

# As coronavirus spreads, infectious disease doctors suggest travel history be made 5th vital sign

Joanne Finnegan

It may be time to add a fifth “vital sign” when physicians and other clinicians evaluate patients: their travel history.

Asking about travel history when evaluating patients could help to prevent the spread of novel coronavirus and manage any future pandemics, two infectious disease doctors wrote in a [commentary](#) in the Annals of Internal Medicine.

Typically, clinicians assess patients’ vital signs when evaluating their health—temperature, heart rate, respiratory rate, and blood pressure.

“Given the increasing frequency of emerging infectious diseases that are geographically linked, is it time to add a ‘fifth vital sign’?” wrote the authors, Trish M. Perl, M.D., chief of the division of infectious diseases and geographic medicine at the University of Texas Southwestern Medical Center, and Connie Savor Price, M.D., chief medical officer at Denver Health and a professor in the division of infectious diseases at the University of Colorado School of Medicine.

That fifth vital sign could help to prevent the spread of geographically linked emerging infectious diseases such as coronavirus, which has been officially named COVID-19.

“The current outbreak is an opportune time to consider adding travel history to the routine. The COVID outbreak is clearly moving at a tremendous pace, with new clusters appearing daily,” said Perl, in a university [announcement](#). “This pace is a signal to us that it is a matter of time before we will see more of these infections in the U.S. What is different with this outbreak is that this virus is more fit and transmissible and hence there has been much more transmission.”

While the numbers are changing daily, in the U.S., there are now more than 100 confirmed cases of coronavirus in 15 states and six deaths linked to the virus.

The infectious disease doctors said a simple, targeted travel history can help put infectious symptoms in context for physicians and caregiver teams, and then trigger a more detailed history, further testing and rapid implementation of protective measures. The added vital sign could signal a lurking communicable infection and flag potential risks to healthcare personnel and other patients.

Shared electronic health records also can integrate travel history with computerized decision-making support to suggest specific diagnoses in recent travelers, the authors said.

“We have the infrastructure to do this easily with the electronic medical record, we just need to implement it in a way to make it useful to the care teams,” said Perl. “Once the infrastructure is built, we’ll also need to communicate what is called ‘situational awareness’ to ensure that providers know what geographic areas have infections so that they can act accordingly.”

COVID-19 began in China and has continued to spread to more countries. Epidemics in Iran, Italy, and South Korea have shown no signs of slowing.

In fact, when the early coronavirus outbreak was concentrated in China, Anthony Fauci, M.D., director of the National Institute of Allergy and Infectious Diseases at the National Institutes of Health, urged clinicians faced with a patient with respiratory symptoms and a fever—the signs of coronavirus—to [ask them if they have traveled to China](#).

The emergence of other diseases in the past two decades—including SARS, MERS and Ebola—demonstrates the need for action, the authors said.

Adding travel history as a vital sign would require training for all members of the healthcare team on how to integrate key epidemiologic information into their risk assessments in much the same way clinicians are trained to ask about tobacco use to assess a patient’s risks for cancer and heart disease.

“We believe that the urgent threat of communicable diseases makes the collection of travel history necessary,” the authors wrote.

Both MERS and SARS were associated with specific travel. MERS was associated with travel to the Arabian Peninsula and SARS was associated with travel primarily to Hong Kong, Singapore and Beijing, the authors noted. “Currently COVID is similar in that there are geographic clusters, but those lines may be blurring as the outbreak expands,” Perl said.

Perl and Price said ascertaining travel history is critical to protect both patients and those caring for them. They noted that in 2014, a patient presented to a Dallas emergency department after returning from Liberia with low-grade fever, abdominal pain, dizziness, nausea and headache. The patient had Ebola, but clinicians did not include travel history in the patient’s vitals and the diagnosis was initially missed, compromising the well-being of the patient and caregivers.