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


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Four human coronaviruses (HCoV-229E, HCoV-HKU1, HCoV-NL63, and HCoV-OC43) are associated with a range of respiratory outcomes, including bronchiolitis and pneumonia. Their epidemiologies and clinical characteristics are poorly described and are often reliant on case reports. To address these problems, we conducted a large-scale comprehensive screening for all four coronaviruses by analysis of 11,661 diagnostic respiratory samples collected in Edinburgh, United Kingdom, over 3 years between July 2006 and June 2009 using a novel four-way multiplex real-time reverse transcription-PCR (RT-PCR) assay. Coronaviruses were detected in 0.3 to 0.85% of samples in all age groups. Generally, coronaviruses displayed marked winter seasonality between the months of December and April and were not detected in summer months, which is comparable to the pattern seen with influenza viruses. HCoV-229E was the exception; detection was confined to the winter of 2008 and was sporadic in the following year. There were additional longer-term differences in detection frequencies between seasons, with HCoV-OC43 predominant in the first and third seasons and HCoV-HKU1 dominating in the second (see Results for definitions of seasons). A total of 11 to 41% of coronaviruses detected were in samples testing positive for other respiratory viruses, although clinical presentations of coronavirus monoinfections were comparable to those of viruses which have an established role in respiratory disease, such as respiratory syncytial virus, influenza virus, and parainfluenza viruses. The novel multiplex assay for real-time pan-coronavirus detection enhances respiratory virus diagnosis, overcomes potential diagnostic problems arising through seasonal variation in coronavirus frequency, and provides novel insights into the epidemiology and clinical implications of coronaviruses.

Four human coronaviruses (human coronavirus 229E [HCoV-229E], HCoV-HKU1, HCoV-NL63, and HCoV-OC43) are associated with a range of respiratory symptoms, including high-morbidity outcomes such as pneumonia and bronchiolitis (26, 31, 35). Specifically, HCoV-NL63 has been associated with croup (33) and HCoV-HKU1 with febrile convulsion (18). Coronaviruses are frequently codetected with other respiratory viruses, particularly with human respiratory syncytial virus (HRSV) (17). Whether coronaviruses contribute to disease severity in such coinfections is currently unclear. Other coronaviruses infecting humans include human enteric coronavirus, which is closely related to HCoV-OC43 and is associated with necrotizing enterocolitis and gastroenteritis (10, 27).

Coronaviruses are globally distributed (7, 32, 34, 38), although there are differences in the frequency of detection of the four viruses in different parts of the world at different times (6, 11, 15, 16, 22, 28, 29). Longitudinal studies of coronavirus epidemiology are lacking in the literature and are restricted to descriptions representing a maximum of 1 year for four respiratory coronaviruses or 2 years for three coronaviruses (9, 17, 18). This inevitably makes direct comparisons of the coronaviruses difficult with respect to their epidemiologies, clinical presentations, and etiological roles in respiratory disease.

To directly address this situation, we conducted a large-scale survey of the incidences and epidemiological and clinical correlations of the four coronaviruses detected among 11,661 respiratory samples collected over a 3-year study period in Edinburgh, United Kingdom. Clinical presentations of study subjects infected with each of the coronaviruses were directly compared, and their roles in pediatric and adult respiratory disease were assessed.

MATERIALS AND METHODS

Sample collection. Respiratory samples collected at hospital and primary care settings in southeast Scotland are referred to the Royal Infirmary of Edinburgh (RIE) Specialist Virology Centre (SVC) for routine respiratory virus screening. Referral of samples to the RIE SVC is done by patient assessment following established clinical protocols. Samples were labeled with anonymous identifiers and deposited in the SVC sample archive prior to testing. Samples were stored at −80°C. A range of sample types are referred, including bronchial, nasal, nasopharyngeal (the most common category), oral, and tracheal samples.

A total of 11,661 respiratory samples from 7,383 patients referred to the RIE SVC between July 2006 and June 2009 were labeled with anonymous identifiers and archived with approval from the Lothian Regional Ethics Committee (08/S11/02/2). Stored data included age band, recorded clinical information, referral source, month of sample collection, and results of routine virological testing of the sample. As part of routine virological screening, RNA and DNA were extracted using a Qiagen BioRobot MDx system and screened for HRSV, adenovirus (AdV), parainfluenza viruses 1, 2, and 3 (PIV-1 to PIV-3) and influenza A and B viruses by the use of multiplex one-step real-time reverse transcription-PCR (RT-PCR) (14, 30). Extracted nucleic acids were stored at −20°C.
Clinical data interpretation. Clinical symptoms recorded on sample referral forms were categorized into seven groups—immunocompromised, chronic respiratory condition, lower respiratory tract infection (LRTI), upper respiratory tract infection, fever, rash, and diarrhea. Invasive specimens were assignable to two or more categories, and so categories were treated in a hierarchical manner, whereby samples were preferentially assigned to categories in the order listed above. The immunocompromised group included patients with cancer and transplant patients. Coryza, cough, and sore throat were classified in the order listed above. The immunocompromised group included patients with carcinoma and transplant patients. Coryza, cough, and sore throat were classified in the order listed above. The immunocompromised group included patients with carcinoma and transplant patients. Coryza, cough, and sore throat were classified in the order listed above.

Sensitivity of real-time multiplex PCR for coronavirus detection. RNA transcripts of the four coronaviruses were used as standards to determine assay sensitivity. HCoV-229E, HCoV-NL63, and HCoV-OC43 cDNAs (processed using nucleic acid extraction and reverse transcription as described below) were subjected to single-round real-time PCR as described below. PCR products were cloned into PCR2.1 T/A cloning vector (Invitrogen, Paisley, United Kingdom) and tested by multiplex PCR under the conditions described below. Samples for which no clinical data were available were excluded from the clinical data analysis. Chronic respiratory conditions included asthma and cystic fibrosis. The “other” group included symptoms which may be associated with but are not restricted to infection with respiratory pathogens, e.g., pyrexia, neurological and gastrointestinal symptoms, and requirement for ventilation. The “none” group included symptoms or data not associated with respiratory tract infection, e.g., rash or urinary tract infection.

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NL63, and 18 for HCoV-OC43 in 10 μl of RNA. No nonspecific reactions were observed. As RNAs were pooled in groups of 10, 1 μl of each RNA was tested in the initial screening process. Consequently, the minimum theoretical concentration of viral RNA required for detection was likely a 10-fold increase compared to the calculated values.

Detection of coronaviruses in Edinburgh and assay sensitivity. All coronavirus-positive pools detected by real-time PCR were found to include at least one coronavirus-positive component by nested PCR. Some pools comprised samples positive for different coronaviruses, some contained more than one sample positive for the same coronavirus, and two samples were found to be positive for both HCoV-OC43 and HCoV-NL63. Of the 11,661 samples, 267 (2.30%) were positive for at least one coronavirus (Table 2); of all virus detections, 8.15% were of coronaviruses.

Coronavirus-positive samples detected by the nested PCR were rescreened using real-time RT-PCR to establish CT values; of these, 86.2% (232/269) tested positive for coronavirus by the real-time RT-PCR. In some cases, a sample that tested as negative on rescreening represented the only coronavirus-positive sample in its pool; therefore, these results were not attributed to false positives in the nested PCR screening.

Patient parameters. Coronaviruses were detected in all age groups, most frequently (4.86%) in the 7- to 12-month age category (Fig. 1). Significantly more males (64.6%; \( P = 0.0332 \)) were infected with HCoV-OC43 than females. More males than females were infected with HCoV-NL63, but this result

![Detection frequency](https://example.com/detection_frequency.png)

FIG. 1. Percentages of detection frequencies of the four coronaviruses HCoV-229E, HCoV-HKU1, HCoV-NL63, and HCoV-OC43 by age group. The total number of samples within each age band is indicated at head of each column.

<table>
<thead>
<tr>
<th>Virus</th>
<th>No. of samples with indicated virus(es) detected</th>
</tr>
</thead>
<tbody>
<tr>
<td>AdV</td>
<td>783 16 3 3 2 49 119 3 3 7 17 6.7</td>
</tr>
<tr>
<td>Flu A</td>
<td>336 1 0 0 1 9 0 0 0 4 2.9</td>
</tr>
<tr>
<td>Flu B</td>
<td>131 0 0 1 0 0 0 0 1 0 1.1</td>
</tr>
<tr>
<td>PIV-1</td>
<td>75 0 1 3 0 2 0 0 0 0 0.64</td>
</tr>
<tr>
<td>PIV-2</td>
<td>39 0 6 0 0 0 0 0 0 0.33</td>
</tr>
<tr>
<td>PIV-3</td>
<td>380 11 0 2 2 1 3.3</td>
</tr>
<tr>
<td>HRSV</td>
<td>1300 1 17 10 26 11.1</td>
</tr>
<tr>
<td>HCoV-229E</td>
<td>35 0 0 0 0.30</td>
</tr>
<tr>
<td>HCoV-HKU1</td>
<td>61 0 0 0 0.52</td>
</tr>
<tr>
<td>HCoV-NL63</td>
<td>75 2 0.64</td>
</tr>
<tr>
<td>HCoV-OC43</td>
<td>111 0.85</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Detection rate (%)</th>
</tr>
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**TABLE 2. Detection of respiratory viruses over 3 years from 11,661 samples**

**a** Flu A, influenza A virus; Flu B, influenza B virus.

**b** Boldface indicates total number of virus detections.
did not reach significance (62.7%; P = 0.132). HCoV-HKU1 and HCoV-229E infected approximately equal numbers of males and females (the proportions of those infected who were male were 50.8% and 51.4%, respectively).

**Circulation trends.** Coronaviruses displayed the marked seasonality typical of other respiratory viruses, with high detection frequencies in winter months but few or no detections in the summer (Fig. 2). The exception was HCoV-229E, which was detectable primarily in the winter of the second year of the study and sporadically through the third year of study.

HCoV-OC43 displayed biennial peaks in detection frequency; it was present in 2.96% of samples collected in the first season (December 2006 to April 2007), in only January of the second season (November 2007 to March 2008) (0.83%), and in 3.17% of samples collected in the third season (November 2008 to January 2009) (P < 0.0001 for the first and third seasons compared to the second).

For HCoV-HKU1, in contrast to the pattern described for HCoV-OC43, the peak detection frequency occurred in the second season (1.92% of samples collected in November 2007 to March 2008). Conversely, when HCoV-OC43 was circulating at the highest frequency, detection frequencies of HCoV-HKU1 did not exceed 1% (P < 0.0001 for the first and third seasons compared to the second).

HCoV-NL63 was detected later than other coronaviruses in all three seasons (in December or January), and detection frequencies peaked in February to April. Detection frequencies between seasons were more consistent than for the other coronaviruses, although a significantly higher HCoV-NL63 detection frequency was observed in the first year of study than in the second and third years (P < 0.001 and P = 0.0200, respectively).

**Clinical associations of coronavirus infections.** Clinical data were available for 6,068/11,661 (52.0%) of samples included in the study. Although high rates of coinfection with other respiratory viruses were detected (11 to 41% of coronavirus-positive samples tested positive for at least one other respiratory virus), single infections associated with respiratory outcomes were observed for three coronaviruses (HCoV-HKU1, HCoV-NL63, and HCoV-OC43). HCoV-OC43, HCoV-NL63, and HCoV-HKU1 had clinical profiles similar to those of respiratory viruses currently included in routine diagnostic screening (Fig. 3A), with HCoV-OC43 associated with LRTI in over 40% of single infections for which clinical data were available—a higher proportion than that seen with influenza A virus. HCoV-229E was not associated with any cases of LRTI or URTI in otherwise healthy individuals and was found in over 70% of cases representing samples from immunocompromised patients (Fig. 3B).

Coronaviruses were not associated only with respiratory outcomes. Febrile convulsions were not reported for any patients testing singly positive for coronavirus, although one patient testing singly positive for HCoV-HKU1 had meningitis and one patient testing singly positive for HCoV-OC43 had seizures. Of 35 samples testing singly positive for HCoV-OC43, two were associated with vomiting, though one of these was taken from an immunocompromised patient.

Croup has previously been associated with HCoV-NL63 infection (19, 33, 37) but was not reported in association with any of the 41 samples with clinical data testing singly positive for HCoV-NL63; 3 samples were associated with cough and 1 was associated with wheezing.

For children under 2 years of age with LRTI, coronaviruses represented the only virus detected in 20 of 916 (2.18%) samples, compared with a rate of 5 of 336 (1.49%) samples collected from patients over the age of 45 with LRTI. The difference was not significant (P = 0.5).

For all four coronaviruses combined, the detection frequency in samples from patients with respiratory symptoms (URTI and LRTI) exceeded the proportion seen with samples taken from patients whose symptoms were categorized as “none” (i.e., no respiratory symptoms; Fig. 3C), providing epidemiologic evidence for the role of these three viruses in the etiology of respiratory disease.

No differences were found between the C_{50} values of coronavirus-positive samples associated with differing respiratory outcomes (data not shown).

**Coinfections.** High rates of coinfection with other respiratory viruses were observed for all coronaviruses (Table 2). Similar rates of LRTI and URTI were observed in single coro-
FIG. 3. (A) Comparison of the clinical presentations of study subjects infected with coronaviruses to the clinical presentations of those infected with respiratory viruses included in diagnostic screening (adenovirus [AdV], influenza A virus, influenza B virus, PIV-1, PIV-2, PIV-3, and HRSV). Only single infections are included in the analysis. The y axis indicates proportions of subjects with symptoms or diagnoses of LRTI or URTI or symptoms not associated with respiratory infection (“None”). (B) Proportions of samples testing singly positive for each of the respiratory viruses from patients with immunosuppression. (C) Proportions of samples from patients with LRTI or URTI or with no respiratory symptoms (“None”) testing singly positive for each respiratory virus.
Coronavirus infections (HCoV-HKU1 and HCoV-OC43) compared to cases in which a coronavirus was detected as part of a mixed infection. LRTI and URTI were observed at a higher frequency in single compared to mixed infections with HCoV-NL63 (Table 3).

Of all samples testing positive for coronavirus and another respiratory virus, 63.5% tested positive for HRSV. Coronavirus infection seasonality most closely resembles that of influenza (Fig. 2), and so the coinfection frequency of HRSV with coronaviruses is compared to the coinfection frequency of HRSV with influenza virus. Of 1,300 HRSV-positive samples, 270 (20.8%) tested positive for HRSV and coronavirus infections (HCoV-HKU1 and HCoV-OC43) compared to cases in which a coronavirus was detected as part of a mixed infection. LRTI and URTI were observed at a higher frequency in single compared to mixed infections with HCoV-NL63 (Table 3).

Samples from patients testing positive for a routine virus were more likely to have LRTI when coronavirus was also detected (52.2% compared to 43.2%), though this result did not reach significance ($P = 0.231$).

$C_r$ values were available for most coronavirus-positive samples (229/286; Table 4). Few differences in $C_r$ value were observed between singly infected coronavirus-positive samples and coronavirus-positive samples also testing positive for another virus (Table 4).

**DISCUSSION**

Human coronaviruses are increasingly recognized as respiratory pathogens associated with a broadening range of clinical outcomes, whereas they were once recognized as "common cold" viruses. Here we demonstrate that HCoV-OC43, HCoV-NL63, and HCoV-HKU1 were specifically associated with lower respiratory tract disease in the study population. Three of the four coronaviruses were more frequently detected as the sole pathogen in subjects with LRTI than in those with no respiratory symptoms and were detected as often as PIV-1 and PIV-2 (Fig. 3A). Samples representing monoinfections were frequently (26/184 [14.1%]) from subjects in intensive care and/or high-dependency units, with presentations that included severe lower respiratory tract disease and pyrexia, and case reports have associated all coronaviruses with high morbidity and/or fatal outcomes (23, 25, 26, 34).

HCoV-OC43 was the most commonly detected coronavirus, followed by HCoV-NL63 and HCoV-HKU1, with similar moderate detection frequencies, and HCoV-229E, with a comparatively low detection frequency; this observation has been previously reported (18). However, in contrast to the results of a previous study (18), we found that HCoV-HKU1 was detected as frequently in patients with LRTI as in those with URTI, and there was a lack of association between HCoV-229E infection and respiratory symptoms in otherwise healthy individuals. HCoV-NL63 detection peaked in winter and spring (January to April), which contrasts with the summer-to-autumn seasonality reported to occur in the tropics (4, 18), though the autumn-to-winter seasonality of HCoV-HKU1 and HCoV-OC43 infections and lack of a discernible seasonality of HCoV-229E infections were epidemiologically comparable features of both regions.

In 42% and 38% of infections with HCoV-OC43 and HCoV-HKU1, other respiratory viruses were codetected, most commonly HRSV. There were significantly more HRSV-positive samples that tested positive for coronavirus compared to the numbers of samples testing negative for all viruses included in routine diagnostics (one-tailed test; $P = 1.34 \times 10^{-5}$). The high rate of coinfection of coronaviruses with HRSV observed here was previously demonstrated (17). No differences in clinical outcome were observed for those coinfected with HRSV and coronavirus compared with those singly infected with either virus, and so HRSV presumably facilitates coronavirus infections (or vice versa) without exacerbating morbidity. HCoV-OC43 was significantly more frequently detected in hospitalized males than in females, an attribute that HCoV-OC43 shares with HRSV (8, 21, 24). No difference was observed between the sex distribution of HCoV-OC43 in singly infected subjects and the sex distribution in those coinfected with HRSV, indicating that the observed sex bias was coincidental and is not attributable to high coinfection rates.

The coronavirus load in singly positive samples was not different from the coronavirus load in samples in which co-pathogens were detected. This suggests that infection with another respiratory virus does not affect the ability of coronaviruses to establish infection and further demonstrates that, in mixed infections in respiratory patients, detection of coronaviruses should not be interpreted as representing an incidental infection that does not contribute to disease.

HCoV-229E differed clinically from other coronaviruses and

**TABLE 3. Detection frequencies of coronavirus cases of LRTI and URTI**

<table>
<thead>
<tr>
<th>Clinical outcome</th>
<th>HCoV-229E (all)</th>
<th>HCoV-HKU1</th>
<th>HCoV-NL63</th>
<th>HCoV-OC43</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single</td>
<td>Mixed</td>
<td>Single</td>
<td>Mixed</td>
</tr>
<tr>
<td>LRTI</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>URTI</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

**TABLE 4. Coronavirus $C_r$ values for singly infected and coinfected samples**

<table>
<thead>
<tr>
<th>CoV $C_r$ value</th>
<th>HCoV-229E</th>
<th>HCoV-HKU1</th>
<th>HCoV-NL63</th>
<th>HCoV-OC43</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single</td>
<td>Coinfection</td>
<td>Single</td>
<td>Coinfection</td>
</tr>
<tr>
<td>$&lt;30$</td>
<td>15</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>30–35</td>
<td>15</td>
<td>1</td>
<td>19</td>
<td>8</td>
</tr>
<tr>
<td>$&gt;35$</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
other respiratory viruses in general; 70% of detections were in samples from immunocompromised patients. HCoV-229E has previously been associated with infections of immunocompro-
mised individuals (9, 26). The further association of HCoV-
NL63 with this group was previously suggested in a report of a
smaller epidemiologic study (9) and in a case report (23).
Evidence indicating the role of these coronaviruses in disease
etiology in immunocompromised individuals increasingly
points to the conclusion that detection of infections by these
viruses should be considered to require alternative diagnoses
for immunocompromised individuals with respiratory tract
symptoms.

Most individuals seroconvert for HCoV-229E, HCoV-NL63,
and HCoV-OC43 in childhood (5, 13, 15, 20). No cell culture
system is currently available for HCoV-HKU1 analyses, and so
seroprevalence studies rely on alternative techniques (1). Re-
peated infections throughout life also.

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(08/S11/02/2).

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