

Coronavirus Infections in Children Including COVID-19

An Overview of the Epidemiology, Clinical Features, Diagnosis, Treatment and Prevention Options in Children

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Abstract: Coronaviruses (CoVs) are a large family of enveloped, single-stranded, zoonotic RNA viruses. Four CoVs commonly circulate among humans: HCoV2-229E, -HKU1, -NL63 and -OC43. However, CoVs can rapidly mutate and recombine leading to novel CoVs that can spread from animals to humans. The novel CoVs severe acute respiratory syndrome coronavirus (SARS-CoV) emerged in 2002 and Middle East respiratory syndrome coronavirus (MERS-CoV) in 2012. The 2019 novel coronavirus (SARS-CoV-2) is currently causing a severe outbreak of disease (termed COVID-19) in China and multiple other countries, threatening to cause a global pandemic. In humans, CoVs mostly cause respiratory and gastrointestinal symptoms. Clinical manifestations range from a common cold to more severe disease such as bronchitis, pneumonia, severe acute respiratory distress syndrome, multi-organ failure and even death. SARS-CoV, MERS-CoV and SARS-CoV-2 seem to less commonly affect children and to cause fewer symptoms and less severe disease in this age group compared with adults, and are associated with much lower case-fatality rates. Preliminary evidence suggests children are just as likely as adults to become infected with SARS-CoV-2 but are less likely to be symptomatic or develop severe symptoms. However, the importance of children in transmitting the virus remains uncertain. Children more often have gastrointestinal symptoms compared with adults. Most children with SARS-CoV present with fever, but this is not the case for the other novel CoVs. Many children affected by MERS-CoV are asymptomatic. The majority of children infected by novel CoVs have a documented household contact, often showing symptoms before them. In contrast, adults more often have a nosocomial exposure. In this review, we summarize epidemiologic, clinical and diagnostic findings, as well as treatment and prevention options for common circulating and novel CoVs infections in humans with a focus on infections in children.

Key Words: severe acute respiratory syndrome coronavirus, Middle East respiratory syndrome coronavirus, severe acute respiratory syndrome coronavirus 2, epidemiology, symptoms, laboratory, imaging, treatment, vaccines, prevention, treatment, vaccines, prevention, SARS-CoV, MERS-CoV, SARS-CoV-2

(*Pediatr Infect Dis J* 2020;XX:00–00)

Coronaviruses (CoVs) comprise a large family of enveloped, single-stranded, zoonotic RNA viruses belonging to the family *Coronaviridae*, order *Nidovirales* (Fig.1).¹ They can infect a variety

of animals (including livestock, companion animals and birds), in which they can cause serious respiratory, enteric, cardiovascular and neurologic disease.^{2,3} In humans, CoVs mostly cause respiratory and gastrointestinal symptoms ranging from the common cold to more severe disease such as bronchitis, pneumonia, severe acute respiratory distress syndrome (ARDS), coagulopathy, multi-organ failure and death.^{4–8} Human coronaviruses (HCoVs) have also been associated with exacerbations of chronic obstructive pulmonary disease,⁹ cystic fibrosis¹⁰ and asthma.^{11,12}

CoVs are classified into *Alphacoronaviruses* and *Betacoronaviruses* (which are mainly found in mammals such as bats, rodents, civets and humans) and *Gammacoronaviruses* and *Deltacoronaviruses* (which are mainly found in birds).^{8,13,14} Four CoVs commonly circulate among humans: HCoV2-229E, -HKU1, -NL63 and -OC43.^{15,16} These viruses are believed to have originally derived from bats (NL63, 229E),^{17,18} dromedary camels (229E)¹⁹ and cattle (OC43).²⁰ The origin of HCoV-HKU1 remains unknown. Several CoVs are known to circulate in animals (with bats acting as the main reservoir) but have not been associated with human infection.^{3,21,22} CoVs are capable of rapid mutation and recombination leading to novel CoVs that can spread from animals to humans. This occurred in China in 2002 when the novel CoV severe acute respiratory syndrome coronavirus (SARS-CoV) emerged, thought to have been transmitted from civet cats or bats to humans.^{22–25} Another novel CoVs emerged in Saudi Arabia in 2012, Middle East respiratory syndrome coronavirus (MERS-CoV), which is transmitted from dromedary camels to humans.^{26,27} The 2019 novel CoV (SARS-CoV-2), which originated in China and is currently causing outbreaks globally, is a novel *Betacoronavirus* belonging to the lineage B or subgenus sarbecovirus, which includes SARS-CoV.²⁸ Sequencing shows that the genome is most closely related (87%–89% nucleotide identity) to the bat SARS-related CoV found in Chinese horseshoe bats (bat-SL-CoVZC45).^{28,29} The outbreak of SARS-CoV-2 started in Wuhan city, Hubei province, China, where The Health Commission of Hubei province first announced a cluster of adults with pneumonia of unexplained etiology on December 31, 2019. A local seafood and animal market was identified as a potential source. However, the main driver of the outbreak is symptomatic and asymptomatic humans infected with SARS-CoV-2 from whom the virus can spread to others through respiratory droplets or direct contact.²⁸ From Wuhan city SARS-CoV-2 has spread to other Chinese cities and internationally, threatening to cause a global pandemic. The term COVID-19 is used for the clinical disease caused by SARS-CoV-2.³⁰

In this review, we summarize epidemiologic, clinical and diagnostic findings, as well as treatment and prevention options for common circulating and novel CoVs infections in humans with a focus on infections in children.

EPIDEMIOLOGY

Common Circulating HCoVs

Common circulating HCoVs can be isolated from 4% to 6% of children hospitalized for acute respiratory tract infections^{11,15,31} and from 8% of children in an ambulatory setting (Table 1).^{15,32,33}

Accepted for publication March 3, 2020.

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P.Z. is supported by a Fellowship from the European Society for Paediatric Infectious Diseases.

The authors have no conflicts of interest to disclose.

P.Z. drafted the initial article. N.C. critically revised the article and both authors approved the final article as submitted.

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ISSN: 0891-3668/20/XXXX-0000

DOI: 10.1097/INF.0000000000002660

Children under the age of 3 years and children with heart disease are the most frequently affected.^{4,15,35,36} Reinfections later in life are common^{32,115,116} despite the fact that most individuals seroconvert to HCoVs during childhood.^{117–120} In contrast to other respiratory tract viruses [eg, respiratory syncytial virus (RSV)], there is no decrease in the relative prevalence of HCoVs infections with increasing age.^{4,5,15,36}

In 11%–46% of cases, common circulating HCoVs are found as coinfections with other respiratory viruses such as adeno-, boca-, rhino-, RSV, influenza or parainfluenza virus.^{5,15,16,31–33,36,79,81,121,122} Symptomatic children whose only detectable respiratory virus is a HCoV are reported to more likely suffer from an underlying chronic disease compared with children coinfecting with other respiratory viruses.³¹

Of the 4 common circulating HCoVs, NL63 and OC43 are the most frequently isolated species.^{4,11,15,35,36} Cyclical patterns have been observed for 229E and OC43, with outbreaks occurring every 2–4 years.^{4,15,32,35,82,116,119} Seasonal patterns have also been observed: in the Northern Hemisphere, common circulating HCoVs mostly cause infections in humans between December and May, and in the Southern Hemisphere between March and November with peaks in late winter/early spring for 229E and OC43 and in autumn for NL63.^{4,5,11,15,32,123} HCoV-HKU1 has been reported to mainly occur in spring and summer in Hong Kong,^{11,124} but in winter and spring in the United Kingdom and Brazil.^{4,15}

SARS-CoV and MERS-CoV

SARS-CoV is a novel group 2b *Betacoronavirus* which initially emerged in Guangdong province, south China in 2002,^{23–25} then spread to Hong Kong and from there rapidly to many other countries.¹²⁵ It caused severe lower respiratory tract infection with a severe morbidity and a high case-fatality rate (approaching 50% in individuals over 60 years of age, overall 10%).^{63,106,107,126} Person-to-person transmission of SARS-CoV is well established.⁵⁵ The virus has spread to 29 countries and has been estimated to have caused more than 8000 infections and 774 deaths worldwide (Table 1).⁵²

MERS-CoV is a novel group 2c *Betacoronavirus* which first appeared in Saudi Arabia in 2012.^{26,27,127} It can spread from person-to-person¹²⁸ and can cause severe lower respiratory tract infections with a case-fatality rate of 20% to 40%.^{67,106,108–112} Apart from being endemic in the Middle East, there was a nosocomial outbreak of MERS-CoV in South Korea in 2014, involving 16 hospitals and 186 patients, caused by a medical doctor returning from the Middle East.^{49,68} MERS-CoV spread to 27 countries causing an estimated 2494 infections and 858 deaths (Table 1).⁵³

The overall reproductive number (R0) for SARS-CoV was estimated to be 0.3–2.9^{37,39,40,42,43,47} and for MERS-CoV to be 0.5–3.5 (Table 1).^{39,46,48} R0s largely depend on geographic location, stage of the outbreak and inclusion of only nosocomial versus general transmission. Both viruses have been associated with early super-spreading events with R0s of up to 22 for SARS-CoV^{39,40,43} and up to 30 for MERS-CoV.^{39,49} These large numbers of secondary infections have been mostly associated with nosocomial outbreaks: 30% of all SARS-CoV cases (mostly health care workers) and 44%–100% of all MERS-CoV cases (mostly patients) occurred from nosocomial transmissions.^{39,55,56} These super-spreading events were followed by reduced spread in the following generations of viruses with a decrease in the R0s to 0.8 for SARS-CoV³⁹ and to 0.7 for MERS-CoV (Table 1).¹²⁸ Therefore, both SARS-CoV and MERS-CoV have low potential for long-term sustained community transmission. No human SARS-CoV infections have been detected since July 2003. However, SARS-CoV-like viruses can be found in bats, which are known to be able infect human cells without adaptation, making it possible for SARS-CoVs to reemerge⁸⁴ (as has now happened with SARS-CoV-2). The zoonotic transmission of MERS-CoV to humans has continued, attributed to the role of dromedary camels as a reservoir and their close contact with humans (in contrast to human-bat-interactions).²¹

SARS-CoV-2

Early in the SARS-CoV-2 outbreak, it was shown that person-to-person transmission was the main driver.²⁸ The R0 for

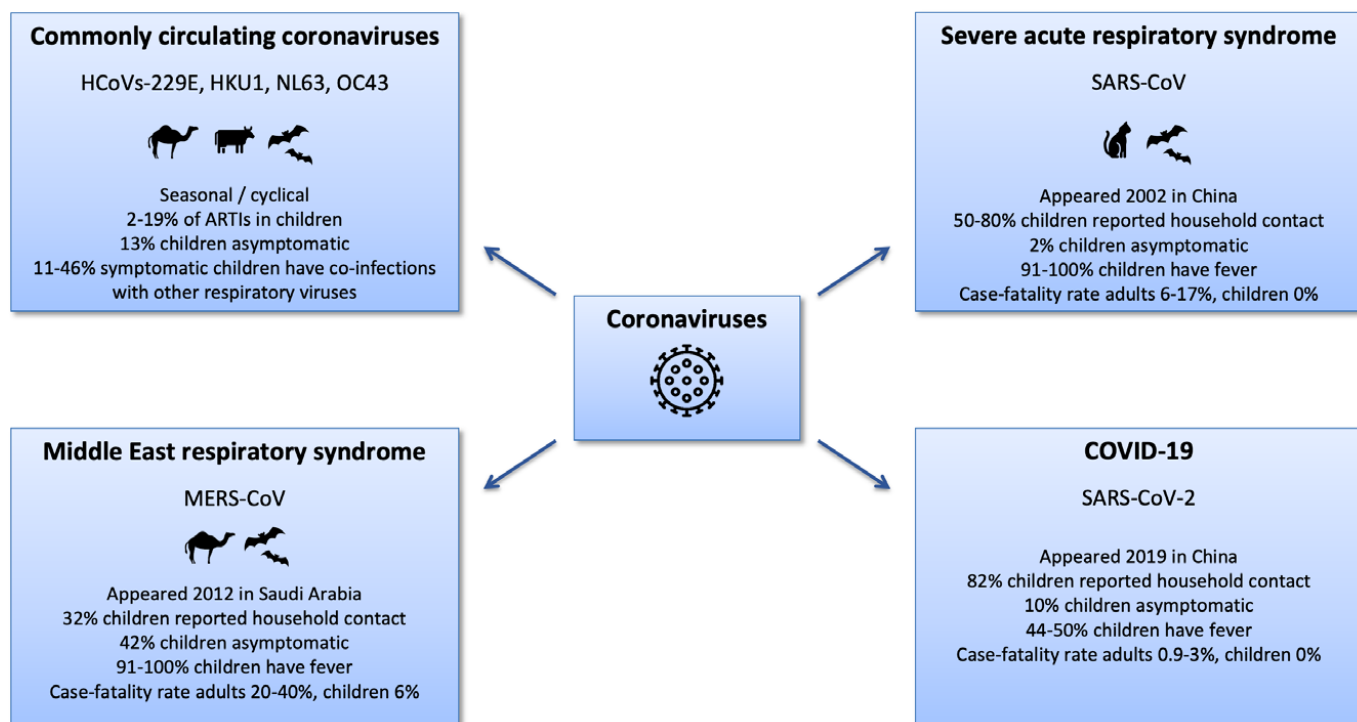


FIGURE 1. Summary of coronavirus diseases. COVID-19 indicates coronavirus disease 2019.

TABLE 1. Characteristics of Human Coronaviruses

	Commonly Circulating HCoV-229E, HKU1, NL63, and OC43, unless otherwise specified	Novel Coronaviruses	SARS-CoV	MERS-CoV	SARS-CoV-2
Prevalence (for 229E, HKU1, NL63, and OC43, unless otherwise specified)	Eight countries: 6% in children with ARTIs (ambulatory, >1 yr) ³³ Brazil: 5% in children with ARTIs (ambulatory and hospitalized, >9 yr) ⁴ China: 2% in children with fever and upper ARTIs (ambulatory and hospitalized, >5 yr) ³⁵ France: 6% (HCoV-OC43) in children and adults with ARTIs (ambulatory and hospitalized, October to April) ⁵ Hong Kong: 4% (HCoV-229E, -OC43, -NL63) in children with ARTIs (hospitalized, >1 yr) ¹¹ Israel: 10% in children and adults with ARTIs (ambulatory and hospitalized, September to April) ³⁶ Nepal: 8% of infants < 6 mo with upper ARTIs (ambulatory, >3 yr) ³² United Kingdom: 5% in infants 7–12 mo with ARTIs (ambulatory and hospitalized, over 3 yr) ¹⁶ United States: 19% in adolescents with ARTIs (ambulatory, October to January), ¹⁶ 6% in children with ARTIs (hospitalized, >1 yr) ³¹	Saudi Arabia: 0% of 2235 children with ARTIs (ambulatory and hospitalized, over 2 yr, 2012–2013) ³⁴	Unknown	Saudi Arabia: 0% of 2235 children with ARTIs (ambulatory and hospitalized, over 2 yr, 2012–2013) ³⁴	Unknown
Mean reproductive number	Worldwide: overall 2.9 (95% CI: 2.2–3.6) ³⁷ Singapore plus Toronto: overall 1.0 (95% CI: 0.7–1.2) ³⁹ Beijing: overall 0.9 (90% CI: 0.3–1.5) ⁴⁰ , early phase 1.9 (90% CI: 0.4–3.32) ⁴⁰ Hong Kong: overall 0.7 (95% CI: 0.7–0.8), ⁴² early phase 3.6 (95% CI: 3.1–4.2), ⁴² overall 1.7 (IQR, 0.4–2.3), ⁴³ overall 0.9 (95% CI: 0.7–1.1), ⁴⁴ early phase 2.7 (95% CI: 2.2–3.7) ⁴⁴ Singapore: overall 1.6 (90% CI: 0.5–2.7), ⁴⁰ early phase 2.6 (90% CI: 0.5–4.5), ⁴⁰ overall 0.7 (95% CI: 0.6–0.9), ⁴² early phase 3.1 (95% CI: 2.3–4.0), ⁴² 1.8 (IQR, 0.5–2.5), ⁴³ early phase 2.2, ³⁹ range 2.2–3.6 ⁴⁵ Taiwan: overall 2.6 (90% CI: 0.3–5.3) ⁴⁷ Toronto: overall 1.0 (95% CI: 0.9–1.2), ⁴² early phase 2.7 (95% CI: 1.8–3.6), ⁴² overall 0.9 (IQR, 0.2–1.2), ⁴⁴ early phase 7 ³⁹ Vietnam: overall 0.3 (95% CI: 0.1–0.7), ⁴² early phase 0.7 (95% CI: 0.7–0.8), ⁴² overall 2.4 (95% CI: 1.8–3.1) ⁴²	Worldwide: overall 1.0 (95% CI: 0.6–1.3) ³⁷ Saudi Arabia plus South Korea: overall 0.9 (95% CI: 0.4–1.4) ³⁹ Jeddah: overall range 3.5–6.7 ⁴¹ Riyadh: overall range 2.0–2.8 ⁴¹ Middle East: overall 0.5 (95% CI: 0.3–0.8), ⁴⁶ early phase 3 ³⁹ Saudi Arabia: overall 0.5 (95% CI: 0.3–0.6) ⁴⁶ South Korea: early phase 30, ³⁹ range 2.0–8.1 ⁴⁹	Worldwide: overall 1.0 (95% CI: 0.6–1.3) ³⁷ Saudi Arabia plus South Korea: overall 0.9 (95% CI: 0.4–1.4) ³⁹ Jeddah: overall range 3.5–6.7 ⁴¹ Riyadh: overall range 2.0–2.8 ⁴¹ Middle East: overall 0.5 (95% CI: 0.3–0.8), ⁴⁶ early phase 3 ³⁹ Saudi Arabia: overall 0.5 (95% CI: 0.3–0.6) ⁴⁶ South Korea: early phase 30, ³⁹ range 2.0–8.1 ⁴⁹	Worldwide: overall 1.0 (95% CI: 0.6–1.3) ³⁷ Saudi Arabia plus South Korea: overall 0.9 (95% CI: 0.4–1.4) ³⁹ Jeddah: overall range 3.5–6.7 ⁴¹ Riyadh: overall range 2.0–2.8 ⁴¹ Middle East: overall 0.5 (95% CI: 0.3–0.8), ⁴⁶ early phase 3 ³⁹ Saudi Arabia: overall 0.5 (95% CI: 0.3–0.6) ⁴⁶ South Korea: early phase 30, ³⁹ range 2.0–8.1 ⁴⁹	Wuhan: 2.7 (2.5–3.9) (as of February 2020) ³⁸ 2.2 (2.0–2.6)–3.6 (2.9–4.4) (as of January 2020) ³⁰
Zoonotic origin	Bats (NL63, 229E) ^{17,18} Dromedary camels (229E) ¹⁹ Cattle (OC43) ²⁰	Dromedary camels ²⁷ (bats as reservoirs) ²¹	Civet cats ^{24,25} (bats as reservoirs) ^{21,22}	Dromedary camels ²⁷ (bats as reservoirs) ²¹	Pangolin suspected but unproven ⁵¹
Outbreak extent and numbers (adults and children)	Unknown	29 countries ⁵² 8000 infections ⁵² 774 deaths ⁵²	29 countries ⁵³ 2494 infections ⁵³ 3584 deaths ⁵³	27 countries ⁵⁵ 2494 infections ⁵³ 3584 deaths ⁵³	102 countries ⁵⁴ 105,586 infections ⁵⁴ 3584 deaths ⁵⁴ (as of March 9, 2020)
Transmission in adults	Unknown	30% nosocomial (mostly health care workers) ⁵⁵ 13%–21% household contacts ⁵⁵	30% nosocomial (mostly health care workers) ⁵⁵ 13%–21% household contacts ⁵⁵	44%–100% nosocomial (mostly patients) ^{56,55,56} 22%–39% household contacts ^{56,55,56}	Unknown
Transmission in children	Unknown	50%–80% household contacts ^{57–59} 30% nosocomial contacts ⁵⁷	50%–80% household contacts ^{57–59} 30% nosocomial contacts ⁵⁷	32% household contacts ⁶⁰ 23% other contacts ⁶⁰ 19% nosocomial infections ⁶⁰	82% household contacts ⁶¹
Incubation period	2–5 d ^{20,62}	4–6 d (range 2–10 d) ^{63–66} 95% develop symptoms within 13 d ^{63,64}	4–6 d (range 2–10 d) ^{63–66} 95% develop symptoms within 13 d ^{63,64}	5–7 d (range 4–13 d) ^{64,67–71} 95% develop symptoms within 13 d ^{64,67–70}	5–6 d (range 2–14 d) ^{38,64,72}

(Continued)

TABLE 1. (Continued)

		Novel Coronaviruses		
		SARS-CoV	MERS-CoV	SARS-CoV-2
Commonly Circulating HCoV				
Serial interval mean	Unknown	6 d (interquartile range, 4–9 d) ⁴⁰ 8 d (95% CI: 1.6–19.2 d) ³⁷ 8 d (SD 4 d) ⁴⁵	7 d (SD 4 d) ⁴⁸ 8 d (95% CI: 2.5–25.3 d) ³⁷ 12 d (SD 3 d) ⁷⁰	8 d ³⁸
Shedding duration	6 d (3–10 d) in children in daycare ⁷³	Mostly after onset of symptoms ^{74,75}	Mostly after onset of symptoms ⁷⁰	Unknown
Asymptomatic proportion of children	13% asymptomatic ¹⁶	2% asymptomatic ^{57,59}	42% asymptomatic ^{60,76}	9%–11% asymptomatic ^{61,77}
Clinical features in children	Fever, ^{5,11,22} rhinitis, ^{5,11} conjunctivitis, ⁷⁸ otitis, ⁵ pharyngitis, ^{5,11} laryngitis, ⁵ croup, ^{4,79,80} headache, ^{5,16,81} bronchitis, ^{5,11} bronchiolitis, ^{5,11} wheezing, ^{4,11,32} asthma exacerbations, ^{1,12} pneumonia, ^{5,81,82} gastrointestinal symptoms, ^{5–7} febrile seizures, ^{7,11} neurologic disseminated ⁸³	Fever (91%–100%), ^{57–59} myalgia (10%–40%), ^{57,84} rhinitis (33%–60%), ^{38,57,84} sore throat (5%–30%), ^{38,57,84} cough (43%–80%), ^{38,57,84} dyspnea (10%–14%), ^{38,84} headache (14%–40%), ^{38,57,84} vomiting (20%), ^{36,57} abdominal pain (10%), ⁵⁷ diarrhea (10%), ^{38,84} febrile seizures (10%) ⁵⁷	Fever (57%), ^{37,76} vomiting (28%), ^{37,76} cough and diarrhea (28%), ^{61,72} rhinitis, ⁷² fatigue, ⁷² headache, ⁷² diarrhea, ⁷² dyspnea, ⁷² cyanosis, ⁷² poor feeding ⁷²	Fever (44%–50%), ^{61,72,77} cough (38%), ^{61,72} rhinitis, ⁷² fatigue, ⁷² headache, ⁷² diarrhea, ⁷² dyspnea, ⁷² cyanosis, ⁷² poor feeding ⁷²
Laboratory findings in children	Not reported	Not reported	Normal WBC ⁷⁶	Normal or reduced WBC ^{91,72}
Imaging findings in children	Not reported	Decreased neutrophil count ⁸⁵ Decreased lymphocyte count ^{57–59,86} Thrombocytopenia ^{57–59,86}	Decreased neutrophil count ⁸⁵ Decreased lymphocyte count ^{57–59,86} Thrombocytopenia ^{57–59,86}	Decreased neutrophil count ⁹¹ Decreased lymphocyte count ^{61,72}
Diagnosics (adults and children)	Multi- or monoplex RT-PCR or RNA sequencing on nasopharyngeal or oropharyngeal swabs, sputum, endotracheal aspirate or bronchoalveolar lavage ^{6,15,90}	Increased alanine aminotransferase ^{57–59,86} Increased lactate dehydrogenase ⁵⁷	Normal liver function tests ⁷⁶ Normal urea and creatinine levels ^{57,6}	Abnormal liver function tests ⁷² Increased lactate dehydrogenase ⁶¹
Case-fatality rate in adults	Sporadic cases reported in immunosuppressed adults ^{104,105}	Deranged coagulation and increased D-dimers in severe cases ^{57–59,86}	RT-PCR or sequencing of RNA on nasopharyngeal or oropharyngeal swabs, sputum, endotracheal aspirate or bronchoalveolar lavage ^{94–96}	Increased D-dimers in severe cases ⁷²
Case-fatality rate in children	Unknown	20%–40% ^{67,106,108–112}	RT-PCR on stool (not routine) ⁹¹ Serology (not in acute phase) ^{100–102}	Chest CT: bilateral multiple patchy, nodular ground-glass opacities, speckled ground-glass opacities and/or infiltrating shadows in middle and outer zone of the lung or under the pleura ^{61,88}

*Case series consisted of 7 children only.

ARTI indicates acute respiratory tract infection; CI, confidence interval; IQR, interquartile range; PCT, procalcitonin; WBC, white blood cell.

SARS-CoV-2 is currently estimated at 2.7.³⁸ The incubation period is estimated at 5–6 days, which is similar to that for SARS-CoV and MERS-CoV.^{38,63–65,67–72} The serial interval is estimated to be 8 days, also similar to the other novel CoVs (Table 1).^{38,45,48,70} By March 2020, the World Health Organization reported that SARS-CoV-2 had spread to over 100 countries and caused over 100,000 infections and over 3500 deaths.⁵⁴ At that time the case-fatality rate was uncertain but estimated at 0.9%–3%,^{54,113,114} which is much lower than for SARS-CoV and MERS-CoV (6%–17% and 20%–40%, respectively).^{63,67,106–112}

SYMPTOMS

Common HCoVs

In children, common circulating HCoVs can cause common cold symptoms such as fever,^{5,11,32} rhinitis,^{5,11} otitis,⁵ pharyngitis,^{5,11} laryngitis⁵ and headache,^{5,16,81} but also bronchitis,^{5,11} bronchiolitis,^{5,11} wheezing,^{4,11,32} pneumonia,^{5,81,82} and, in up to 57% of cases, gastrointestinal symptoms (which are more common in children than adults).^{5–7} In a study including children and adults, fatigue, headache, myalgia and sore throat were more common in HCoV-infected patients compared with RSV-infected patients, while fever, cough and dyspnea were more frequent in the later.³⁶ Fewer patients infected with HCoVs had fever compared with those infected with RSV or influenza.³⁶

In children, HCoV-NL63 has been associated with conjunctivitis,⁷⁸ croup,^{11,79,80} asthma exacerbations,^{11,12} febrile seizures¹¹ and HCoV-HKU1 with febrile seizures.⁷ Rare cases of neurologic diseases have also been described (eg, the detection of HCoV in cerebrospinal fluid in a child presenting with acute disseminated encephalomyelitis⁸³ or in cerebrospinal fluid of adults with multiple sclerosis).^{129,130} A suspected association between HCoVs and Kawasaki disease could not be confirmed.^{131,132} Common HCoVs can be isolated from asymptomatic individuals.¹⁶ During an infection, the viral load is high in the first 2 days and decreases thereafter.²⁹ A correlation between viral load and severity of disease has not been observed.²⁹ This contrasts with SARS-CoV for which a higher initial viral load is independently associated with a worse prognosis, including a higher case-fatality rate.^{133,134} Virus particles can be isolated from nasopharyngeal secretions up to 14 days after the onset of infection.¹³⁵

SARS-CoV

There are 3 case series that report a total of 41 children who were affected by SARS-CoV.^{57–59} The virus was associated with milder disease in children compared with adults, and no deaths have been reported in children.^{57–59,86} Symptomatic children with SARS-CoV infection were reported to have fever (91%–100%),^{57–59} myalgia (10%–40%),^{57,58} rhinitis (33%–60%),^{57–59} sore throat (5%–30%),^{57–59} cough (43%–80%),^{57–59} dyspnea (10%–14%),^{38,84} headache (14%–40%)^{57–59} and, less commonly, vomiting (20%),^{57,59} abdominal pain (10%),⁵⁷ diarrhea (10%)^{58,59} and febrile seizures (10%).⁵⁷ In total, 50%–80% of children had other family members who were infected^{57–59} and 30% had a nosocomial contact with SARS-CoV.⁵⁷ Most children recover quickly from an infection with SARS-CoV.⁸⁶ However, abnormalities on chest computed tomography (CT) can persist for several months (eg, air trapping and ground-glass opacifications).¹³⁶

There is no evidence that SARS-CoV can be vertically transmitted to the fetus.¹³⁷ However, SARS-CoV infections during pregnancy have been associated with possible miscarriage, intrauterine growth retardation and preterm delivery.^{137,138}

MERS-CoV

Most case series of patients infected with MERS-CoV report a low proportion (0.1%–4%) of children.^{34,76,109,110,139,140} In a

large case series of 2235 children with acute respiratory tract infection who presented to a tertiary hospital in Saudi Arabia during the MERS-CoV epidemic (2012–2013), none tested positive for MERS-CoV (Table 1).³⁴ There are 2 small case series of children infected with MERS-CoV: one including 31 children with a mean age of 10 years⁶⁰ and the other one only 7 children.⁷⁶ In both studies, 42% of children were asymptomatic.^{60,76} In the case series of 7 children, 57% suffered from fever, 28% from vomiting and diarrhea and 14% from cough and shortness of breath.⁷⁶ Two children required oxygen supplementation and one mechanical ventilation.⁷⁶ In the other case series, 2 died (6%).⁶⁰ The main sources of MERS-CoV infection in children were household (32%) and other contacts (23%), followed by nosocomial transmission (19%).⁶⁰

Eight cases of MERS-CoV maternal infections during pregnancy have been reported (occurring between 20 and 28 weeks of pregnancy), three of the affected infants died.^{141–144}

SARS-CoV-2

Different case definitions for COVID-19 cases in adults and children from authoritative sources as of March 2020 are detailed in Table 2. Children are less commonly affected by SARS-CoV-2, the Chinese Centers for Disease Control and Prevention reports that of the 72,314 cases reported as of February 11, 2020, only 2% were in individuals of less than 19 years of age.¹¹⁴ There are 3 case series of children who have been infected with SARS-CoV-2.^{61,72,77} The first included 20 children up to January 31, 2020, in the Province of Zhejiang,⁷² the second 34 children between January 19, 2020, and February 7, 2020, in the Province of Shenzhen,⁶¹ and the third 9 infants from different provinces in China.⁷⁷ The case series with 34 children provides the most clinical details: none of the children had an underlying disease, 65% had common respiratory symptoms, 26% had mild disease and 9% were asymptomatic.⁶¹ The most common symptoms were fever (50%) and cough (38%).⁶¹ In the case series of 20 children, presentation was with low to moderate or no fever, rhinitis, cough, fatigue, headache, diarrhea and, in more severe cases, with dyspnea, cyanosis and poor feeding, but the numbers were not specified.⁷² In the series of 9 infants, only 4 were reported to have fever. One infant was asymptomatic.⁷⁷ Additional asymptomatic children infected with SARS-CoV-2 outside these case series have also been described (eg, a 10-year-old asymptomatic child with radiologic ground-glass lung opacities on chest CT).²⁸ Most infected children recover 1–2 weeks after the onset of symptoms and no deaths from SARS-CoV-2 had been reported by February 2020.⁷²

From these series, it appears that children have milder clinical symptoms than adults^{61,72} (as has been reported for SARS-CoV and MERS-CoV infections),^{57–60,76,86} which could mean children might not be tested for SARS-CoV-2 as frequently as adults. It has therefore been suggested that asymptomatic or mildly symptomatic children might transmit the disease.¹⁴⁷ However, the majority of children infected with SARS-CoV-2 thus far have been part of a family cluster outbreak [100% in the infants series, in which other family member had symptoms before the infants in all cases; 82% in the case series of 34 children;⁶¹ and the majority in the one with 20 children (exact number not specified)].⁷² This is similar to SARS-CoV, in which 50%–80%^{57–59} of children were reported to have an affected household contact⁶⁰ and to MERS-CoV in which it was 32%.⁶⁰

A study prepublished in early March 2020 suggests that children are just as likely as adults to become infected with SARS-CoV-2 but are less likely to be symptomatic or develop severe symptoms.²⁴⁶ However, the importance of children in transmitting the virus remains uncertain.

From a small case series of 9 mothers who were infected with SARS-CoV-2, there is, to date, no evidence that SARS-CoV-2 can be vertically transmitted to the infant.¹⁴⁸

TABLE 2. Case Definitions for SARS-CoV-2 Infections in Adults and Children (as of February 2020)**Adults: Original case definition from the Chinese CDC³⁸**

A suspected or probable case is defined as a case that meets: (1) three clinical criteria or (2) two clinical criteria and one epidemiologic criterion
Clinical criteria:

1. Fever
2. Radiographic evidence of pneumonia or acute respiratory distress syndrome
3. Low or normal white blood cell count or low lymphocyte count

Epidemiologic criteria:

1. Living in Wuhan or travel history to Wuhan within 14 d before symptom onset
2. Contact with patients with fever and symptoms of respiratory infection within 14 d before symptom onset
3. Link to any confirmed cases or clusters of suspected cases

Adults: Case definition from the US CDC (February 13, 2020)¹⁴⁵

- A. Fever or signs/symptoms of lower respiratory illness (eg, cough or shortness of breath) AND close contact with a laboratory-confirmed SARS-CoV-2 patient within 14 d of symptom onset
- B. Fever and signs/symptoms of lower respiratory illness (eg, cough or shortness of breath) AND a history of travel from Hubei Province, China within 14 d of symptom onset
- C. Fever or signs/symptoms of lower respiratory illness (eg, cough or shortness of breath) requiring hospitalization AND a history from mainland China within 14 d of symptom onset

Adults: Case definition from the World Health Organisation (WHO) (27th February 2020), which also form the basis for the European Centre for Disease Prevention and Control (ECDC) case definition¹⁴⁶

Suspected case

- A. Patient with acute respiratory infection [fever and at least one sign/symptom of respiratory disease (eg, cough, shortness of breath)] AND with no other aetiology that fully explains the clinical presentation AND a history of travel to or residence in a country/area or territory reporting local transmission of COVID-19 during the 14 days prior to symptom onset; OR
- B. A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to onset of symptoms; OR
- C. A patient with severe acute respiratory infection (as above) AND requiring hospitalization AND with no other aetiology that fully explains the clinical presentation.

Children: Case definition by the National Clinical Research Center for Child Health, Zhejiang University School of Medicine (adapted from Chen et al⁷²)

A suspected or probable case is defined as a case that meets: two clinical criteria and one epidemiologic criterion

Clinical criteria:

1. Fever, fatigue, dry cough; some pediatric patients may have no fever
2. Patients with the following chest imaging findings: multiple small patchy shadows and interstitial changes, mostly in the lung periphery, bilateral multiple ground-glass opacity, infiltrating shadows, pulmonary consolidation on chest radiography or ground-glass opacities, bilateral segmental lung consolidation, especially in the periphery on chest CT
3. White blood cell counts are normal or decreased, or with decreased lymphocyte count

Epidemiologic criteria:

1. Children with a travel or residence history in Wuhan City and neighboring areas, or other areas with persistent local transmission within 14 d prior to disease onset
2. Children with a history of contacting patients with fever or respiratory symptoms who have a travel or residence history in Wuhan City and neighboring areas, or in other areas with persistent local transmission within 14 d prior to disease onset
3. Children with a history of contacting confirmed or suspected cases infected with SARS-CoV-2 within 14 d prior to disease onset
4. Children who are related with a cluster outbreak: in addition to this patient, there are other patients with fever or respiratory symptoms, including suspected or confirmed cases infected with SARS-CoV-2
5. Newborns delivered by suspected or confirmed SARS-CoV-2-infected mothers

A confirmed case is defined as a case that meets any of the following criteria:

1. Throat swab, sputum, stool or blood samples tested positive for SARS-CoV-2 nucleic acid using RT-PCR
2. Genetic sequencing of throat swab, sputum, stool or blood samples being highly homologous with the known SARS-CoV-2
3. SARS-CoV-2 granules being isolated by culture from throat swab, sputum, stool or blood samples

CDC indicates Centers for Disease Control and Prevention.

LABORATORY FINDINGS

Laboratory findings from children are similar with infections caused by different novel CoVs (Table 1). The white blood cell count is typically normal or reduced with decreased neutrophil⁸⁵ and/or lymphocyte counts.^{57–59,72,86} Thrombocytopenia may occur.^{57–59,76,86} C-reactive protein and procalcitonin levels are often normal.⁷² In severe cases, elevated liver enzymes,^{57–59,72,86} lactate dehydrogenase levels,⁵⁷ as well as an abnormal coagulation and elevated D-dimers have been reported.^{57–59,72,86}

SARS-CoV-2

The same laboratory findings as above have been observed for children infected with SARS-CoV-2.⁶¹ In the case series of 34 children, the white blood cell count was normal in 83%, neutropenia and lymphopenia were each found in 1 case (3%). The lactate

dehydrogenase level was elevated in 30% of cases.⁶¹ C-reactive protein and procalcitonin levels were each elevated in 1 case only (3%).

RADIOLOGIC FINDINGS

Similar to the laboratory findings, radiologic findings from children are also similar across infections with different novel CoVs (Table 1). On chest radiography, children mostly show bilateral patchy airspace consolidations often at the periphery of the lungs, peribronchial thickening and ground-glass opacities.^{57–59,76,86,87} Chest CT mostly shows airspace consolidations and ground-glass opacities.⁸⁹

SARS-CoV-2

CT changes observed in children infected with SARS-CoV-2 include bilateral multiple patchy, nodular ground-glass opacities,

speckled ground-glass opacities and/or infiltrating shadows in the middle and outer zone of the lung or under the pleura.^{61,88} These findings are unspecific and milder compared with those in adults.⁸⁸

DIAGNOSIS

The main basis for diagnosis of infections with HCoV is real-time polymerase chain reaction (RT-PCR) on upper or lower respiratory secretions.^{5,15,90–96} For SARS-CoV, MERS-CoV and SARS-CoV-2, higher viral loads have been detected in samples from the lower respiratory tract compared with the upper respiratory tract.^{28,149} Therefore, in clinically suspected cases with an initially negative result on nasopharyngeal or throat swab, repeat testing of upper respiratory tract samples or (preferably) testing of lower respiratory tract samples should be done. RT-PCRs on stool samples can be positive for HCoVs but is not used for routine diagnosis.^{91,98,99} For SARS-CoV and SARS-CoV-2, rare cases with positive PCRs in blood have been reported.^{28,150} Serology has been used to diagnose infections with SARS-CoV and MERS-CoV, but is not useful in the acute phase of the infection.^{100–103} Cross-reactivities between antibodies against SARS-CoV and common CoVs have been observed.¹⁵¹

SARS-CoV-2

Whole genome sequencing allowed the rapid development of molecular diagnostic tests for SARS-CoV-2.²⁸ RT-PCR for genes encoding the internal RNA-dependent RNA polymerase and surface spike glycoprotein are commonly used.²⁸

TREATMENT

Supportive treatment including sufficient fluid and calorie intake, and additional oxygen supplementation should be used in the treatment of children infected with HCoVs. The aim is to prevent ARDS, organ failure and secondary nosocomial infections. If bacterial infection is suspected broad-spectrum antibiotics such as second or third generation cephalosporins may be used.

SARS-CoV

In the absence of specific antiviral drugs for CoVs, broad-spectrum antiviral drugs, such as interferon alpha and beta or ribavirin were used for the treatment of SARS-CoV, including in children.^{57–59} Ribavirin was subsequently shown to be ineffective or even harmful because it can cause hemolytic anemia or liver dysfunction.¹⁵² In adults, interferon-alpha alone or together with ribavirin also did not consistently improve outcomes.^{152,153} There is some evidence that intravenous corticosteroids led to clinical and radiologic improvement in SARS-CoV-infected individuals.⁵⁸ However, a systematic review showed that the evidence for this is inconclusive and corticosteroids might also be harmful (delayed viral clearance, avascular necrosis, osteoporosis, new onset of diabetes).¹⁵² There is some evidence from adult studies that lopinavir/ritonavir (Kaletra) started early during infection is associated with improved clinical outcomes (decreased intubation, ARDS and death rates).^{154,155} However, a systematic review found inconclusive results for the use of lopinavir/ritonavir because of a possible selection bias in many of the studies.¹⁵² Inconclusive results were also found for intravenous immunoglobulins because studies did not account for comorbidities, stage of illness and effect of other treatments.¹⁵² There is no evidence for the use of monoclonal antibodies against tumor necrosis factor alpha.¹⁵⁶

MERS-CoV

There are no studies on treatment outcomes for MERS-CoV in children. In adults, as for SARS-CoV, interferon or ribavirin

alone or in combination have not been shown to have a clear benefit.^{157–159} Mycophenolate mofetil, which inhibits guanine (and therefore RNA) synthesis, was identified as a potential anti-MERS-CoV drug in vitro.¹⁶⁰ However, animal studies showed that the drug leads to worse outcomes with higher viral loads in lung and extrapulmonary tissues.¹⁶¹ Consistent with this, renal transplant patients on mycophenolate mofetil have been reported to develop severe and sometimes fatal MERS-CoV infections.¹⁶²

SARS-CoV-2

Until the results of on-going clinical trials become available, there is no definitive evidence on which to base treatment of patients infected with SARS-CoV-2. The only treatment recommendation for children, published by the Zhejiang University School of Medicine, suggests the use of nebulized interferon alpha-2b and oral lopinavir/ritonavir together with corticosteroids for complications (ARDS, encephalitis, hemophagocytic syndrome or septic shock) and intravenous immunoglobulin for severe cases.⁷²

However, as none of these therapies have shown a clear benefit in the treatment of other novel CoVs, it is questionable whether they will be beneficial in the treatment of SARS-CoV-2. Neither the World Health Organization nor the US Centers for Disease Control and Prevention recommends any specific treatment in children or adults.^{97,163} Despite this, in the previously mentioned case series of the 34 children infected with SARS-CoV-2, 59% were treated with lopinavir/ritonavir.⁶¹ None of the children received glucocorticoids or immunoglobulins.⁶¹

Other Therapeutic Options

Monoclonal Antibodies

Despite their diversity, CoVs share many proteins among different species, which is helpful for the design of new drugs. One of them is the surface structural spike glycoprotein S, which is responsible for virus-cell interaction.¹⁶⁴ Monoclonal antibodies (from convalescent human plasma, animal plasma or manufactured) against the spike glycoprotein S have been shown to inhibit fusion of CoVs with human cells and to decrease mortality rate in SARS-CoV-infected patients.^{165–171} A protein, which also inhibits the spike glycoprotein S, although it is not a monoclonal antibody, has been isolated from a red alga called *Griffithsia*.¹⁷² However, to date, it has only been tested in animal studies.¹⁷²

Angiotensin-converting enzyme 2, dipeptidyl peptidase 4, aminopeptidase N, O-acetylated sialic acid are further host receptors for HCoVs and monoclonal antibodies against these proteins might be useful in treatment of infections.^{173–176} However, rapid mutation of CoVs poses a potential problem, which might be diminished by using several monoclonal antibodies targeting different epitopes.¹⁶⁶

Protease Inhibitors

Endosomal and nonendosomal virus entry into cells can be reduced by inhibiting responsible proteases.^{177–179} Papain-like proteases (PLpro) are involved in viral replication in CoVs and are further potential targets for treatment. Numerous PLpro inhibitors have been identified. However, none of them has been validated in vivo studies.^{180,181} Moreover, PLpro enzymes differ between CoVs species, making PLpro inhibitors narrow-spectrum antiviral drugs against CoVs.¹⁸²

A further protein involved in viral replication is CoV main proteinase, which is inhibited by lopinavir. However, as previously mentioned, lopinavir (plus ritonavir) has been shown to be effective against CoVs in animal and nonrandomized studies of SARS-CoV-infected humans.^{154,161} However, as previously mentioned, these results are considered inconclusive because of potential selection bias.¹⁵²

Chloroquine

Chloroquine, which is commonly used against malaria and autoimmune diseases, increases the endosomal pH thereby inhibiting virus-cell fusion, and is therefore a potential broad-spectrum antiviral drug.¹⁸³ It also interferes with glycosylation of cellular receptors of SARS-CoV.¹⁸⁴ In addition, *in vitro* studies show that chloroquine inhibits entry and postentry stages of SARS-CoV-2 into cells.¹⁸⁵ Moreover, chloroquine possesses immune-modulating activity, which might enhance its antiviral effect *in vivo*.¹⁸⁵

RNA Synthesis Inhibitors

As previously mentioned, ribavirin, a guanosine analog has been shown to be ineffective or even harmful against SARS-CoV¹⁵² and MERS-CoV.^{157–159} Immucillin-A, a new adenosine analog that has recently been developed, inhibits the viral RNA polymerase of a wide range of RNA viruses, including SARS-CoV and MERS-CoV,¹⁸⁶ and might be useful in the treatment of other HCoVs. Furthermore, inhibitors of helicase (which are proteins unwinding double-stranded RNA into single strands during replication) might be useful in treatment of CoVs.¹⁸⁷ RNA synthesis inhibitors, which reduce the formation of double-membrane vesicles, a hallmark of CoV2 replication, have been identified as potential antiviral drugs.^{188,189} A double-stranded RNA activated caspase oligomerizer (DRACO) that targets long viral double-stranded RNA and induces apoptosis of infected cells, but spares healthy cells, might also be useful in the treatment of CoVs.¹⁹⁰

VACCINES

Several vaccines against HCoVs are in development with the aim of preventing infection, reducing disease severity and viral shedding. The main antigens for vaccine development are the structural spike glycoprotein S or its receptor-binding domain (RBD).¹⁹¹ However, the propensity of CoVs to rapidly mutate and recombine poses a potential problem for vaccine development.^{192–194} Furthermore, the enhanced disease after viral challenges postvaccination has been observed in animal models after several different vaccines.^{195–197}

Live-attenuated Vaccines

The advantage of live-attenuated vaccines is that they usually induce a robust and long-lasting immune response, including cellular and humoral immunity to many different antigens. In SARS-CoV animal studies, attenuated mutants with deletion of the structural E gene have been shown to induce neutralizing antibodies, reduce viral loads and protect from clinical symptoms of SARS-CoV infection.^{198–200} In contrast, deletion of open reading frames had little or no effect on viral loads *in vitro* and *in vivo*.²⁰¹ Other strategies under development for live-attenuated vaccines against CoVs are genome rearrangement or gene knockouts.^{202–204} These have the advantage that the vaccine virus cannot recombine with wild viruses.

Inactivated Vaccines

In mouse models, inactivated vaccines successfully induce cellular and humoral immunity (with many different neutralization antibodies) against SARS-CoV^{191,205–207} and humoral immunity against MERS-CoV.^{208,209} In a human phase I trial, inactivated vaccines against SARS-CoV were well tolerated and elicited neutralizing antibodies.²¹⁰ However, no challenge studies have been done in humans, and in monkey challenge studies, no clear evidence of protection was shown despite the induction of strong cellular and humoral responses.²¹¹ Moreover, concerns have been raised that inactivated vaccines against SARS-CoV and MERS-CoV may lead to harmful immune and/or inflammatory responses postchallenge.^{195,209}

Subunit and Recombinant Vaccines

Subunit vaccines are purified antigens, usually combined with adjuvants and are the most popular method in the development of vaccines against novel CoVs. For SARS-CoV and MERS-CoV, these are mostly developed from spike glycoprotein S, RBD or nucleocapsid protein.^{212–216} Some studies show that subunit vaccines given intranasally might induce stronger immune responses and mucosal immunity.²¹⁷ Several subunit vaccines have shown to be successful in animal challenging studies.^{218–220}

In a study in monkeys, recombinant RBD protein was used to successfully reduce viral loads in lungs and oropharynx and to prevent MERS-CoV pneumonia.²¹⁸ In mice, similar results were achieved using recombinant RBD protein vaccines from SARS-CoV.²²¹

Viral Vectors Vaccines

Adenovirus-based vectors encoding SARS proteins (eg, nucleocapsid protein, spike glycoprotein S and other membrane proteins) have been shown to be immunogenic in mice and rhesus macaques in whom they induced humoral and cellular vaccine responses.^{222,223} Adenovirus-based vaccines carrying parts MERS-CoV have been shown to reduce morbidity and mortality (undetectable or reduced pulmonary viral loads) in mouse models.^{196,224} Initially, pulmonary hemorrhages were observed postviral challenge.¹⁹⁶ However, adding a CD40 ligand to the vaccine enhanced immunogenicity and efficacy, and also prevented inadvertent pulmonary pathology, which makes this vaccine a promising strategy.¹⁹⁶ Nonetheless, preexisting immunity against adenovirus might reduce efficacy. This might be addressed by giving a viral-based vaccine followed by a recombinant vaccine as a booster.²²⁵ A adenovirus-based MERS-CoV vaccine has moved into a phase I clinical trial.²²⁶

One study, comparing an inactivated SARS-CoV vaccine with an adenovirus-based vaccine against SARS-CoV, found that the first led to higher humoral responses.²²⁷ Adenovirus-based vaccines administered intranasally led to immunoglobulin A antibody production which has been associated with superior protection from virus replication in lungs.²²⁷ This indicates that measuring serum neutralizing antibodies might not be a sufficient way of assessing vaccine efficacy for HCoV as mucosal immunity might be more important.

For SARS-CoV, a poxvirus has also been used as a vector for an intranasally and intramuscularly administered vaccine. This vaccine-induced neutralizing antibodies and reduced viral loads in the respiratory tract of challenged mice.²²⁸ However, a similar vaccine used in ferrets led to increased liver damage after SARS-CoV challenge.¹⁹⁷

Further vector vaccines for SARS-CoV that have been tested in animals are based on recombinant parainfluenza virus,^{229,230} live-attenuated recombinant measles virus,²³¹ attenuated rabies virus²³² and attenuated *Salmonella*.²³³

DNA Vaccines

Vaccines containing DNA encoding the spike glycoprotein seem to induce a more robust response of neutralizing antibodies against MERS-CoV than vaccines only containing the RBD protein. They have been shown to protect rhesus macaques from MERS-CoV pneumonia.^{234,235} Three DNA vaccines against MERS-CoV have advanced into clinical trials.^{236–238}

OTHER STRATEGIES FOR CONTROLLING EMERGING CORONAVIRUSES

After quickly spreading across the globe, SARS-CoV was contained in 2003 after a highly effective global public health response. This highlights the urgent need for rapid and effectful strategies of infection control. One of the main challenges with novel CoVs is the high potential for nosocomial transmission.²³⁹ Health care settings seem to increase the risk of viral transmission

due to aerosol-generating procedures such as intubation and bronchoscopy. Appropriate hospital hygiene practices are therefore crucial to limit nosocomial outbreaks. The main aims are to effectively triage patients with fever, respiratory symptoms and a contact history²⁴⁰ and to apply stringent infection control measures such as isolating patients and quarantine contacts as early as possible. Ideally, each patient is placed in a single negative pressure room. If this is not possible, patients and health care workers should be cohorted.²⁴¹ Protective gear should include water-resistant gowns, disposable gloves, N95 masks and goggles or face shields.²⁴⁰ Only suction catheters and mechanical respirators with a closed-circuit system and viral filters should be used.²⁴⁰ In contrast, nebulizers, oxygen masks or nasal continuous positive airway pressure systems should not be used on an open ward.^{240,241} Needless to say, strict hand hygiene needs to be applied and visitors should be avoided or limited to an absolute minimum. HCoV have been shown to persist on dry surfaces for up to 9 days.^{242–244} The persistence depends on temperature (shorter duration at 30–40°C) and humidity (longer at higher humidity).²⁴⁵ HCoVs, including novel CoVs, can be inactivated by heating to 56°C for 30 minutes or by using lipid solvents such as ethanol (>75%), isopropanol (>70%), formaldehyde (>0.7%), povidone-iodine (>0.23%), sodium hypochlorite (>0.21%), hydrogen peroxide (>0.5%), but not chlorhexidine.^{72,244}

SUMMARY

SARS-CoV, MERS-CoV and SARS-CoV-2 infections seem to affect children less commonly and less severely as compared with adults. This might be because children are less frequently exposed to the main sources of transmission (which until now has been disproportionately nosocomial) or because they are less exposed to animals. However, it could also be that children are less frequently symptomatic or have less severe symptoms and are therefore less often tested, leading to an underestimate of the true numbers infected. In relation to SARS-CoV-2, a study pre-published in early March 2020 suggests that children are just as likely as adults to become infected with this virus but are less likely to be symptomatic or develop severe symptoms.²⁴⁶ However, the importance of children in transmitting the virus remains uncertain. The majority of children infected by a novel CoV reported thus far have a documented household contact, often showing symptoms before them, suggesting the possibility that children are not an important reservoir for novel CoVs. The clinical, laboratory and radiologic features in children are similar for all novel CoVs, except more children infected with SARS-CoV presented with fever compared with SARS-CoV-2 or MERS-CoV. To date, no deaths in children have been reported for SARS-CoV or SARS-CoV-2, except (in the case of the former) for infants of mothers who were infected during pregnancy.

REFERENCES

- Fehr AR, Perlman S. Coronaviruses: an overview of their replication and pathogenesis. *Methods Mol Biol.* 2015;1282:1–23.
- Amer HM. Bovine-like coronaviruses in domestic and wild ruminants. *Anim Health Res Rev.* 2018;19:113–124.
- Saif LJ. Animal coronaviruses: what can they teach us about the severe acute respiratory syndrome? *Rev Sci Tech.* 2004;23:643–660.
- Cabeça TK, Granato C, Bellei N. Epidemiological and clinical features of human coronavirus infections among different subsets of patients. *Influenza Other Respir Viruses.* 2013;7:1040–1047.
- Vabret A, Mourez T, Gouarin S, et al. An outbreak of coronavirus OC43 respiratory infection in Normandy, France. *Clin Infect Dis.* 2003;36:985–989.
- Esper F, Ou Z, Huang YT. Human coronaviruses are uncommon in patients with gastrointestinal illness. *J Clin Virol.* 2010;48:131–133.
- Vabret A, Dina J, Gouarin S, et al. Detection of the new human coronavirus HKU1: a report of 6 cases. *Clin Infect Dis.* 2006;42:634–639.
- Woo PC, Lau SK, Chu CM, et al. Characterization and complete genome sequence of a novel coronavirus, coronavirus HKU1, from patients with pneumonia. *J Virol.* 2005;79:884–895.
- Gorse GJ, O'Connor TZ, Hall SL, et al. Human coronavirus and acute respiratory illness in older adults with chronic obstructive pulmonary disease. *J Infect Dis.* 2009;199:847–857.
- da Silva Filho LV, Zerbini RM, Tateno AF, et al. The differential clinical impact of human coronavirus species in children with cystic fibrosis. *J Infect Dis.* 2012;206:384–388.
- Chiu SS, Chan KH, Chu KW, et al. Human coronavirus NL63 infection and other coronavirus infections in children hospitalized with acute respiratory disease in Hong Kong, China. *Clin Infect Dis.* 2005;40:1721–1729.
- McIntosh K, Ellis EF, Hoffman LS, et al. The association of viral and bacterial respiratory infections with exacerbations of wheezing in young asthmatic children. *J Pediatr.* 1973;82:578–590.
- Woo PC, Lau SK, Lam CS, et al. Discovery of seven novel Mammalian and avian coronaviruses in the genus deltacoronavirus supports bat coronaviruses as the gene source of alphacoronavirus and betacoronavirus and avian coronaviruses as the gene source of gammacoronavirus and deltacoronavirus. *J Virol.* 2012;86:3995–4008.
- Lau SK, Woo PC, Li KS, et al. Discovery of a novel coronavirus, China Rattus coronavirus HKU24, from Norway rats supports the murine origin of Betacoronavirus 1 and has implications for the ancestor of Betacoronavirus lineage A. *J Virol.* 2015;89:3076–3092.
- Gaunt ER, Hardie A, Claas EC, et al. Epidemiology and clinical presentations of the four human coronaviruses 229E, HKU1, NL63, and OC43 detected over 3 years using a novel multiplex real-time PCR method. *J Clin Microbiol.* 2010;48:2940–2947.
- Davis BM, Foxman B, Monto AS, et al. Human coronaviruses and other respiratory infections in young adults on a university campus: prevalence, symptoms, and shedding. *Influenza Other Respir Viruses.* 2018;12:582–590.
- Huynh J, Li S, Yount B, et al. Evidence supporting a zoonotic origin of human coronavirus strain NL63. *J Virol.* 2012;86:12816–12825.
- Pfefferle S, Oppong S, Drexler JF, et al. Distant relatives of severe acute respiratory syndrome coronavirus and close relatives of human coronavirus 229E in bats, Ghana. *Emerg Infect Dis.* 2009;15:1377–1384.
- Corman VM, Eckerle I, Memish ZA, et al. Link of a ubiquitous human coronavirus to dromedary camels. *Proc Natl Acad Sci U S A.* 2016;113:9864–9869.
- Vijgen L, Keyaerts E, Moës E, et al. Complete genomic sequence of human coronavirus OC43: molecular clock analysis suggests a relatively recent zoonotic coronavirus transmission event. *J Virol.* 2005;79:1595–1604.
- de Wit E, van Doremalen N, Falzarano D, et al. SARS and MERS: recent insights into emerging coronaviruses. *Nat Rev Microbiol.* 2016;14:523–534.
- Shi Z, Hu Z. A review of studies on animal reservoirs of the SARS coronavirus. *Virus Res.* 2008;133:74–87.
- Drosten C, Günther S, Preiser W, et al. Identification of a novel coronavirus in patients with severe acute respiratory syndrome. *N Engl J Med.* 2003;348:1967–1976.
- Wang M, Yan M, Xu H, et al. SARS-CoV infection in a restaurant from palm civet. *Emerg Infect Dis.* 2005;11:1860–1865.
- Luk HKH, Li X, Fung J, et al. Molecular epidemiology, evolution and phylogeny of SARS coronavirus. *Infect Genet Evol.* 2019;71:21–30.
- de Groot RJ, Baker SC, Baric RS, et al. Middle East respiratory syndrome coronavirus (MERS-CoV): announcement of the Coronavirus Study Group. *J Virol.* 2013;87:7790–7792.
- Ommeh S, Zhang W, Zohaib A, et al. Genetic evidence of Middle East respiratory syndrome coronavirus (MERS-Cov) and widespread seroprevalence among camels in Kenya. *Virol Sin.* 2018;33:484–492.
- Chan JF, Yuan S, Kok KH, et al. A familial cluster of pneumonia associated with the 2019 novel coronavirus indicating person-to-person transmission: a study of a family cluster. *Lancet.* 2020;395:514–523.
- Zhu N, Zhang D, Wang W, et al. A novel coronavirus from patients with pneumonia in China, 2019. *N Engl J Med.* 2020;382:727–733.
- World Health Organization. Coronavirus disease 2019 (COVID-19) Situation Report - 32. 2020. Available at: https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200221-sitrep-32-covid-19.pdf?sfvrsn=4802d089_2. Accessed March 2, 2020.
- Kuypers J, Martin ET, Heugel J, et al. Clinical disease in children associated with newly described coronavirus subtypes. *Pediatrics.* 2007;119:e70–e76.

32. Uddin SMI, Englund JA, Kuypers JY, et al. Burden and risk factors for coronavirus infections in infants in rural Nepal. *Clin Infect Dis*. 2018;67:1507–1514.
33. Taylor S, Lopez P, Weckx L, et al. Respiratory viruses and influenza-like illness: epidemiology and outcomes in children aged 6 months to 10 years in a multi-country population sample. *J Infect*. 2017;74:29–41.
34. Fagbo SF, Garbati MA, Hasan R, et al. Acute viral respiratory infections among children in MERS-endemic Riyadh, Saudi Arabia, 2012–2013. *J Med Virol*. 2017;89:195–201.
35. Zhang SF, Tuo JL, Huang XB, et al. Epidemiology characteristics of human coronaviruses in patients with respiratory infection symptoms and phylogenetic analysis of HCoV-OC43 during 2010–2015 in Guangzhou. *PLoS One*. 2018;13:e0191789.
36. Friedman N, Alter H, Hindiyeh M, et al. Human coronavirus infections in Israel: epidemiology, clinical symptoms and summer seasonality of HCoV-HKU1. *Viruses*. 2018;10:1–9.
37. Peak CM, Childs LM, Grad YH, et al. Comparing nonpharmaceutical interventions for containing emerging epidemics. *Proc Natl Acad Sci U S A*. 2017;114:4023–4028.
38. Wu JT, Leung K, Leung GM. Nowcasting and forecasting the potential domestic and international spread of the 2019-nCoV outbreak originating in Wuhan, China: a modelling study. *Lancet*. 2020;395:689–697.
39. Chowell G, Abdirizak F, Lee S, et al. Transmission characteristics of MERS and SARS in the healthcare setting: a comparative study. *BMC Med*. 2015;13:210.
40. Lloyd-Smith JO, Schreiber SJ, Kopp PE, et al. Superspreading and the effect of individual variation on disease emergence. *Nature*. 2005;438:355–359.
41. Majumder MS, Rivers C, Lofgren E, et al. Estimation of MERS-coronavirus reproductive number and case fatality rate for the spring 2014 Saudi Arabia outbreak: insights from publicly available data. *PLoS Curr*. 2014;6:1–20.
42. Wallinga J, Teunis P. Different epidemic curves for severe acute respiratory syndrome reveal similar impacts of control measures. *Am J Epidemiol*. 2004;160:509–516.
43. Chowell G, Castillo-Chavez C, Fenimore PW, et al. Model parameters and outbreak control for SARS. *Emerg Infect Dis*. 2004;10:1258–1263.
44. Riley S, Fraser C, Donnelly CA, et al. Transmission dynamics of the etiological agent of SARS in Hong Kong: impact of public health interventions. *Science*. 2003;300:1961–1966.
45. Lipsitch M, Cohen T, Cooper B, et al. Transmission dynamics and control of severe acute respiratory syndrome. *Science*. 2003;300:1966–1970.
46. Kucharski AJ, Althaus CL. The role of superspreading in Middle East respiratory syndrome coronavirus (MERS-CoV) transmission. *Euro Surveill*. 2015;20:14–18.
47. Chen SC, Chang CF, Liao CM. Predictive models of control strategies involved in containing indoor airborne infections. *Indoor Air*. 2006;16:469–481.
48. Cauchemez S, Nouvellet P, Cori A, et al. Unraveling the drivers of MERS-CoV transmission. *Proc Natl Acad Sci U S A*. 2016;113:9081–9086.
49. Park JE, Jung S, Kim A, et al. MERS transmission and risk factors: a systematic review. *BMC Public Health*. 2018;18:574.
50. Zhao S, Lin Q, Ran J, et al. Preliminary estimation of the basic reproduction number of novel coronavirus (2019-nCoV) in China, from 2019 to 2020: a data-driven analysis in the early phase of the outbreak. *Int J Infect Dis*. 2020;92:214–217.
51. Cyranoski D. Mystery deepens over animal source of coronavirus. 2020. Accessed March 4, 2020. Available at: <https://www.nature.com/articles/d41586-020-00548-w>.
52. World Health Organization. Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003. 2004. Available at: https://www.who.int/csr/sars/country/table2004_04_21/en/. Accessed March 5, 2020.
53. Middle East respiratory syndrome coronavirus (MERS-CoV), MERS Monthly Summary, November 2019. <https://www.who.int/emergencies/mers-cov/en/>. Accessed March 5, 2020.
54. World Health Organization. Coronavirus disease 2019 (COVID-19) Situation Report – 48. 2020. Available at: https://www.who.int/docs/default-source/coronavirus/situation-reports/20200308-sitrep-48-covid-19.pdf?sfvrsn=16f7ccef_4. Accessed March 9, 2020.
55. Zhong NS, Zheng BJ, Li YM, et al. Epidemiology and cause of severe acute respiratory syndrome (SARS) in Guangdong, People's Republic of China, in February, 2003. *Lancet*. 2003;362:1353–1358.
56. Hunter JC, Nguyen D, Aden B, et al. Transmission of Middle East respiratory syndrome coronavirus infections in healthcare settings, Abu Dhabi. *Emerg Infect Dis*. 2016;22:647–656.
57. Hon KL, Leung CW, Cheng WT, et al. Clinical presentations and outcome of severe acute respiratory syndrome in children. *Lancet*. 2003;361:1701–1703.
58. Chiu WK, Cheung PC, Ng KL, et al. Severe acute respiratory syndrome in children: experience in a regional hospital in Hong Kong. *Pediatr Crit Care Med*. 2003;4:279–283.
59. Bitnun A, Allen U, Heurter H, et al; Other Members of the Hospital for Sick Children SARS Investigation Team. Children hospitalized with severe acute respiratory syndrome-related illness in Toronto. *Pediatrics*. 2003;112:e261.
60. Al-Tawfiq JA, Kattan RF, Memish ZA. Middle East respiratory syndrome coronavirus disease is rare in children: an update from Saudi Arabia. *World J Clin Pediatr*. 2016;5:391–396.
61. Wang XF, Yuan J, Zheng YJ, et al. [Clinical and epidemiological characteristics of 34 children with 2019 novel coronavirus infection in Shenzhen]. *Zhonghua Er Ke Za Zhi*. 2020;58:E008.
62. Lessler J, Reich NG, Brookmeyer R, et al. Incubation periods of acute respiratory viral infections: a systematic review. *Lancet Infect Dis*. 2009;9:291–300.
63. Leung GM, Hedley AJ, Ho LM, et al. The epidemiology of severe acute respiratory syndrome in the 2003 Hong Kong epidemic: an analysis of all 1755 patients. *Ann Intern Med*. 2004;141:662–673.
64. Jiang X, Rayner S, Luo MH. Does SARS-CoV-2 has a longer incubation period than SARS and MERS? *J Med Virol*. 2020;1–3. [Epub ahead of print]
65. Lau EH, Hsiung CA, Cowling BJ, et al. A comparative epidemiologic analysis of SARS in Hong Kong, Beijing and Taiwan. *BMC Infect Dis*. 2010;10:50.
66. Chan-Yeung M, Xu RH. SARS: epidemiology. *Respirology*. 2003;8(suppl):S9–S14.
67. Assiri A, Al-Tawfiq JA, Al-Rabeeh AA, et al. Epidemiological, demographic, and clinical characteristics of 47 cases of Middle East respiratory syndrome coronavirus disease from Saudi Arabia: a descriptive study. *Lancet Infect Dis*. 2013;13:752–761.
68. Korea Centers for Disease Control and Prevention. Middle East respiratory syndrome coronavirus outbreak in the republic of Korea, 2015. *Osong Public Health Res Perspect*. 2015;6:269–278.
69. Zumla A, Hui DS, Perlman S. Middle East respiratory syndrome. *Lancet*. 2015;386:995–1007.
70. Cowling BJ, Park M, Fang VJ, et al. Preliminary epidemiological assessment of MERS-CoV outbreak in South Korea, May to June 2015. *Euro Surveill*. 2015;20:7–13.
71. Virlogeux V, Fang VJ, Park M, et al. Comparison of incubation period distribution of human infections with MERS-CoV in South Korea and Saudi Arabia. *Sci Rep*. 2016;6:35839.
72. Chen ZM, Fu JF, Shu Q, et al. Diagnosis and treatment recommendations for pediatric respiratory infection caused by the 2019 novel coronavirus. *World J Pediatr*. 2020. [Epub ahead of print]
73. Martin ET, Fairchok MP, Stednick ZJ, et al. Epidemiology of multiple respiratory viruses in childcare attendees. *J Infect Dis*. 2013;207:982–989.
74. Anderson RM, Fraser C, Ghani AC, et al. Epidemiology, transmission dynamics and control of SARS: the 2002–2003 epidemic. *Philos Trans R Soc Lond B Biol Sci*. 2004;359:1091–1105.
75. Peiris JS, Chu CM, Cheng VC, et al; HKU/UCH SARS Study Group. Clinical progression and viral load in a community outbreak of coronavirus-associated SARS pneumonia: a prospective study. *Lancet*. 2003;361:1767–1772.
76. Alfaraq SH, Al-Tawfiq JA, Altuwaijri TA, et al. Middle East respiratory syndrome coronavirus in pediatrics: a report of seven cases from Saudi Arabia. *Front Med*. 2019;13:126–130.
77. Wei M, Yuan J, Liu Y, et al. Novel coronavirus infection in hospitalized infants under 1 year of age in China. *JAMA*. 2020. [Epub ahead of print]
78. van der Hoek L, Pyrc K, Jebbink MF, et al. Identification of a new human coronavirus. *Nat Med*. 2004;10:368–373.
79. van der Hoek L, Sure K, Ithorst G, et al. Croup is associated with the novel coronavirus NL63. *PLoS Med*. 2005;2:e240.
80. Pyrc K, Berkhout B, van der Hoek L. The novel human coronaviruses NL63 and HKU1. *J Virol*. 2007;81:3051–3057.
81. Greenberg SB. Update on human rhinovirus and coronavirus infections. *Semin Respir Crit Care Med*. 2016;37:555–571.

82. McIntosh K, Kapikian AZ, Turner HC, et al. Seroepidemiologic studies of coronavirus infection in adults and children. *Am J Epidemiol*. 1970;91:585–592.
83. Yeh EA, Collins A, Cohen ME, et al. Detection of coronavirus in the central nervous system of a child with acute disseminated encephalomyelitis. *Pediatrics*. 2004;113(1 pt 1):e73–e76.
84. Ge XY, Li JL, Yang XL, et al. Isolation and characterization of a bat SARS-like coronavirus that uses the ACE2 receptor. *Nature*. 2013;503:535–538.
85. Cheng FW, Ng PC, Chiu WK, et al. A case-control study of SARS versus community acquired pneumonia. *Arch Dis Child*. 2005;90:747–749.
86. Leung CW, Kwan YW, Ko PW, et al. Severe acute respiratory syndrome among children. *Pediatrics*. 2004;113:e535–e543.
87. Babyn PS, Chu WC, Tsou IY, et al. Severe acute respiratory syndrome (SARS): chest radiographic features in children. *Pediatr Radiol*. 2004;34:47–58.
88. Feng K, Yun YX, Wang XF, et al. [Analysis of CT features of 15 children with 2019 novel coronavirus infection]. *Zhonghua Er Ke Za Zhi*. 2020;58:E007.
89. Li AM, Ng PC. Severe acute respiratory syndrome (SARS) in neonates and children. *Arch Dis Child Fetal Neonatal Ed*. 2005;90:F461–F465.
90. Vabret A, Mouton F, Mourez T, et al. Direct diagnosis of human respiratory coronaviruses 229E and OC43 by the polymerase chain reaction. *J Virol Methods*. 2001;97:59–66.
91. Cheng PK, Wong DA, Tong LK, et al. Viral shedding patterns of coronavirus in patients with probable severe acute respiratory syndrome. *Lancet*. 2004;363:1699–1700.
92. Chim SS, Chiu RW, Lo YM. Genomic sequencing of the severe acute respiratory syndrome-coronavirus. *Methods Mol Biol*. 2006;336:177–194.
93. Chim SS, Tong YK, Hung EC, et al. Genomic sequencing of a SARS coronavirus isolate that predated the Metropole Hotel case cluster in Hong Kong. *Clin Chem*. 2004;50:231–233.
94. Lee JS, Ahn JS, Yu BS, et al. Evaluation of a Real-Time Reverse Transcription-PCR (RT-PCR) assay for detection of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) in clinical samples from an outbreak in South Korea in 2015. *J Clin Microbiol*. 2017;55:2554–2555.
95. Kim MN, Ko YJ, Seong MW, et al. Analytical and clinical validation of six commercial Middle East respiratory syndrome coronavirus RNA detection kits based on real-time reverse-transcription PCR. *Ann Lab Med*. 2016;36:450–456.
96. Al Johani S, Hajeer AH. MERS-CoV diagnosis: an update. *J Infect Public Health*. 2016;9:216–219.
97. World Health Organization. WHO interim guidance on clinical management of severe acute respiratory infection when novel coronavirus (nCoV) infection is suspected. 2020. Available at: <https://apps.who.int/iris/handle/10665/330893>. Accessed March 5, 2020.
98. Jevšnik M, Steyer A, Zrim T, et al. Detection of human coronaviruses in simultaneously collected stool samples and nasopharyngeal swabs from hospitalized children with acute gastroenteritis. *Viral J*. 2013;10:46.
99. Zhou J, Li C, Zhao G, et al. Human intestinal tract serves as an alternative infection route for Middle East respiratory syndrome coronavirus. *Sci Adv*. 2017;3:eaa04966.
100. Chen X, Zhou B, Li M, et al. Serology of severe acute respiratory syndrome: implications for surveillance and outcome. *J Infect Dis*. 2004;189:1158–1163.
101. Bermingham A, Heinen P, Iturriza-Gómara M, et al. Laboratory diagnosis of SARS. *Philos Trans R Soc Lond B Biol Sci*. 2004;359:1083–1089.
102. Zhao LQ, Qian Y, Zhu RN, et al. [Serological analysis of SARS coronavirus in children diagnosed clinically as severe acute respiratory syndrome cases during SARS epidemic in Beijing]. *Zhonghua Er Ke Za Zhi*. 2006;44:262–266.
103. Müller MA, Meyer B, Corman VM, et al. Presence of Middle East respiratory syndrome coronavirus antibodies in Saudi Arabia: a nationwide, cross-sectional, serological study. *Lancet Infect Dis*. 2015;15:559–564.
104. Oosterhof L, Christensen CB, Sengeløv H. Fatal lower respiratory tract disease with human corona virus NL63 in an adult haematopoietic cell transplant recipient. *Bone Marrow Transplant*. 2010;45:1115–1116.
105. Cabeça TK, Bellei N. Human coronavirus NL-63 infection in a Brazilian patient suspected of H1N1 2009 influenza infection: description of a fatal case. *J Clin Virol*. 2012;53:82–84.
106. Munster VJ, Koopmans M, van Doremalen N, et al. A novel coronavirus emerging in China - key questions for impact assessment. *N Engl J Med*. 2020;382:692–694.
107. Jia N, Feng D, Fang LQ, et al. Case fatality of SARS in mainland China and associated risk factors. *Trop Med Int Health*. 2009;14(suppl 1):21–27.
108. Nassar MS, Bakhrebah MA, Meo SA, et al. Middle East respiratory syndrome coronavirus (MERS-CoV) infection: epidemiology, pathogenesis and clinical characteristics. *Eur Rev Med Pharmacol Sci*. 2018;22:4956–4961.
109. Aleanizy FS, Mohmed N, Alqahtani FY, et al. Outbreak of Middle East respiratory syndrome coronavirus in Saudi Arabia: a retrospective study. *BMC Infect Dis*. 2017;17:23.
110. Alhamlan FS, Majumder MS, Brownstein JS, et al. Case characteristics among Middle East respiratory syndrome coronavirus outbreak and non-outbreak cases in Saudi Arabia from 2012 to 2015. *BMJ Open*. 2017;7:e011865.
111. World Health Organization. Disease outbreak news. 24 February 2020. Middle East respiratory syndrome coronavirus (MERS-CoV) – The Kingdom of Saudi Arabia. Available at: <https://www.who.int/csr/don/24-february-2020-mers-saudi-arabia/en/>. Accessed March 5, 2020.
112. Oh MD, Park WB, Park SW, et al. Middle East respiratory syndrome: what we learned from the 2015 outbreak in the Republic of Korea. *Korean J Intern Med*. 2018;33:233–246.
113. National Health Commission of the People's Republic of China. 2020. Available at: <http://www.nhc.gov.cn/xcs/yqtb/202002/6c305f6d70f545d59548ba17d79b8229.shtml>. Accessed February 15 2020.
114. Wu Z, McGoogan JM. Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China: summary of a report of 72 314 cases from the Chinese center for disease control and prevention. *JAMA*. 2020. [Epub ahead of print]
115. Isaacs D, Flowers D, Clarke JR, et al. Epidemiology of coronavirus respiratory infections. *Arch Dis Child*. 1983;58:500–503.
116. Monto AS, Lim SK. The Tecumseh study of respiratory illness. VI. Frequency of and relationship between outbreaks of coronavirus infection. *J Infect Dis*. 1974;129:271–276.
117. Dijkman R, Jebbink MF, El Idrissi NB, et al. Human coronavirus NL63 and 229E seroconversion in children. *J Clin Microbiol*. 2008;46:2368–2373.
118. Hasony HJ, Macnaughton MR. Prevalence of human coronavirus antibody in the population of southern Iraq. *J Med Virol*. 1982;9:209–216.
119. Kaye HS, Marsh HB, Dowdle WR. Seroepidemiologic survey of coronavirus (strain OC 43) related infections in a children's population. *Am J Epidemiol*. 1971;94:43–49.
120. Leung TF, Li CY, Lam WY, et al. Epidemiology and clinical presentations of human coronavirus NL63 infections in hong kong children. *J Clin Microbiol*. 2009;47:3486–3492.
121. Jin Y, Zhang RF, Xie ZP, et al. Newly identified respiratory viruses associated with acute lower respiratory tract infections in children in Lanzou, China, from 2006 to 2009. *Clin Microbiol Infect*. 2012;18:74–80.
122. Wu PS, Chang LY, Berkhout B, et al. Clinical manifestations of human coronavirus NL63 infection in children in Taiwan. *Eur J Pediatr*. 2008;167:75–80.
123. Lina B, Valette M, Foray S, et al. Surveillance of community-acquired viral infections due to respiratory viruses in Rhone-Alpes (France) during winter 1994 to 1995. *J Clin Microbiol*. 1996;34:3007–3011.
124. Lau SK, Woo PC, Yip CC, et al. Coronavirus HKU1 and other coronavirus infections in Hong Kong. *J Clin Microbiol*. 2006;44:2063–2071.
125. Guan Y, Peiris JS, Zheng B, et al. Molecular epidemiology of the novel coronavirus that causes severe acute respiratory syndrome. *Lancet*. 2004;363:99–104.
126. Tsang KW, Ho PL, Ooi GC, et al. A cluster of cases of severe acute respiratory syndrome in Hong Kong. *N Engl J Med*. 2003;348:1977–1985.
127. Mackay IM, Arden KE. MERS coronavirus: diagnostics, epidemiology and transmission. *Viral J*. 2015;12:222.
128. Breban R, Riou J, Fontanet A. Interhuman transmissibility of Middle East respiratory syndrome coronavirus: estimation of pandemic risk. *Lancet*. 2013;382:694–699.
129. Cristallo A, Gambaro F, Biamonti G, et al. Human coronavirus polyadenylated RNA sequences in cerebrospinal fluid from multiple sclerosis patients. *New Microbiol*. 1997;20:105–114.
130. Dessau RB, Lisby G, Frederiksen JL. Coronaviruses in spinal fluid of patients with acute monosymptomatic optic neuritis. *Acta Neurol Scand*. 1999;100:88–91.
131. Shimizu C, Shike H, Baker SC, et al. Human coronavirus NL63 is not detected in the respiratory tracts of children with acute Kawasaki disease. *J Infect Dis*. 2005;192:1767–1771.

132. Chang LY, Chiang BL, Kao CL, et al; Kawasaki Disease Research Group. Lack of association between infection with a novel human coronavirus (HCoV), HCoV-NH, and Kawasaki disease in Taiwan. *J Infect Dis*. 2006;193:283–286.
133. Chu CM, Poon LL, Cheng VC, et al. Initial viral load and the outcomes of SARS. *CMAJ*. 2004;171:1349–1352.
134. Chen WJ, Yang JY, Lin JH, et al. Nasopharyngeal shedding of severe acute respiratory syndrome-associated coronavirus is associated with genetic polymorphisms. *Clin Infect Dis*. 2006;42:1561–1569.
135. van Elden LJ, van Loon AM, van Alphen F, et al. Frequent detection of human coronaviruses in clinical specimens from patients with respiratory tract infection by use of a novel real-time reverse-transcriptase polymerase chain reaction. *J Infect Dis*. 2004;189:652–657.
136. Li AM, So HK, Chu W, et al. Radiological and pulmonary function outcomes of children with SARS. *Pediatr Pulmonol*. 2004;38:427–433.
137. Shek CC, Ng PC, Fung GP, et al. Infants born to mothers with severe acute respiratory syndrome. *Pediatrics*. 2003;112:e254.
138. Wong SF, Chow KM, Leung TN, et al. Pregnancy and perinatal outcomes of women with severe acute respiratory syndrome. *Am J Obstet Gynecol*. 2004;191:292–297.
139. Saeed AA, Abedi GR, Alzahrani AG, et al. Surveillance and testing for Middle East respiratory syndrome coronavirus, Saudi Arabia, April 2015–February 2016. *Emerg Infect Dis*. 2017;23:682–685.
140. Memish ZA, Al-Tawfiq JA, Makhdoom HQ, et al. Screening for Middle East respiratory syndrome coronavirus infection in hospital patients and their healthcare worker and family contacts: a prospective descriptive study. *Clin Microbiol Infect*. 2014;20:469–474.
141. Payne DC, Iblan I, Alqasrawi S, et al; Jordan MERS-CoV Investigation Team. Stillbirth during infection with Middle East respiratory syndrome coronavirus. *J Infect Dis*. 2014;209:1870–1872.
142. Alserahi H, Wali G, Alshukairi A, et al. Impact of Middle East respiratory syndrome coronavirus (MERS-CoV) on pregnancy and perinatal outcome. *BMC Infect Dis*. 2016;16:105.
143. Malik A, El Masry KM, Ravi M, et al. Middle East respiratory syndrome coronavirus during pregnancy, Abu Dhabi, United Arab Emirates, 2013. *Emerg Infect Dis*. 2016;22:515–517.
144. Assiri A, Abedi GR, Al Masri M, et al. Middle East respiratory syndrome coronavirus infection during pregnancy: a report of 5 cases from Saudi Arabia. *Clin Infect Dis*. 2016;63:951–953.
145. Centers for Disease Control and Prevention CfDCaP. Evaluating and reporting persons under investigation (PU). 2020. Available at: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html>. Accessed March 5, 2020.
146. World Health Organization. Global Surveillance for human infection with novel coronavirus (2019-nCoV). 2020. Available at: [https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-\(2019-ncov\)](https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov)) and <https://www.ecdc.europa.eu/en/case-definition-and-european-surveillance-human-infection-novel-coronavirus-2019-ncov>. Accessed March 5, 2020.
147. Guan WJ, Ni ZY, Hu Y, Liang WH, Ou CQ, He JX, et al. Clinical Characteristics of Coronavirus Disease 2019 in China. *N Engl J Med*. 2020.
148. Chen H, Guo J, Wang C, et al. Clinical characteristics and intrauterine vertical transmission potential of COVID-19 infection in nine pregnant women: a retrospective review of medical records. *The Lancet*. 2020:1–7. [Epub ahead of print]
149. Memish ZA, Al-Tawfiq JA, Makhdoom HQ, et al. Respiratory tract samples, viral load, and genome fraction yield in patients with Middle East respiratory syndrome. *J Infect Dis*. 2014;210:1590–1594.
150. Hung IF, Cheng VC, Wu AK, et al. Viral loads in clinical specimens and SARS manifestations. *Emerg Infect Dis*. 2004;10:1550–1557.
151. Che XY, Qiu LW, Liao ZY, et al. Antigenic cross-reactivity between severe acute respiratory syndrome-associated coronavirus and human coronaviruses 229E and OC43. *J Infect Dis*. 2005;191:2033–2037.
152. Stockman LJ, Bellamy R, Garner P. SARS: systematic review of treatment effects. *PLoS Med*. 2006;3:e343.
153. Cheng VC, Chan JF, To KK, et al. Clinical management and infection control of SARS: lessons learned. *Antiviral Res*. 2013;100:407–419.
154. Chan KS, Lai ST, Chu CM, et al. Treatment of severe acute respiratory syndrome with lopinavir/ritonavir: a multicentre retrospective matched cohort study. *Hong Kong Med J*. 2003;9:399–406.
155. Chu CM, Cheng VC, Hung IF, et al; HKU/UCH SARS Study Group. Role of lopinavir/ritonavir in the treatment of SARS: initial virological and clinical findings. *Thorax*. 2004;59:252–256.
156. Ng PC, Lam CW, Li AM, et al. Inflammatory cytokine profile in children with severe acute respiratory syndrome. *Pediatrics*. 2004;113(1 pt 1):e7–e14.
157. Omrani AS, Saad MM, Baig K, et al. Ribavirin and interferon alfa-2a for severe Middle East respiratory syndrome coronavirus infection: a retrospective cohort study. *Lancet Infect Dis*. 2014;14:1090–1095.
158. Shalhoub S, Farahat F, Al-Jiffri A, et al. IFN- α 2a or IFN- β 1a in combination with ribavirin to treat Middle East respiratory syndrome coronavirus pneumonia: a retrospective study. *J Antimicrob Chemother*. 2015;70:2129–2132.
159. Al-Tawfiq JA, Momattin H, Dib J, et al. Ribavirin and interferon therapy in patients infected with the Middle East respiratory syndrome coronavirus: an observational study. *Int J Infect Dis*. 2014;20:42–46.
160. Chan JF, Chan KH, Kao RY, et al. Broad-spectrum antivirals for the emerging Middle East respiratory syndrome coronavirus. *J Infect*. 2013;67:606–616.
161. Chan JF, Yao Y, Yeung ML, et al. Treatment with lopinavir/ritonavir or interferon- β 1b improves outcome of MERS-CoV infection in a nonhuman primate model of common marmoset. *J Infect Dis*. 2015;212:1904–1913.
162. AlGhamdi M, Mushtaq F, Awn N, et al. MERS CoV infection in two renal transplant recipients: case report. *Am J Transplant*. 2015;15:1101–1104.
163. Centers for Disease Control and Prevention CfDCaP. Interim clinical guidance for management of patients with confirmed 2019 novel coronavirus (2019-nCoV) infection. 2020. Available at: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>. Accessed February 21, 2020.
164. Zumla A, Chan JF, Azhar EI, et al. Coronaviruses - drug discovery and therapeutic options. *Nat Rev Drug Discov*. 2016;15:327–347.
165. Cheng Y, Wong R, Soo YO, et al. Use of convalescent plasma therapy in SARS patients in Hong Kong. *Eur J Clin Microbiol Infect Dis*. 2005;24:44–46.
166. Jiang L, Wang N, Zuo T, et al. Potent neutralization of MERS-CoV by human neutralizing monoclonal antibodies to the viral spike glycoprotein. *Sci Transl Med*. 2014;6:234ra59.
167. Ying T, Du L, Ju TW, et al. Exceptionally potent neutralization of Middle East respiratory syndrome coronavirus by human monoclonal antibodies. *J Virol*. 2014;88:7796–7805.
168. Tang XC, Agnihotram SS, Jiao Y, et al. Identification of human neutralizing antibodies against MERS-CoV and their role in virus adaptive evolution. *Proc Natl Acad Sci U S A*. 2014;111:E2018–E2026.
169. Channappanavar R, Lu L, Xia S, et al. Protective effect of intranasal regimens containing peptidic Middle East respiratory syndrome coronavirus fusion inhibitor against MERS-CoV infection. *J Infect Dis*. 2015;212:1894–1903.
170. Soo YO, Cheng Y, Wong R, et al. Retrospective comparison of convalescent plasma with continuing high-dose methylprednisolone treatment in SARS patients. *Clin Microbiol Infect*. 2004;10:676–678.
171. Pang H, Liu Y, Han X, et al. Protective humoral responses to severe acute respiratory syndrome-associated coronavirus: implications for the design of an effective protein-based vaccine. *J Gen Virol*. 2004;85(pt 10):3109–3113.
172. Barton C, Kouokam JC, Lasnik AB, et al. Activity of and effect of subcutaneous treatment with the broad-spectrum antiviral lectin grifithsin in two laboratory rodent models. *Antimicrob Agents Chemother*. 2014;58:120–127.
173. Li W, Moore MJ, Vasilieva N, et al. Angiotensin-converting enzyme 2 is a functional receptor for the SARS coronavirus. *Nature*. 2003;426:450–454.
174. Raj VS, Mou H, Smits SL, et al. Dipeptidyl peptidase 4 is a functional receptor for the emerging human coronavirus-EMC. *Nature*. 2013;495:251–254.
175. Huang X, Dong W, Milewska A, et al. Human coronavirus HKU1 spike protein uses O-acetylated sialic acid as an attachment receptor determinant and employs hemagglutinin-esterase protein as a receptor-destroying enzyme. *J Virol*. 2015;89:7202–7213.
176. Vijgen L, Keyaerts E, Zlateva K, et al. Identification of six new polymorphisms in the human coronavirus 229E receptor gene (aminopeptidase N/CD13). *Int J Infect Dis*. 2004;8:217–222.
177. Shirato K, Kawase M, Matsuyama S. Middle East respiratory syndrome coronavirus infection mediated by the transmembrane serine protease TMPRSS2. *J Virol*. 2013;87:12552–12561.
178. Zhou Y, Vedantham P, Lu K, et al. Protease inhibitors targeting coronavirus and filovirus entry. *Antiviral Res*. 2015;116:76–84.
179. Kawase M, Shirato K, van der Hoek L, et al. Simultaneous treatment of human bronchial epithelial cells with serine and cysteine protease

- inhibitors prevents severe acute respiratory syndrome coronavirus entry. *J Virol*. 2012;86:6537–6545.
180. Báez-Santos YM, St John SE, Mesecar AD. The SARS-coronavirus papain-like protease: structure, function and inhibition by designed antiviral compounds. *Antiviral Res*. 2015;115:21–38.
 181. Ratia K, Pegan S, Takayama J, et al. A noncovalent class of papain-like protease/deubiquitinase inhibitors blocks SARS virus replication. *Proc Natl Acad Sci U S A*. 2008;105:16119–16124.
 182. Lee H, Lei H, Santarsiero BD, et al. Inhibitor recognition specificity of MERS-CoV papain-like protease may differ from that of SARS-CoV. *ACS Chem Biol*. 2015;10:1456–1465.
 183. Savarino A, Di Trani L, Donatelli I, et al. New insights into the antiviral effects of chloroquine. *Lancet Infect Dis*. 2006;6:67–69.
 184. Vincent MJ, Bergeron E, Benjannet S, et al. Chloroquine is a potent inhibitor of SARS coronavirus infection and spread. *Virology*. 2005;2:69.
 185. Wang M, Cao R, Zhang L, et al. Remdesivir and chloroquine effectively inhibit the recently emerged novel coronavirus (2019-nCoV) in vitro. *Cell Res*. 2020:269–271. [Epub ahead of print]
 186. Warren TK, Wells J, Panchal RG, et al. Protection against filovirus diseases by a novel broad-spectrum nucleoside analogue BCX4430. *Nature*. 2014;508:402–405.
 187. Adedeji AO, Singh K, Kassim A, et al. Evaluation of SSSA10-001 as a replication inhibitor of severe acute respiratory syndrome, mouse hepatitis, and Middle East respiratory syndrome coronaviruses. *Antimicrob Agents Chemother*. 2014;58:4894–4898.
 188. Lundin A, Dijkman R, Bergström T, et al. Targeting membrane-bound viral RNA synthesis reveals potent inhibition of diverse coronaviruses including the Middle East respiratory syndrome virus. *PLoS Pathog*. 2014;10:e1004166.
 189. Rappe JCF, de Wilde A, Di H, et al. Antiviral activity of K22 against members of the order Nidovirales. *Virus Res*. 2018;246:28–34.
 190. Rider TH, Zook CE, Boettcher TL, et al. Broad-spectrum antiviral therapeutics. *PLoS One*. 2011;6:e22572.
 191. He Y, Li J, Du L, et al. Identification and characterization of novel neutralizing epitopes in the receptor-binding domain of SARS-CoV spike protein: revealing the critical antigenic determinants in inactivated SARS-CoV vaccine. *Vaccine*. 2006;24:5498–5508.
 192. Su S, Wong G, Shi W, et al. Epidemiology, genetic recombination, and pathogenesis of coronaviruses. *Trends Microbiol*. 2016;24:490–502.
 193. Kim DW, Kim YJ, Park SH, et al. Variations in spike glycoprotein gene of MERS-CoV, South Korea, 2015. *Emerg Infect Dis*. 2016;22:100–104.
 194. Sohrab SS, Azhar EI. Genetic diversity of MERS-CoV spike protein gene in Saudi Arabia. *J Infect Public Health*. 2019. [Epub ahead of print]
 195. He Y, Zhou Y, Siddiqui P, et al. Inactivated SARS-CoV vaccine elicits high titers of spike protein-specific antibodies that block receptor binding and virus entry. *Biochem Biophys Res Commun*. 2004;325:445–452.
 196. Hashem AM, Algaissi A, Agrawal AS, et al. A highly immunogenic, protective, and safe adenovirus-based vaccine expressing Middle East respiratory syndrome coronavirus S1-CD40L fusion protein in a transgenic human dipeptidyl peptidase 4 mouse model. *J Infect Dis*. 2019;220:1558–1567.
 197. Czub M, Weingartl H, Czub S, et al. Evaluation of modified vaccinia virus Ankara based recombinant SARS vaccine in ferrets. *Vaccine*. 2005;23:2273–2279.
 198. DeDiego ML, Alvarez E, Almazán F, et al. A severe acute respiratory syndrome coronavirus that lacks the E gene is attenuated in vitro and in vivo. *J Virol*. 2007;81:1701–1713.
 199. Lamirande EW, DeDiego ML, Roberts A, et al. A live attenuated severe acute respiratory syndrome coronavirus is immunogenic and efficacious in golden Syrian hamsters. *J Virol*. 2008;82:7721–7724.
 200. DeDiego ML, Pewe L, Alvarez E, et al. Pathogenicity of severe acute respiratory coronavirus deletion mutants in hACE-2 transgenic mice. *Virology*. 2008;376:379–389.
 201. Yount B, Roberts RS, Sims AC, et al. Severe acute respiratory syndrome coronavirus group-specific open reading frames encode nonessential functions for replication in cell cultures and mice. *J Virol*. 2005;79:14909–14922.
 202. de Haan CA, Masters PS, Shen X, et al. The group-specific murine coronavirus genes are not essential, but their deletion, by reverse genetics, is attenuating in the natural host. *Virology*. 2002;296:177–189.
 203. Almazán F, DeDiego ML, Sola I, et al. Engineering a replication-competent, propagation-defective Middle East respiratory syndrome coronavirus as a vaccine candidate. *mBio*. 2013;4:e00650–e00613.
 204. Menachery VD, Gralinski LE, Mitchell HD, et al. Middle East respiratory syndrome coronavirus nonstructural protein 16 is necessary for interferon resistance and viral pathogenesis. *mSphere*. 2017;2:e00346–e00417.
 205. Xiong S, Wang YF, Zhang MY, et al. Immunogenicity of SARS inactivated vaccine in BALB/c mice. *Immunol Lett*. 2004;95:139–143.
 206. Takasuka N, Fujii H, Takahashi Y, et al. A subcutaneously injected UV-inactivated SARS coronavirus vaccine elicits systemic humoral immunity in mice. *Int Immunol*. 2004;16:1423–1430.
 207. Spruth M, Kistner O, Savidis-Dacho H, et al. A double-inactivated whole virus candidate SARS coronavirus vaccine stimulates neutralising and protective antibody responses. *Vaccine*. 2006;24:652–661.
 208. Deng Y, Lan J, Bao L, et al. Enhanced protection in mice induced by immunization with inactivated whole viruses compare to spike protein of Middle East respiratory syndrome coronavirus. *Emerg Microbes Infect*. 2018;7:60.
 209. Agrawal AS, Tao X, Algaissi A, et al. Immunization with inactivated Middle East respiratory syndrome coronavirus vaccine leads to lung immunopathology on challenge with live virus. *Hum Vaccin Immunother*. 2016;12:2351–2356.
 210. Lin JT, Zhang JS, Su N, et al. Safety and immunogenicity from a phase I trial of inactivated severe acute respiratory syndrome coronavirus vaccine. *Antivir Ther*. 2007;12:1107–1113.
 211. Zhou J, Wang W, Zhong Q, et al. Immunogenicity, safety, and protective efficacy of an inactivated SARS-associated coronavirus vaccine in rhesus monkeys. *Vaccine*. 2005;23:3202–3209.
 212. Jaume M, Yip MS, Kam YW, et al. SARS CoV subunit vaccine: antibody-mediated neutralisation and enhancement. *Hong Kong Med J*. 2012;18(suppl 2):31–36.
 213. Du L, He Y, Zhou Y, et al. The spike protein of SARS-CoV—a target for vaccine and therapeutic development. *Nat Rev Microbiol*. 2009;7:226–236.
 214. Adney DR, Wang L, van Doremalen N, et al. Efficacy of an adjuvanted Middle East respiratory syndrome coronavirus spike protein vaccine in dromedary camels and alpacas. *Viruses*. 2019;11:E212.
 215. Wang Y, Tai W, Yang J, et al. Receptor-binding domain of MERS-CoV with optimal immunogen dosage and immunization interval protects human transgenic mice from MERS-CoV infection. *Hum Vaccin Immunother*. 2017;13:1615–1624.
 216. Tai W, Zhao G, Sun S, et al. A recombinant receptor-binding domain of MERS-CoV in trimeric form protects human dipeptidyl peptidase 4 (hDPP4) transgenic mice from MERS-CoV infection. *Virology*. 2016;499:375–382.
 217. Ma C, Li Y, Wang L, et al. Intranasal vaccination with recombinant receptor-binding domain of MERS-CoV spike protein induces much stronger local mucosal immune responses than subcutaneous immunization: implication for designing novel mucosal MERS vaccines. *Vaccine*. 2014;32:2100–2108.
 218. Lan J, Yao Y, Deng Y, et al. Recombinant receptor binding domain protein induces partial protective immunity in rhesus macaques against Middle East respiratory syndrome coronavirus challenge. *EBioMedicine*. 2015;2:1438–1446.
 219. Jiaming L, Yanfeng Y, Yao D, et al. The recombinant N-terminal domain of spike proteins is a potential vaccine against Middle East respiratory syndrome coronavirus (MERS-CoV) infection. *Vaccine*. 2017;35:10–18.
 220. Zhang N, Channappanavar R, Ma C, et al. Identification of an ideal adjuvant for receptor-binding domain-based subunit vaccines against Middle East respiratory syndrome coronavirus. *Cell Mol Immunol*. 2016;13:180–190.
 221. Chen WH, Du L, Chag SM, et al. Yeast-expressed recombinant protein of the receptor-binding domain in SARS-CoV spike protein with deglycosylated forms as a SARS vaccine candidate. *Hum Vaccin Immunother*. 2014;10:648–658.
 222. Zakhartchouk AN, Viswanathan S, Mahony JB, et al. Severe acute respiratory syndrome coronavirus nucleocapsid protein expressed by an adenovirus vector is phosphorylated and immunogenic in mice. *J Gen Virol*. 2005;86(pt 1):211–215.
 223. Gao W, Tamin A, Soloff A, et al. Effects of a SARS-associated coronavirus vaccine in monkeys. *Lancet*. 2003;362:1895–1896.
 224. Munster VJ, Wells D, Lambe T, et al. Protective efficacy of a novel simian adenovirus vaccine against lethal MERS-CoV challenge in a transgenic human DPP4 mouse model. *NPJ Vaccines*. 2017;2:28.
 225. Rocha CD, Caetano BC, Machado AV, et al. Recombinant viruses as tools to induce protective cellular immunity against infectious diseases. *Int Microbiol*. 2004;7:83–94.
 226. Hill, A. Safety and immunogenicity of a candidate MERS-CoV vaccine (MERS001). 2018. Available at: <https://clinicaltrials.gov/ct2/show/study/NCT03399578>. Accessed February 22, 2020.

227. See RH, Zakhartchouk AN, Petric M, et al. Comparative evaluation of two severe acute respiratory syndrome (SARS) vaccine candidates in mice challenged with SARS coronavirus. *J Gen Virol*. 2006;87(pt 3):641–650.
228. Bisht H, Roberts A, Vogel L, et al. Severe acute respiratory syndrome coronavirus spike protein expressed by attenuated vaccinia virus protectively immunizes mice. *Proc Natl Acad Sci U S A*. 2004;101:6641–6646.
229. Buchholz UJ, Bukreyev A, Yang L, et al. Contributions of the structural proteins of severe acute respiratory syndrome coronavirus to protective immunity. *Proc Natl Acad Sci U S A*. 2004;101:9804–9809.
230. Bukreyev A, Lamirande EW, Buchholz UJ, et al. Mucosal immunisation of African green monkeys (*Cercopithecus aethiops*) with an attenuated parainfluenza virus expressing the SARS coronavirus spike protein for the prevention of SARS. *Lancet*. 2004;363:2122–2127.
231. Liniger M, Zuniga A, Tamin A, et al. Induction of neutralising antibodies and cellular immune responses against SARS coronavirus by recombinant measles viruses. *Vaccine*. 2008;26:2164–2174.
232. Faber M, Lamirande EW, Roberts A, et al. A single immunization with a rhabdovirus-based vector expressing severe acute respiratory syndrome coronavirus (SARS-CoV) S protein results in the production of high levels of SARS-CoV-neutralizing antibodies. *J Gen Virol*. 2005;86(pt 5):1435–1440.
233. Luo F, Feng Y, Liu M, et al. Type IVB pilus operon promoter controlling expression of the severe acute respiratory syndrome-associated coronavirus nucleocapsid gene in *Salmonella enterica* Serovar Typhi elicits full immune response by intranasal vaccination. *Clin Vaccine Immunol*. 2007;14:990–997.
234. Wang L, Shi W, Joyce MG, et al. Evaluation of candidate vaccine approaches for MERS-CoV. *Nat Commun*. 2015;6:7712.
235. Muthumani K, Falzarano D, Reuschel EL, et al. A synthetic consensus anti-spike protein DNA vaccine induces protective immunity against Middle East respiratory syndrome coronavirus in nonhuman primates. *Sci Transl Med*. 2015;7:301ra132.
236. Modjarrad, K. Phase I, open label dose ranging safety study of GLS-5300 in healthy volunteers. 2016. Available at: <https://clinicaltrials.gov/ct2/show/NCT02670187?term=GLS-5300>. Accessed February 22, 2020.
237. Maslow, J. Evaluate the safety, tolerability and immunogenicity study of GLS-5300 in healthy volunteers. 2018. Available at: <https://clinicaltrials.gov/ct2/show/NCT03721718>. Accessed February 22, 2020.
238. Addo, M. Safety, tolerability and immunogenicity of vaccine candidate MVA-MERS-S. 2018. Available at: <https://clinicaltrials.gov/ct2/show/NCT03615911#outcomemeasures>. Accessed February 22, 2020.
239. Bin SY, Heo JY, Song MS, et al. Environmental contamination and viral shedding in MERS patients during MERS-CoV outbreak in South Korea. *Clin Infect Dis*. 2016;62:755–760.
240. Ng PC, So KW, Leung TF, et al. Infection control for SARS in a tertiary neonatal centre. *Arch Dis Child Fetal Neonatal Ed*. 2003;88:F405–F409.
241. Leung TF, Ng PC, Cheng FW, et al. Infection control for SARS in a tertiary paediatric centre in Hong Kong. *J Hosp Infect*. 2004;56:215–222.
242. Dowell SF, Simmerman JM, Erdman DD, et al. Severe acute respiratory syndrome coronavirus on hospital surfaces. *Clin Infect Dis*. 2004;39:652–657.
243. Otter JA, Donskey C, Yezli S, et al. Transmission of SARS and MERS coronaviruses and influenza virus in healthcare settings: the possible role of dry surface contamination. *J Hosp Infect*. 2016;92:235–250.
244. Kampf G, Todt D, Pfaender S, et al. Persistence of coronaviruses on inanimate surfaces and its inactivation with biocidal agents. *J Hosp Infect*. 2020:246–251. [Epub ahead of print]
245. Ijaz MK, Brunner AH, Sattar SA, et al. Survival characteristics of airborne human coronavirus 229E. *J Gen Virol*. 1985;66(pt 12):2743–2748.
246. Bi Q, Wu Y, Mei S, et al. Epidemiology and transmission of COVID-19 in Shenzhen China: analysis of 391 cases and 1,286 of their close contacts. medRxiv 2020. Available at: <https://doi.org/10.1101/2020.03.03.20028423>. Accessed March 4, 2020.