was wearing a hair net under his mask, which was visible through the visor.

Wearing respirators in this manner reduces the protection afforded. The correct way to wear the respirator head harness is under the hood of the protective suit. Hair nets are not to be worn under the respirator.

Protective equipment gives a false sense of security when worn incorrectly. The 3 workers in the picture were doing just that.

SARS is a very serious disease, and full protection is a must.

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**Medical myth:
The usefulness of pelvic exam**

To the Editor: When I first read the article by Brown and Herbert¹ in *CJEM*, I thought it was amusing. However, its conclusion was illogical and not supported by the studies cited. I believed that this was not a critical review of the literature and was not a threat to the time-honoured practice of pelvic examination used to guide ancillary investigations. It was not going to change my practice.

I have since discovered that some of my less experienced colleagues have misinterpreted this article and have stopped doing pelvic exams — instead, they are arranging outpatient ultrasounds for the next day, since our hospital does not provide 24-hour availability. My colleagues no longer perform speculum examinations to assess bleeding, discharge, foreign bodies, traumatic or other lesions; and they do not remove products of conception from the cervical os. Nor do they perform bimanual pelvic examination for the rapid and helpful information it provides. They have accepted Brown and Herbert's "evidence-based" statements questioning the usefulness of this procedure. Their change in practice compels me to address the quality of this article and its recommendations.

A key problem is the authors' premise that an investigation is useless unless it has the sensitivity and speci-

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