Dr. John Brackenbury/Science Photo Library

West Nile virus

West Nile virus (WNV) has been described in Africa and the Middle East since the 1930s, but it was only when the illness surfaced in New York City in 1999 that it started to command attention in North America. Since then the disease has spread, and in 2002 the WNV outbreak in North America was the largest ever documented. Caitlin Pepperell and colleagues describe the clinical characteristics of 64 patients admitted to hospital in southern Ontario and retrospectively identified as having been infected with WNV. They describe patient demographics, clinical presentation, neurological manifestions and course in hospital. Of greatest concern is the finding that most of these patients were previously active and living independently in the community, but suffered severe morbidity and mortality. Bob Nosal and Rosana Pellizzari offer a primer on WNV in our Public Health pages. In a related commentary, Howard Shapiro and Sandra Micucci describe how a full response to WNV consists of public education, surveillance and mosquito control; particular attention is paid to the effectiveness and safety of pesticides.

See pages 1399, 1427, 1443 and 1455

Differences in operative mortality

In Canada, regionalization of health services has caused considerable controversy. Advocates for regionalization of surgical procedures, particularly complex ones, often maintain that outcomes are better at hospitals where these operations are performed more frequently. David Urbach and colleagues tested this hypothesis by collecting data concerning 31 632 people who underwent 1 of 5 surgical procedures (2 with high and 3 with low operative mortality) and compared the results from Ontario hospitals with higher and lower operative frequency. They found that restricting some complex procedures to high-volume hospitals might prevent a small number of deaths.

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SARS

When severe acute respiratory syndrome (SARS) hit Canada, it hit quickly. Several hospitals in Toronto found themselves dealing with an extremely contagious disease whose cause, diagnosis and treatment were unknown. The earliest cases presented to community hospitals and, before a diagnosis could be made, infection was passed both to fellow patients and to hospital staff. Hy Dwosh and coworkers describe the pattern of transmission at their community hospital in Richmond Hill, Ont., precipitated by a patient requiring urgent hemodialysis who had been transferred to their hospital after being exposed to SARS at another institution. They describe the clinical course of the subsequent cases and the ensuing public health response, which involved the quarantine of over 5000 people, and trace the pattern of infection that resulted in 15 suspected or probable cases of SARS.

In a related commentary, Richard Schabas argues that the perceived risk of SARS in Canada is disproportionate to the actual risk of getting the disease. He cautions that the actions of the public and their health officials should be based on facts and experience, not fear. In a second commentary, Guénaël Rodier, Director of the World Health Organization's Communicable Disease Surveillance and Response division, explains why Toronto was targeted for a worldwide travel advisory, and why this decision was reversed shortly after its announcement.

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See pages 1415, 1432 and 1434