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Title	Outbreak of SARS-CoV-2 at a large refugee shelter in Toronto, April 2020: a clinical and epidemiologic descriptive analysis
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Reviewer 1	Dr. Stephen Vaughn
Institution	Cumming School of Medicine, University of Calgary, Calgary, Alta.
General comments (author response in bold)	<p>1. Add : "A Cross-sectional study" to end of title [Editor's note: the study type should be added to the end of the title after a colon. Since the time frame of the study is not a single point, "descriptive analysis" could be considered as well. Thank you. We have modified the title such that it is more reflective of the clinical and epidemiologic evaluation of this outbreak. Our new title is: "Outbreak of SARS-CoV-2 at a Large Refugee Shelter in Toronto, April 2020: A Clinical and Epidemiologic Analysis"</p> <p>2. Please insert a Flow Diagram for Participants including those excluded as previously tested +ve/close contacts, and those excluded & lost to follow-up along the 14 day follow up, as it becomes hard to follow these specifically throughout the paper. (e.g., 60/63 included* - Results 1st sentence) [Editor's note: please cite this diagram in the first paragraph of the Results section.] to do Thank you for the suggestion. We had included a flow diagram (see attached).</p> <p>3. Methods section: Please further delineate if any Refugee claimants were new to Canada (in last 14 days). Clarify if the shelter is exclusively for refugees or if other populations stay there as well and if they are included in this study as well. Thank you for these recommendations. We have added the following clarifications: <i>Page 6 (Participants section): No shelter residents had arrived to Canada in the 14 days prior to testing.</i> <i>Page 5 (Setting section): The shelter provides temporary housing exclusively to refugee claimants and refugees (primarily the former) aged 16 years and older. The average length of stay at the emergency shelter is approximately 3 months; however, shelter stays have been longer during the COVID-19 pandemic.</i></p> <p>4. Results: on day of "comprehensive assessment" 15 item checklist performed as well? Not specifically stated but inferred since Table 2 includes a list of the same symptoms at both time points. Response: Thank you for suggesting this clarification. The clinical assessment on day-1 post-testing included open-ended questioning about symptoms. On data extraction, the documented symptoms were categorized using the 15 item symptom list. We have further clarified this on page 8. Data was manually extracted from the paper-based record of shelter residents who underwent testing and review of EMR charts of those patients who tested positive for COVID-19. The initial symptom screen (fever, cough, shortness of breath) and COVID-19 test results were derived from paper records. Data regarding symptoms day 1 post-testing were extracted from the free text symptoms documented on the clinical assessment forms scanned</p>

	<p><i>into patient EMR charts; symptoms were categorized according to the 15-item symptom list. Data from the day 14 post-testing clinical reassessment were derived from a standardized 15-item symptom-screen template in the patients' EMR charts.</i></p> <p>5. Limitations: Please Add: No documentation of expanded symptom checklist when swab taken. Also, although many patients developed symptoms when screened at day 14, the non-specific nature of these symptoms may limit their clinical utility (e.g., many who remained negative would have likely reported one or more symptoms as well if they were screened).</p> <p>Thank you for this recommendation. We have incorporated these suggestions into our limitations section (page 13): <i>While we conducted limited symptom screening on day 1, comprehensive clinical assessment on day 2, and retrospective systematic symptom evaluation on day 14, daily comprehensive symptom screening may have provided a more accurate depiction of symptom emergence and evolution during the study period, and the day 14 symptom screen is prone to recall bias. In particular, we may have identified more individuals with a diverse range of symptoms at the time of testing if they were screened using an expanded standardized symptom checklist (such as the 15-item symptom screen used on day 14). However, the non-specific nature of some of the symptoms (for example, malaise) may have limited clinical utility as a symptom screen.</i></p> <p>6. Were interviews conducted with translation services? Yes, thank you for noting this important detail. We have added this statement to page 8: <i>Clinical encounters were conducted with professional medical interpreters via telephone where needed (i.e. for any patient who could not communicate in English or who requested an interpreter).</i></p>
Reviewer 2	Dr. Samir Patel
Institution	Public Health Ontario, University of Toronto, Toronto, Ont.
General comments (author response in bold)	<p>The goal of this study was to describe an outbreak of COVID-19 in congregate settings such as refugee shelter. This is a well written report.</p> <p>1. How did the outbreak declare itself (i.e. how many cases were initially positive)? At the time of the study, an outbreak was defined by Toronto Public Health, as one or more cases of COVID-19 at a shelter. We have incorporated this on page 5. At the time of shelter-wide testing on April 20, 2020, 10 individuals had already tested positive for COVID-19 (page 6).</p> <p>2. On page 7: Line 44: should the denominator not be 25? instead of 24? We were unable to contact one of the 25 individuals who tested positive for the day 1 and day 14 post-testing reassessments, thus the denominator is 24. We have added a flow diagram (attached) to outline participants who were excluded or lost to follow up to further clarify this point. We have also added text on page 7, in addition to the footnote in table 2 that notes one individual could not be contacted. Page 7: Two participants were not available on-site for clinical assessment on April 21, 2020; one was contacted at a later date for symptom review</p>

(reflecting April 21 clinical status) and one individual could not be reached. Page 8 (existing text): One patient who tested positive for SARS-CoV-2 was sent to the emergency department at the time of testing to rule out malaria due to documented fever and headache and origin from a malaria endemic region. His test for SARS-CoV-2 subsequently returned positive and he was discharged from the emergency department but we were unable to reach the patient for reassessment on day 1 and day 14 post-testing.

3. The authors mentioned that 87.5% of patients were symptomatic within 14 days period. Is there any breakdown (i.e., what proportion of patients developed multiple symptoms on day 3, 7, 10, and 14?)

Thank you. This is an excellent suggestion, but unfortunately this data is not available. We contacted patients on day 14 post-testing and asked them about the presence of symptoms based on the 15-item symptom checklist anytime during 14 day period and, specifically, on day 14. However, the exact timing of symptoms during the 14 day period was not collected.