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

**The Chinese Center** for Disease Control and Prevention recently published the largest case series to date of coronavirus disease 2019 (COVID-19) in mainland China (72 314 cases, updated through February 11, 2020). This Viewpoint summarizes key findings from this report and discusses emerging understanding of and lessons from the COVID-19 epidemic.

**Epidemiologic Characteristics of the COVID-19 Outbreak**
Among a total of 72 314 case records (Box), 44 672 were classified as confirmed cases of COVID-19 (62%; diagnosis based on positive viral nucleic acid test result on throat swab samples), 16 186 as suspected cases (22%; diagnosis based on symptoms and exposures only, no test was performed because testing capacity is insufficient to meet current needs), 10 567 as clinically diagnosed cases (15%; this designation is being used in Hubei Province only; in these cases, no test was performed but diagnosis was made based on symptoms, exposures, and presence of lung imaging features consistent with coronavirus pneumonia), and 889 as asymptomatic cases (1%; diagnosis by positive viral nucleic acid test result but lacking typical symptoms including fever, dry cough, and fatigue).1

Most case patients were 30 to 79 years of age (87%), 1% were aged 9 years or younger, 1% were aged 10 to 19 years, and 3% were age 80 years or older. Most cases were diagnosed in Hubei Province (75%) and most reported Wuhan-related exposures (86%; ie, Wuhan resident or visitor or close contact with Wuhan resident or visitor). Most cases were classified as mild (81%; ie, nonpneumonia and mild pneumonia). However, 14% were severe (ie, dyspnea, respiratory frequency ≥30/min, blood oxygen saturation ≥93%, partial pressure of arterial oxygen to fraction of inspired oxygen ratio <300, and/or lung infiltrates >50% within 24 to 48 hours), and 5% were critical (ie, respiratory failure, septic shock, and/or multiple organ dysfunction or failure) (Box).1

The overall case-fatality rate (CFR) was 2.3% (1023 of 44 672 confirmed cases). No deaths occurred in the group aged 9 years and younger, but cases in those aged 70 to 79 years had an 8.0% CFR and cases in those aged 80 years and older had a 14.8% CFR. No deaths were reported among mild and severe cases. The CFR was 49.0% among critical cases. CFR was elevated among those with preexisting comorbid conditions—10.5% for cardiovascular disease, 7.3% for diabetes, 6.3% for chronic respiratory disease, 6.0% for hypertension, and 5.6% for cancer. Among the 44 672 cases, a total of 1716 were health workers (3.8%), 1080 of whom were in Wuhan (63%). Overall, 14.8% of confirmed cases among health workers were classified as severe or critical and 5 deaths were observed.1

COVID-19 rapidly spread from a single city to the entire country in just 30 days. The sheer speed of both the geographical expansion and the sudden increase in numbers of cases surprised and quickly overwhellmed health and public health services in China, particularly in Wuhan City and Hubei Province. Epidemic curves reflect what may be a mixed outbreak pattern, with early cases suggestive of a continuous common source, potentially zoonotic spillover at Huanan Seafood Wholesale Market, and later cases suggestive of a propagated source as the virus began to be transmitted from person to person (Figure 1).1

**Comparison of COVID-19 With SARS and MERS**
The current COVID-19 outbreak is both similar and different to the prior severe acute respiratory syndrome...
Daily numbers of confirmed cases are plotted by date of onset of symptoms (blue) and by date of diagnosis (orange). Because, on retrospective investigation, so few cases experienced illness in December, these cases are shown in the inset. The difference between the cases by date of symptom onset curve (blue) and the cases by date of diagnosis curve (orange) illustrates lag time between the start of illness and diagnosis of COVID-19 by viral nucleic acid testing. The graph’s x-axis (dates from December 8, 2019, to February 11, 2020) is also used as a timeline of major milestones in the epidemic response. The first few cases of pneumonia of unknown etiology are shown in blue boxes on December 26 (n = 4) and 28-29 (n = 3). Most other cases that experienced onset of symptoms in December were only discovered when retrospectively investigated. Major epidemic response actions taken by the Chinese government are shown in brown boxes. The normally scheduled Lunar New Year national holiday is shown in light yellow, whereas the extended holiday during which attendance at school and work was prohibited (except for critical personnel such as health workers and police) is shown in dark yellow. This figure was adapted with permission. CDC indicates Chinese Center for Disease Control and Prevention; HICWM, Hubei Integrated Chinese and Western Medicine; 2019-nCoV, 2019 novel coronavirus; WHO, World Health Organization.
Since 2002, the Chinese government has improved its epidemic response capacity. Some of these efforts are evident in the response to COVID-19 (Figure 2). For example, in the 2002-2003 SARS outbreak, 300 cases and 5 deaths already occurred before the outbreak was reported to the WHO. However, in the COVID-19 outbreak, only 27 cases and zero deaths had occurred when the WHO was notified (January 3, 2020) (Figure 2). From the time of WHO notification, 2 months elapsed before SARS-CoV was identified compared with only 1 week from the time of WHO notification until 2019-nCoV was identified.

The timing of the COVID-19 outbreak, prior to China’s annual Lunar New Year holiday, was an important factor as China considered how to respond to the outbreak. Culturally, this is the largest and most important holiday of the year. It is the expectation that people return to their family homes, which is the cause for the several billion person-trips made by residents and visitors during this time, mostly on crowded planes, trains, and buses. Knowing this meant each infected person could have numerous close contacts over a protracted time and across long distances, the government needed to quickly act. However, it was not only the speed of the government’s response, but also the magnitude of that response that were influenced by the impending holiday travel time. Knowing that specific treatment and prevention options, such as targeted antiviral drugs and vaccines, were not yet available for COVID-19, China focused on traditional public health outbreak response tactics—social distancing, quarantine, social distancing, and community containment.1,2

Identified case patients with COVID-19 were immediately isolated in designated wards in existing hospitals, and 2 new hospitals were rapidly built to isolate and care for the increasing numbers of cases in Wuhan and Hubei. People who had been in contact with COVID-19 cases were asked to quarantine themselves at home or were taken to special quarantine facilities, where they could be monitored for onset of symptoms. Enormous numbers of large gatherings were canceled, including all Lunar New Year celebrations, and traffic in Wuhan and in cities across Hubei was restricted and closely monitored. Virtually all transportation was subsequently restricted at a national level. All of these measures were instituted to achieve social distancing. In addition, an estimated 40 million to 60 million residents of Wuhan and 15 other surrounding cities within Hubei Province were subjected to community containment measures. Although these types of traditional outbreak response actions have been successfully used in the past, they have never been executed on such a large scale.

There have been some questions about whether these actions are reasonable and proportional responses to the outbreak. Some have argued that a number of these approaches may infringe on the civil liberties of citizens, and some of these measures have been referred to as “draconian.” However, it is not only individual rights that must be considered. The rights of those who are not infected, but at risk of infection, must be considered as well. Whether these approaches have been effective (eg, in terms of reduced infections and deaths averted), and whether these potential benefits have outweighed the costs (eg, economic losses), will be debated for years.1,2

Next Steps
Importantly, another major goal of China’s current outbreak response activities is to help “buy time” for science to catch up before COVID-19 becomes too widespread. China must now focus on adjusting tactics and strategies as new evidence becomes available.3,4 Much remains to be done and many questions remain unanswered. China is very grateful for the help it is receiving from the international scientific, health, and public health communities. The global society is more interconnected than ever, and emerging pathogens do not respect geopolitical boundaries.
Figure 2. Timeline Comparing the Severe Acute Respiratory Syndrome (SARS) and Coronavirus Disease 2019 (COVID-19) Outbreaks

Proactive investment in public health infrastructure and capacity is crucial to effectively respond to epidemics like COVID-19, and it is critical to continue to improve international surveillance, cooperation, coordination, and communication about this major outbreak and to be even better prepared to respond to future new public health threats.

**REFERENCES**


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