Emerging Hand Foot Mouth Disease in Bangladeshi Children- First Report of Rapid Appraisal on Pocket Outbreak: Clinico-epidemiological Perspective Implicating Public Health Emergency [version 2; peer review: 1 approved, 1 approved with reservations]


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Abstract

Background: Hand, foot and mouth disease (HFMD) is a common contagious disease among children under 5 years, particularly in the Asia-Pacific-region. We report a localized outbreak of childhood HFMD for the first time from Bangladesh, diagnosed only based on clinical features due to gross lack in laboratory-diagnostic facilities.

Methods: Following the World Health Organization’s case-definition, we conducted a rapid-appraisal of HFMD among all of the 143 children attending Pabna Medical College and General Hospital with fever, mouth ulcers and extremity rash. Data were collected between September and November 2017 using a preset syndromic approach and stringent differential diagnostic-protocols.

Results: The mean age of children was 2.9±2.3 years. Age did not differ with sex (P=0.98), first sibling being more belonging to middle-income families (62%). Younger children (<5 years) were more likely to suffer with moderate-to-high (38.5°C) fever (P<0.04), painful oral ulcers (P<0.03) and painful/itchy rash (P<0.01). Sex did not differ with other symptoms, but boys had less painful oral ulcers than girls (P<0.04). Fever (63%) and chicken-pox-like-rash (62%) was observed more in mid-October to mid-November more than September to mid-October (P<0.01 and P<0.03, respectively).

Open Peer Review

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Invited Reviewers

1 2

Report

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Clinical Research Unit, Hanoi, Vietnam
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mid-November than September to mid-October (P<0.01 and P<0.03, respectively). No differences in symptoms (fever, oral ulcers and extremity rash) were observed with precipitation, nor with ambient temperature. Children <5 years (85%) had quicker recovery (within 5 days) than those ≥5 years (69%), (P<0.04), with marginal differences in sex (P<0.05).

**Conclusions:** Our findings highlight the potential usefulness in diagnosing HFMD based on clinical parameters, although stringent differential diagnosis remains indispensable. It is particularly applicable for resource-constrained countries who lack appropriate virology/essential laboratory equipment. Since no specific treatment or effective vaccination is available for this disease, supportive therapy and preventive measures remain the primary methods to circumvent transmission augmented by climate-related factors. Standardized virology laboratory warrants appropriate diagnosis and globally representative multivalent vaccine is deemed essential towards preventing HFMD.

**Keywords**
Emerging Childhood-HFMD, Bangladesh, Rapid-Appraisal, Pocket-Outbreak

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Prepared based on syndromic case-definition, showing the serotypes of enterovirus A, the most common being enterovirus A71 (EV A71) and coxsackievirus A16 (CV-A16) and more recently, also (CV A-6, and CV A-10). EV-A71 is associated with a higher proportion of severe illnesses. A little change was brought in the 2nd paragraph of the Introduction with “HFMD is caused by several serotypes of enterovirus A, the most common being enterovirus A71 (EV A71) and coxsackievirus A16 (CV-A16) and more recently, also (CV A-6, and CV A-10). EV-A71 is associated with a higher proportion of severe illnesses”.

In addition to mentioning it in Figure 4, the WHO recommended case definition has been re-emphasized as mentioned in the 2nd line of ‘Method’ and also in the ‘Clinical diagnostic tool’ section. After cross checking with the relevant reference(s) the sentence “Despite epidemiological forecasts that HFMD outbreaks occur in a 2–3 year cyclical pattern two large epidemics broke out in 2 consecutively years: one in Malaysia during 1997 and the other in Taiwan, the following year” has been removed from the 2nd paragraph of the ‘Potentials & dynamics of HFMD outbreak’ section.

The importance of EV-A71 as the main pathogen causing proportionately more severe cases of HFMD was reinforced and thus edited in the 3rd paragraph of the ‘Laboratory diagnosis of HFMD’ section.

See referee reports

Introduction

Of all commonly occurring febrile illness and rash syndromes\textsuperscript{1}, hand, foot and mouth disease (HFMD) remains the most among young children\textsuperscript{2,3}. Although this viral infection remains largely contagious\textsuperscript{4,5}, it is self-limiting and benign. Severe cases occur with a low incidence (3.2% to 8.5%) and fatalities are rare\textsuperscript{6,7}. Starting in the West during the mid-1970’s\textsuperscript{8,9} HFMD emerged in the Asia-Pacific region in mid-1990\textsuperscript{6,10} heralding as a major public health hazard\textsuperscript{2,6,10}. Epidemiologically, it follows a 2–3 years cyclical pattern\textsuperscript{11} but may break out anytime\textsuperscript{3} as has occurred in India (Orissa\textsuperscript{12} and Calcutta\textsuperscript{13}), bordering with Bangladesh.

With the complaints of mild-to-moderate fever (\(\geq 38.5^\circ\text{C}\); 101.3°F) childhood HFMD, characteristically manifest with body rashes\textsuperscript{14,15}, mostly of the knees and buttocks\textsuperscript{13,14}, augmented by painful oral/buccal ulcers and blisters. Papulo-vesicular rash in the extremities consequently forms pustules\textsuperscript{5}. Most children recover/heal within 7–10 days\textsuperscript{5,8,8}. Of the few complications, neuro-respiratory syndromes\textsuperscript{16} (encephalitis, aseptic meningitis and acute flaccid paralysis)\textsuperscript{1,17} occur mainly in younger children; these are rare but seldom fatal\textsuperscript{1,18}. HFMD is caused by several serotypes of enterovirus A, the most common being enterovirus A71 (EV A71)\textsuperscript{18,19} and coxsackievirus A16 (CV-A16) and more recently, also (CV A-6, and CV A-10)\textsuperscript{20,21,22}. EV-A71 is associated with a higher proportion of severe illnesses\textsuperscript{2,21}. Reportedly, these viruses are transmitted\textsuperscript{21,22} through direct contact/blister-fluid, droplets, oro-fecally\textsuperscript{23} and also spread out through contaminated environment, water and food\textsuperscript{18}. 

Reportedly, clinical diagnosis of HFMD is usually established depending on physicians’ suspicions\textsuperscript{18,19} as the sole diagnostic modality\textsuperscript{1}. The diagnosis is primarily based on history of illness, disease-onset, presenting clinical-features\textsuperscript{6,19} and, socio-demographic profile\textsuperscript{3,24,25}. Small erythematous maculopapular lesion (1–5 mm) enlarge (3–15 mm) and progress to vesicular eruptions with a prominent erythematous halo\textsuperscript{3,1}. It is essential to perform stringent differential diagnosis (DD) to distinguish HFMD from a group of diseases. DD includes chickenpox, scabies, measles, erythema multiforme, herpangina, herpetic gingivitis, drug eruption and others\textsuperscript{24,26,27}. Laboratory diagnosis is usually not essential\textsuperscript{3,24,28,29}, and has been described by the World Health Organization (WHO) as optional\textsuperscript{1}. Conversely, the sophisticated laboratory tests used for definitive diagnosis (virus isolation, molecular analysis, PCR, genotyping)\textsuperscript{13,24} are not available in most resource-constrained countries\textsuperscript{12,13,1} like Bangladesh.

Since there is no specific treatment\textsuperscript{29,30,31} for HFMD, care largely remains palliative\textsuperscript{19} with antipyretics/analgesics and antihistamines. Topical anesthetics are rarely used for oral ulcers for soothing and comfort. Povidone-iodine used as a mouth wash/topical application that can relief pain. Since no effective vaccine against HFMD-viruses is available\textsuperscript{1,2}, preventive measures remain the primary method of circumventing HFMD transmission to break infection-chains (droplets, oral-fecal route, and direct contact)\textsuperscript{31,32}. Effective prevention requires personal hygiene, hand washing\textsuperscript{26} and a pollution-free environment\textsuperscript{1} including food and water\textsuperscript{8,27}. Meteorological variations in precipitation\textsuperscript{33} and ambient temperature\textsuperscript{3,28} often impact on HFMD occurrences\textsuperscript{3} in the Asia-Pacific region\textsuperscript{34,10,14,17} along with atmospheric pressure and the relatively higher humidity in summer and early autumn\textsuperscript{18}.

Extracts from extensive reviews, when compared with our intensive observations on upsurge of unusual febrile, rash-associated childhood illnesses between July and August 2017, were indicative of HFMD. A rapid appraisal was therefore, designed as a short-term standardized-surveillance\textsuperscript{1}. Following a pre-set case-definition and syndromic approach (according to the WHO HFMD guidelines\textsuperscript{1}), similar to a study conducted in Thailand\textsuperscript{35} a strategic plan was adopted to conduct this comprehensive study from September to November 2017.

Methods

Set up, patients and research design

Utilizing a pre-set syndromic approach based on case-definition following the WHO’s HFMD guidelines\textsuperscript{1} this rapid appraisal was conducted among all the 143 children attending Pabna Medical College and General Hospital (PMC-GH) between September and November, 2017. PMC-GH is a 250-bed secondary care hospital serving a targeted population of nearly 2.81 million from its 2,371.5 km\textsuperscript{2} catchment area situated in a small poverty-stricken north-western flood-prone plain land on the Ganges Delta basin in Bangladesh.

Research instruments used

Clinical diagnostic tool. Prepared based on syndromic case-definition following the WHO’s HFMD guidelines\textsuperscript{1}, similar to a prior study conducted in Thailand\textsuperscript{35}. Most of the contents of this tool have been shown in Figure 4 (4 A), showing the algorithm of Clinical diagnosis of HFMD\textsuperscript{1}.
Clinical case management protocol. This was prepared incorporating a history of disease, onset, chief complaints and duration of illness, clinical diagnosis and therapeutic intervention. We ascertained clinical outcome by through post-treatment follow-up in the outpatient department of PMC-GH or through cellphone-based enquiry. We performed the clinical diagnosis following WHO guidelines, predominantly based on three main signs and/or symptoms: fever, oral ulcers and rash in extremities. Fever was graded into moderate-to-high (38.5°C) and none-to-low (37-38.4°C), oral ulcers were grouped into three stages: more painful, less painful & painless; and, rashes in extremities into three types: painful and itchy, painless and itchy; and painful but not itchy.

Pain assessment/scoring tool
Since pain remains subjective in younger children in expressing pain intensity properly, we arbitrarily categorized the pain intensity based on following clinical grounds:

i. Nullifying any history of similar disease/disorders in near past
ii. Facial expression of a child with body rash and/or oral ulcer on touch
iii. Impression and/or opinion of child’s parent/guardian in respective cases
iv. Finally, clinician's judgements based on history and presented signs/symptoms

Therapeutic management guideline
A therapeutic guideline was prepared to treat childhood HFMD cases following standard therapeutic plan consisting of: antipyretic/analgesics, antihistamines, anesthetic-cream for topical applications.

Epidemiological tool
This tool consisted of socio-demographic variables and household (HH) income. We categorized the monthly (mon) income (in Bangladeshi takas: BDT) of child’s family according to World Bank (WB) Data Help Desk 2016: as follows:

- Low-income group: HH income of ≤ 6,946/mon
- Lower-mid income group: HH income: 6,947–27,336/mon
- Upper-mid-income group: HH income:27,337–84,564/mon
- High-income group: HH income of ≥ 84,564 BD/mon

(Calculated using USD rate: 1US $=84.31 BDT dated 11.06.18)

Seasonal data collection
Seasonal data on local weather/climate for average temperature and rain precipitation were collected from Pabna Meteorology Department, Bangladesh over the period of September through November 2017. In Bangladesh, early autumn runs from September to mid-October, followed by late autumn/fall from mid-October to mid-November.

All these tools (developed or followed) were duly pre-tested for this rapid-appraisal (small-scale disease surveillance).

Data analysis
Crosschecked data were subjected to Pearson’s chi-squared test, Fisher’s exact test and Spearman correlation analysis using SPSS for Windows v.21, taking P<0.05 as indicating statistical significance (at 95% CI).

Inclusion criteria/patient enrolment
Any child, irrespective of age and sex, attending PMC-GH between September and November 2017 with suspected HFMD (meeting WHO’s recommended criteria) were included in this study. Suspected cases having other serious disease/co-morbidities were excluded, although patients were referred to concerned department for proper clinical management.

Ethical considerations
Following standard procedure of ethical issues, written informed consent was obtained from the parents of children with suspected HFMD prior to enrolment. We detailed the parents/guardian of all children on the purpose and procedures of this study. We also informed the parents on the lack of risk of harm/damage involved in procedures and did not collect body fluids or other biological samples. We informed the parents that they could remove their child at any stage of the study. Complete privacy and anonymity of clinical data was ensured, including its protected use research purposes only. This study had prior approval through the Ethical Committee of Pabna Medical College and General Hospital, Government of the Peoples’ Republic of Bangladesh (Memo No. 1577, dated: 26/08/2017).

Results
Demographic information
The mean (±SD) age of the 143 children was 2.9±2.3 years; 80 (56%) were boys and 63 (44%) were girls. Of the total, 70% were under 5 years old. Age did not differ with sex (P=0.98). Data on HH structure yielded an average size of children’s family as 5.5±6.9 persons/per HH. Of them, 62% having only one (no siblings) and 38% two (first sibling) children, (Table 1).

Following Word Bank, (2016) standard family/HH income-group evidenced that majority families (85%) belonged to middle-income HH/families (34% belonged to upper-middle and 51% to lower-middle income-groups living with a modest HH-budget). The rest (14.7%) belonged to low-income groups lived with a tight HH-budget. Notably, children from mid-income-HHs contracted significantly more HFMD which was more among the first siblings (P<0.01), (Table 1).

Assessment of symptoms
Child’s age was significantly associated with three major clinical signs/symptoms. Younger children (under 5 years old) suffered more (74/91, 81% with moderate-to-high fever than older children (17/91, 19%; P<.04). Similarly, painful oral ulcers (82/111, 74%) and painful itchy rash in extremities (92/116, 79%) were more common in younger than older children (p<0.03 and p<0.01, respectively). Notably, skin rash in
Table 1. Socio-demographic characteristics and household income of child’s family attending the Pabna Medical College and General Hospital with the complaints of hand, foot and mouth disease (n=143 cases).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Groups</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 months–3 years</td>
<td>78 (54.5)</td>
<td></td>
</tr>
<tr>
<td>3.1–5 Years</td>
<td>32 (22.4)</td>
<td></td>
</tr>
<tr>
<td>&gt;5.1 Years</td>
<td>33 (23.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>80 (55.9)</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>63 (44.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Age vs. sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\chi^2$</td>
<td></td>
<td>p=0.98</td>
</tr>
<tr>
<td>Likelihood ratio</td>
<td></td>
<td>p=0.98</td>
</tr>
<tr>
<td>Spearman’s correlation</td>
<td></td>
<td>p &gt;0.87</td>
</tr>
<tr>
<td><strong>Siblings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child 1</td>
<td>89 (62.2)</td>
<td></td>
</tr>
<tr>
<td>Child 2+</td>
<td>54 (37.8)</td>
<td></td>
</tr>
<tr>
<td><strong>Household income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low income</td>
<td>21 (14.7)</td>
<td></td>
</tr>
<tr>
<td>Low-mid-income</td>
<td>73 (51.0)</td>
<td></td>
</tr>
<tr>
<td>Upper-mid-income</td>
<td>49 (34.3)</td>
<td></td>
</tr>
<tr>
<td>High income</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Sibling number vs. household income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$\chi^2$</td>
<td></td>
<td>p &lt;0.01</td>
</tr>
<tr>
<td>Likelihood ratio</td>
<td></td>
<td>p =0.01</td>
</tr>
<tr>
<td>Spearman’s correlation</td>
<td></td>
<td>p &lt;0.01</td>
</tr>
</tbody>
</table>

*Following World Bank Data Help Desk, 2016

Extremities of younger children’s were predominantly more like papulo-vesicular (59/68, 87%) than chicken pox-like (43/75, 57%) lesions (p<0.001). However, sex did not differ with other signs/symptoms except oral ulcers: boys had less painful ulcers (23/32, 72%) than girls (9/32, 28%), (P<0.04), (Table 2).

None of the three major signs/symptoms of HFMD (fever, oral-ulcers/blisters and extremity rash) was associated with seasonal variations except fever and characteristics of rash. Moderate-to high fever (57/91, 63%) was observed more in fall/late-autumn (mid-October through mid-November) than in early autumn (September through mid-October), yielding 37% of cases (34/91), (p<0.01). Similarly, papulo-vascular rashes were more common in fall (42/68, 62%) than in early autumn (26/68, 38%) (P<0.03) (Table 3).

The three major sign/symptoms among these HFMD contracted children were more prevalent on days where 0.0 mm precipitation was recorded. Rain had no significant impact on any of the three major sign/symptoms, unlike on dry days with no rainfall (0.0 mm). Similarly, all major sign/symptoms prevailed more in hot and humid days when the ambient temperature was recorded at ≥30°C (up to a maximum of 36.2°C), with no significant difference among three major sign/symptoms (Table 3).

Findings of post-treatment clinical outcome was associated with age. More young children (<5 years) recovered in <5 days (63/74, 85%) than older peers (≥5 years) (47/69, 69%) who were more likely to recover in >5 days (P<0.05). However, clinical disease/outcome was not associated with children’s sex, although boys were more likely to suffer with the illness for 6–7 days, whereas girls tended to recover within 5 days. However, this was only marginally significant (P<0.05) (Table 4).

Discussion

Basis of this rapid appraisal on HFMD outbreak

Clinico-epidemiological insights from an extensive review on latest literature on HFMD augmented by our careful clinical observations on unusual events of febrile-rash (following WHO’s “Clinical management and public health response for HFMD”1) made us enabled to establish the primary clinical diagnosis of childhood HFMD (M Azraf H Khan: Personal Observations, June–July 2017). Further, concurrent agreement from similar reports attested our diagnosis of HFMD in children, as correct1-3.
### Table 2. Composite table showing association of HFMD clinical features with age and sex.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Body temperature</th>
<th>Clinical manifestation</th>
<th>Rash characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>38.5°C (n=91)</td>
<td>≥37–38.4°C; (n=52)</td>
<td>≥30°C (n=121)</td>
</tr>
<tr>
<td>Child’s age</td>
<td></td>
<td>Oral ulcers</td>
<td>Rash in extremities</td>
</tr>
<tr>
<td>&lt;3 years (n=78)</td>
<td>57</td>
<td>21 54 24</td>
<td>70 08 32</td>
</tr>
<tr>
<td>≥3 but &lt;5 years (n=32)</td>
<td>17</td>
<td>15 28 4</td>
<td>22 10 19</td>
</tr>
<tr>
<td>≥5 years (n=33)</td>
<td>17</td>
<td>29 4 24</td>
<td>9 09 24</td>
</tr>
<tr>
<td>χ²</td>
<td>P&lt;0.04</td>
<td>P&lt;0.03</td>
<td>P&lt;0.01</td>
</tr>
<tr>
<td>Spearman’s correlation</td>
<td>P&lt;0.01</td>
<td>P=0.01</td>
<td>P&lt;0.01</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male (n=80)</td>
<td>52</td>
<td>28 57 23</td>
<td>68 12 44</td>
</tr>
<tr>
<td>Female (n=63)</td>
<td>39</td>
<td>24 54 9</td>
<td>48 15 31</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>P&gt;0.73 (2-sided); P&gt;0.42 (1-sided)</td>
<td>P&gt;0.04 (2-sided); P&gt;0.03 (1-sided)</td>
<td>P&gt;0.20 (2-sided); P&gt;0.13 (1-sided)</td>
</tr>
<tr>
<td>Spearman’s correlation</td>
<td>P&gt;0.71</td>
<td>P&lt;0.04</td>
<td>P&lt;0.18</td>
</tr>
</tbody>
</table>

*Mean ± SD = 2.9 ± 2.3.

### Table 3. Composite table showing association of HFMD clinical features with season/local climate.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Body temperature</th>
<th>Clinical manifestation</th>
<th>Rash characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>38.5°C (n=91)</td>
<td>37–38.4°C C (n=52)</td>
<td>≥30°C (n=121)</td>
</tr>
<tr>
<td>Seasons</td>
<td></td>
<td>Oral ulcers</td>
<td>Rash in extremities</td>
</tr>
<tr>
<td>September-mid-October (n=42)</td>
<td>34</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>Mid-October-mid-November (n=101)</td>
<td>57</td>
<td>44</td>
<td>78</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>χ²&lt;0.01 (2-sided) &amp; χ²&lt;0.01 (1-sided)</td>
<td>χ²&gt;1.0 (2-sided) &amp; χ²&gt;0.53 (1-sided)</td>
<td>χ²&gt;0.48 (2-sided) &amp; χ²&gt;0.26 (1-sided)</td>
</tr>
<tr>
<td>Spearman’s correlation test</td>
<td>P&lt;0.01</td>
<td>P&gt;0.86</td>
<td>P&gt;0.37</td>
</tr>
<tr>
<td>Average rainfall on admittance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.0 mm (n= 107)</td>
<td>67</td>
<td>40</td>
<td>85</td>
</tr>
<tr>
<td>0.17 mm (n= 22)</td>
<td>15</td>
<td>7</td>
<td>17</td>
</tr>
<tr>
<td>&gt;20.1 mm (n= 14)</td>
<td>9</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>χ²-Chi-square test</td>
<td>P =0.88</td>
<td>P&gt;0.44</td>
<td>P&lt;0.78</td>
</tr>
<tr>
<td>Spearman’s correlation test</td>
<td>P&gt;0.70</td>
<td>P =0.32</td>
<td>P&lt;0.76</td>
</tr>
<tr>
<td>Ambient temperature on admittance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24.4–29.9°C (n= 22)*</td>
<td>11</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>≥30°C (n=121)**</td>
<td>80</td>
<td>41</td>
<td>91</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td>P&lt;0.16 (2-sided)</td>
<td>P&lt;0.16 (2-sided) &amp; P&lt;0.08 (1-sided)</td>
<td>P&gt;0.37 (2-sided) &amp; P&lt;0.21 (1-sided)</td>
</tr>
<tr>
<td>Spearman’s correlation test</td>
<td>P&lt;0.15</td>
<td>P&lt;0.11</td>
<td>P&gt;0.28</td>
</tr>
</tbody>
</table>

* Comparatively lower temperature: Arbitrarily set cut-off values of lower temperature (on average). ** Comparatively higher temperature: Arbitrarily set cut-off values of higher temperature (on average)
Table 4. Composite table showing association of HFMD clinical features with season/local climate.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Post-treatment clinical outcome of childhood HFMD like-disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cured in &gt;5 days (n=69)</td>
</tr>
<tr>
<td>Age of children (Mean= 2.9 ± 2.3 years)</td>
<td></td>
</tr>
<tr>
<td>&lt;1–3 years (n=78)</td>
<td>32</td>
</tr>
<tr>
<td>3.1–5 yeas (n=32)</td>
<td>15</td>
</tr>
<tr>
<td>5.1–10 years (n=33)</td>
<td>22</td>
</tr>
<tr>
<td>Chi-square (χ²) test:</td>
<td></td>
</tr>
<tr>
<td>Correlations</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td>Male (n= 80)</td>
<td>44</td>
</tr>
<tr>
<td>Female (n=63)</td>
<td>25</td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td></td>
</tr>
<tr>
<td>Pearson’s correlation</td>
<td></td>
</tr>
</tbody>
</table>

Gauging the potential of a sudden upsurge in HFMD cases in children (during July 2017) attending PMC-GH from its catchment area made us aware on an upcoming localized outbreak. A strategic plan was thus urgently adopted to conduct this rapid appraisal (short-term standardized surveillance) on childhood HFMD utilizing a pre-set case-definition/syndromic approach based on WHO’s HFMD guidelines as depicted in Figure 4 (having fever or a history of fever, papulo-vesicular rash in extremities with or without oral ulcers), similar to a study conducted in Thailand.

The principal objective of this study (rapid appraisal) was to combat the impending HFMD outbreak with a secondary aim of disseminating the existence of newly emerged disease, thus to create a mass awareness. We also aimed to stir-up the local public health emergency squad to cumulate further strength towards combating such upcoming outbreaks in future. Finally, we desired to gauge strength of administrative drive, technical knowhow and clinical skill of PMC-GH team in combating that HFMD cases based on strong yet rational suspicions, as reported by others.

Keys to success of combatting that on-going pocket outbreak, were: i) Sincerity and devotion of PMC-GH team despite huge limitation in manpower and resources, ii) strong clinical eye suspecting HFMD as appropriate diagnosis, iii) instituting supportive therapy instantly, and iv) diagnosing HFMD despite gross lack in diagnostic facilities, though it often remains not essential in such emergencies.

Potentials and dynamics of HFMD outbreaks

HFMD, emerged as a major public health problem in recent years during mid-1970s. It was then, spread out in Asia-Pacific region since mid-1990s, mostly in Malaysia, Taiwan, China and Singapore. Though a longer time series is required to ascertain EV71 outbreaks of HFMD, it generally occurs in 2-to 3-year cyclical pattern in West Pacific Region (WHO/WPRO, 2010) as reported from Singapore, UK, Malaysia and Japan. However, HFMD CA16 outbreak in Singapore also occurred periodically: in 2002, 2005 and 2007 but in 2006 but it was caused by EV71. HFMD outbreaks were also reported from Orissa and Calcutta in India that borders with Bangladesh but strange is no published data or report exist in Bangladesh, yet (until June 2018).

All these facts and figures, including epidemiological hunches and variabilities support our strong speculation of this localized outbreak of HFMD in Pabna that we could combat successfully. We also postulate that HFMD might have emerged in Bangladesh earlier, but, swept on unnoticed being ‘underestimated’ due to its benign nature and self-limiting features, or such latent HFMD cases or small localized outbreaks might remained under-reported or un-reported (Kazi Selim Anwar and Md. Abid Hossain Mollah, personal observation, June 2017).

Clinico-epidemiological perspectives

Using observation (clinical course, disease progression and outcome) re-confirms other reports that childhood-HFMD remains a benign and self-limiting disease. We also attest that HFMD can be diagnosed accurately on physician’s strong rational suspicion and presenting signs/symptoms that can aid as sole diagnostic modality.

In addition to history, onset and presenting clinical features, we considered child’s socio-demographic characteristics, and a positive history of similar sign/symptoms in child’s family, nursery/schools. However, we neither observed such high incidences of severe disease alike from Vietnam (8.5%) nor recorded any fatal case in like others reporting as ‘none’ or ‘rare’.
Our data yielded a significant association between age groups and three major clinical signs/symptoms. Moderate-to-high fever, painful oral ulcer and itchy-painful rash were directly proportional to younger children which remain consistent with other findings. Moderate-to-high fever remains an important, but not mandatory or principal sign of HFMD, as the WHO’s guidelines for clinical and public health response indicate, in agreement with our findings. Oral and/or axillary temperature in 64% of cases revealed a moderate fever (38.5°C), ranging mostly between 37.5°C and 38.2°C; the rest (36%) had no or a low-grade fever (ranging between 37.0 to 38.4°C). This observation led us to postulate variation in body temperature led us to postulate that fever itself should not be considered as the sole symptom to confirm HFMD, rather this remain consistent with Van Pham et al. though others reported high fever in HFMD-cases.

Literature reveals papulo-vesicular rash as the most important characteristic symptoms for HFMD often manifesting as painful chicken-pox-like rashes in 60% cases (Figure 3) though the rest 40% had it less painful or painless. Since pain remains subjective in younger children in expressing pain intensity, we categorized HFMD cases based on having no history of recent pain issues, facial expression of child on slight touch on rash/oral ulcer including mother’s impression plus clinician’s rational judgement. Our findings on itchy rashes remain consistent with others, particularly in its distributions (knees and/or buttock). Itchy rashes in child’s extremities that formed small pustules were filled with turbid fluid (Figure 1) and in some cases it crusted off consequently after 3–4 days- as other reported, as well.

Secondly, most of the children (78%) had characteristic oral ulcers and/or painful blisters in tongue/mouth (Figure 2), that remain similar to several reports. However, the exact reason in 22% less pain or painless oral ulcers/blisters remain unclear. We postulate it could be due to a varied perception and/or different tolerance, unwilling to mention, feeling shy or even being scared. Some of them may have taken analgesics at home prior to attending the hospital which they did not disclose despite repeated probing. Notably, sex of HFMD cases did not significantly differ with any sign/symptom except oral ulcers. More boys had it less painful than girls. Although a study in India reported an overall male-female ratio of 21:17.

Differential Diagnosis of HFMD

Stringently examined thorough DD was performed to differentiate HFMD from closely similar diseases, like chicken-pox/varicella, scabies, measles, erythema multiforme, herpangina, herpetic gingivitis, drug eruptions, as several reports mentioned. Mosquito bite was also included as report from India, underlined it as a simple yet valuable DD-point. Particular attention in the DD was paid on examining the characteristics of skin lesions (macules and papules quickly evolve into small vesicles manifesting on their palms, soles, and buttocks). We observed small vesicles in majority of these children that ruptured with the formation of erosions and crusts as ascribed by Sharma et al. Alike his finding, we also observed those vesicles as 1–5 mm in size as erythematous maculopapular lesions that rapidly enlarged by 3–15 mm progressing to vesicular eruption with...
prominent erythematous halo\textsuperscript{3,14} being comparable to that of a report by Bhumesh et al. from India\textsuperscript{21}.

**Laboratory diagnosis for HFMD**

Laboratory diagnosis is usually not essential\textsuperscript{12,23} to confirm a readily diagnosed HFMD case based on rational judgement of existing clinical features. Even, lab diagnosis often remains unnecessary\textsuperscript{19}. Laboratory tests, such as serotyping, molecular, PCR and genotyping\textsuperscript{1,13,24} and virus culture\textsuperscript{13,24}, may not be feasible, available and more importantly not affordable in resource-constrained countries\textsuperscript{12,21} like Bangladesh, particularly in hard-to-reach/remote areas. Although few studies report high WBC count or blood glucose, as associated with HFMD severity\textsuperscript{13,19,23,24}, it remains scarcely seen in recent literature.

Furthermore, raised blood glucose level may be due to other viral diseases rather than HFMD, and may confound by other infections and/or inflammatory processes. Moreover, drawing intravenous blood from younger children possessing thin veins may be extremely difficult if not possible particularly in primary care health centers in grass-root level. Children often exhibits agitation when attempts are made to draw blood showing grossly non-compliance and non-cooperative.

Virological assays remains the main diagnostic tool. Of the four species in the family of Picornaviridae (groups EV-A, B, C...
Our clinico-epidemiological data, in agreement with other reports, revealed that younger children (<5 years old) recovered quickly (in <5 days) than their elder peers (>5 years old) who recovered in 6–7 days (>5 days). There was a marginal significant difference in sexes: boys had seemingly quicker recovery than girls (P<0.05). Nonetheless, latest literature attest most HFMD-cases recover within 7–10 days. These findings remain consistent with that of others from Asia-Pacific countries, including India, China, and Hong Kong. One limitation is we could not conduct a proper meteorological study as reported from some Asian countries. Contrarily, we only tried to find out briefly if local weather has any impact on HFMD just to acquire a preliminary idea in this aspect. However, the literature did not reveal any such study/report detailing the symptom-specific association of HFMD with seasons that we did, though some of our findings remain comparable with that of others. Thus, data from this rapid appraisal (short-term surveillance) demonstrated certain seasonal characteristics of local weather were associated with fever and rash characteristics. Moderate-to-high fever was observed more often in fall/late-autumn (mid-October to November) than in early autumn. We did not observe any impact of rainfall/precipitation on any of the 3 major signs/symptoms that we evaluated. We observed that childhood HFMD cases occurred mostly in dry weather with no rainfall (0.0 mm) almost equally in all three major signs/symptoms of HFMD including disease severity. These findings on local climatic factors did not corroborate with others.
Socio-demographic characteristics and household economy of child’s family

Another unique strength of our study was to associate socio-demographic &/or HH-economy with child’s family with HFMD. Child’s age (mean ± SD, 2.9± 2.3 years) group remained similar to other reports1,2,7,8,14–21 Child’s age did not differ, significantly with sex. The HH structure revealed an average size of children’s family as 5.5±0.7 persons/HH, 62% of who were the first kids and 38% the second ones. Following World Bank categorized family/HH income /grades13 majority of children’s family (85%) belonged to middle-income HHs living on a modest budget: 34.3% being in upper and 51% in lower, mid-income HHs. The rest 14.7% belonging to low-income HH are compelled to live with a very tight HH budget. Notably, a logical but unique finding, based on ecology, environment and health care utilizations, we observed HFMD cases more among first siblings than their siblings and who used to live in tight/low HH-budget. Of multifaceted reasons for this, we postulate that gross limitation in health care expenditure, distance of PMC-GH from HHs and low level of HH-income remains the major reasons. While it demands further explorations, few reports associating HFMD cases with personal hygiene and surrounding environment18,26,27 remains important to stop transmitting HFMD-virus among adjacent communities.

Prevention and control measures for HFMD

Due to a lack of available vaccines against HFMD-viruses18,17,18 preventive measures remain the primary tool to circumvent HFMD-virus. Preventive methods include good personal hygiene, proper hand washing2 particularly the post-defecation hand wash, pollution free environment26,18 and hygienic sewage management2, ensuring germ-free drinking water and food1. Although avoid person-to-person contact2 through isolation remain justified, it often may not be practical in unprivileged communities of low-income countries having resource-constrained healthcare budget like Bangladesh. But it remains imperative that mass awareness be increased both among the communities and physicians.

Insights on principal findings

• Our clinico-epidemiological observation indicates that childhood-HFMD has emerged in Bangladesh. Earlier outbreaks in Calcutta, India (bordering with Bangladesh) remains indicative of its introduction in this country since few years but remained unreported and thus, unnoticed.

• The physicians’ strong yet rationally judged clinical suspicion (based on signs/ symptoms) could establish a correct diagnosis, of HFMD cases.

• Stringent differential diagnosis remain indispensable to exclude similar fever- or rash-causing illness.

• Laboratory diagnosis seems unessential, particularly during HFMD outbreak situations when proper laboratory- diagnosis (virus culture, serology, molecular analysis) is not readily available.

• We experienced that early forecasting may aid in combating HFMD outbreaks in catchment areas to curb complications more successfully.

• Small-scale/localized outbreaks can be combated utilizing existing health-care/hospital set up/facilities.

• No specific treatment for HFMD exists, although supportive therapy can treat cases of HFMD in a week.

• Healthcare workers must remain aware on the prevention and treatment of HFMD, and, particularly on the warning signs of its severe illness.

• It is imperative to increase mass awareness to stop transmission of HFMD viruses (air/droplet, environment).

• Personal hygiene, hand washing and a pollution-free environment are mainstays of HFMD prevention.

Conclusion

We could diagnose cases of childhood HFMD successfully based on clinical signs/symptoms only and all cases recovered well within a week. Stringent differential diagnosis on similar rash and/or fever diseases/syndromes were deemed indispensable. The local climate may influence HFMD. Time consuming and costly laboratory diagnosis (virological/molecular) is not essential in resource-constrained settings, particularly during outbreak situations. No specific treatments or effective vaccinations exist for this often-underestimated disease yet. Supportive therapy and strict preventive measures is able to circumvent/ destroy EV or CA viruses to combat ongoing HFMD-outbreaks/threats.

Recommendations

Development of a globally representative multivalent HFMD vaccine remains necessary, particularly in countries where HFMD widespread, before it becomes pandemic. Both the government health services and meteorology departments should work together since climate is shown to be an early indicator of potential HFMD outbreaks. Our findings warrant that the countrywide public health emergency operations teams be more alert towards the effective prevention and control of HFMD in resource-constrained countries like Bangladesh. The governments of such countries should come up with a well-designed, sustainable strategic plan to combat upcoming HFMD outbreaks, in close-cooperation with national and global NGOs and UN organs to prevent its pandemic threat in the near future.

Data availability

Dataset 1. Complete raw data from each child assessed as part of this study. DOI: 10.5256/f1000research.15170.d21103839.

Consent

Written informed consent was obtained from the parents/guardians of each child for the publication of this report and the images contained within it.

Author contributions

Md. AzrAf Hossain Khan is currently at Dept. of Dermatology and Venereology, Rajshahi Medical College Hospital, Bangladesh.
Kazi Selim Anwar is currently at Faculty, Dept. of Infectious Diseases, School of Medicine, International University of Health and Welfare (IUHW), Narita, Japan.

Grant information
The author(s) declared that no grants were involved in supporting this work.

Acknowledgments
We sincerely thank Prof. Tetsuya Matsumoto, MD, PhD, Head, Dept. of Infectious Disease, School of Medicine, International University of Health and Welfare (IUHW), Narita, Japan for editing the manuscript and incorporating valuable suggestions. We thank Dr. Asadur Rahman, Dept. of Pharmacology, IUHW, for assisting in figure design/artwork and editing some part of the manuscript. We also thank Januka Khatiwada, Dept. of Public Health, IUHW, for sorting out few technical issues with the SPSS-software. Special thank goes to the PMC-GH authority for allowing us to conduct study successfully. We remain indebted and thankful to all those parents/guardians who allowed their children to take part in the study without which this endeavor would have been in futile.

Supplementary material
Supplementary File 1
STROBE checklist
Click here to access the data

References


31. How are the income group thresholds determined? World Bank Data Help Desk. 2016. Reference Source

32. WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects. Adopted by 64th WMA General Assembly, Fortaleza, Brazil. 2013. Reference Source


Open Peer Review

Current Peer Review Status:  

Version 2  

Reviewer Report 22 May 2019  

https://doi.org/10.5256/f1000research.18298.r48043

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Md. Azizul Haque  
Department of Medicine, Rajshahi Medical College (RMC), Rajshahi, Bangladesh

This is the first reported outbreak of HFMD from Bangladesh. This article will add some valuable information about distribution and burden of HFMD. Following observations has been made regarding this manuscript:

1. In abstract (background): “We report a localized outbreak of childhood HFMD for the first time from Bangladesh, diagnosed only based on clinical features due to gross lack in laboratory-diagnostic facilities.” The word “gross” should be removed from this sentence.
2. In abstract (results): please clarify and rewrite this sentence “Age did not differ with sex (P=0.98)
3. In Introduction “Severe cases occur red with a low incidence (3.2% to 8.5%) and fatalities are rare”, the word “red” should be replaced by “rarely”
4. In results (demographic information), the sentence “Notably, children from mid-income-HHs contracted significantly more HFMD which was more among the first siblings (P<0.01)” should be rewritten as “HFMD cases were significantly more common among children from mid-income households and in the first siblings (p <0.001)
5. In results (assessment of symptoms) in the sentence “Similarly, papulo-vascular rashes were more common in fall…” papulovascular should be replaced with papulo-vesicular.
6. The sentence should be replaced by “The three major sign/symptoms of HFMD were more prevalent on days where 0.0 mm precipitation was recorded.”
7. In the same section “Time to recover from HFMD varies with age of the patient”. In the sentence “More young children (<5 years) recovered in <5 days (63/74, 85%) than older peers (≥5 years) (47/69, 69%) who were more likely to recover in >5 days) (P<0.05).
8. In results (Clinico-epidemiological perspectives) section, the sentence “However, we neither observed such high incidences of severe disease alike from Vietnam (8.5%) nor recorded any fatal case in like others reporting as ‘none’ or ‘rare’ looks out of context and should be removed altogether or moved to complications section. If moved to the complications section, this sentence should also be rewritten as “In our series, we neither observed high incidence of severe disease, nor recorded any fatality.” Then comparison with data from other countries may be done.
1. While discussing severe disease and death, citation from Xing et al should be included, as his group published the largest epidemiologic study to date and showed the rate of severe disease and death in patients affected by HFMD (Xing W., Liao Q., Viboud C. Hand, foot, and mouth disease in China, 2008-12: an epidemiological study\textsuperscript{1})

2. In results (Clinico-epidemiological perspectives) section, the sentence “Moderate-to-high fever, painful oral ulcer and itchy-painful rash were directly proportional to younger children which remain consistent with other findings” should be rewritten as “Moderate-to-high fever, painful oral ulcer and itchy, painful rash were more common in younger children; this finding is consistent with other studies”.

3. In results (Clinico-epidemiological perspectives) section, the sentence “This observation led us to postulate variation in body temperature led us to postulate that fever itself should not be considered as the sole symptom to confirm HFMD, rather this remain consistent with Van Pham et al.8 though others reported high fever in HFMD-cases5,9.” is redundant and should be removed altogether. This is unnecessary repetition of a statement made in the same para (Moderate-to-high fever remains an important, but not mandatory or principal sign of HFMD).

4. In results (Clinico-epidemiological perspectives) section, citation is needed for the sentence “Literature reveals papulo-vesicular rash as the most important characteristic symptoms for HFMD often manifesting as painful chicken-pox-like rashes in 60% cases (Figure 3) though the rest 40% had it less painful or painless.”

5. In results (Clinico-epidemiological perspectives) section, the sentence “Since pain remains subjective in younger children in expressing pain intensity, we categorized HFMD cases based on having no history of recent pain issues, facial expression of child on slight touch on rash/oral ulcer including mother’s impression plus clinician’s rational judgement.” is redundant and should be removed altogether. Pain assessment/scoring tool has been described in detail in the Methods section.

6. In results (Clinico-epidemiological perspectives) section, the sentence “However, the exact reason in 22% less pain or painless oral ulcers/blisters remain unclear.” should be rewritten as “However, the exact reason of less pain/painless oral ulcers/blisters in 22% cases in our study remain unclear.”

7. In Laboratory Diagnosis for HFMD, the sentences “Laboratory diagnosis is usually not essential\textsuperscript{12,23} to confirm a readily diagnosed HFMD case based on rational judgement of existing clinical features. Even, lab diagnosis often remains unnecessary\textsuperscript{19} should be rewritten as “Laboratory diagnosis often remain unnecessary to make a diagnosis of HFMD. Use of WHO clinical case definition and exclusion of differential diagnosis is adequate in most cases.”

8. Reference number 12 may be omitted as authors of that article used RT PCR for virus isolation in 7 cases.

9. The para “Furthermore, raised blood glucose level may be due to other viral diseases rather than HFMD, and may confound by other infections and/or inflammatory processes. Moreover, drawing intravenous blood from younger children possessing thin veins may be extremely difficult if not possible particularly in primary care health centers in grass-root level. Children often exhibits agitation when attempts are made to draw blood showing grossly non-compliance and non-cooperative” is redundant and should be removed.

10. In complications, the sentence “Our finding yielded three cases (2.09\%) complications of mild-to-moderate severity who we had to pay particular attention to” should be rewritten as “In our study, three cases (2.09\%) developed complications of mild to moderate severity requiring special care”.

References

Is the work clearly and accurately presented and does it cite the current literature?
Yes

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Infectious disease, toxicology and rheumatology

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Author Response 23 May 2019

Kazi Selim Anwar, Institute of Epidemiology, Disease Control and Research, Dhaka, Bangladesh

I, on behalf of all authors whole heatedly thank the reviewer for reviewing our online published paper with so much care and attention, yet so productively and meaningfully. We, the authors, remain totally satisfied on the way the reviewer looked into every bits of our paper & in so in-depth, yet so positively.

Comment: Yes we agree to all of the the well-chalked & thoughtful queries, along with all his suggested points to bring some minor changes in our paper, soon.

Final comment for the Reviewer (only if the F1000Research allow me to do so, please):
This is one of the best review I have had encountered ever so far (I am engaged in reviewing at least 6 globally reputed Scopus indexed journals having good impact factors).

May I, thus, recommend the F100Research group/authority to take this reviewer as one of its regular reviewers, like me, who would definitely add more significant values of International Board of Reviewers or Editorial Panel of F100Research. It would facilitate more wider scopes towards more standardized publishing, I believe, that the journal has been doing that always, of course!
Dr. Kazi Selim Anwar, in favour of all authors of this online published paper.

Competing Interests: No competing interests were disclosed.

Reviewer Report 04 December 2018

https://doi.org/10.5256/f1000research.18298.r40496

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H Rogier van Doorn
Oxford University Clinical Research Unit, University of Oxford, Oxford, UK

I thank the authors for addressing a number of my comments.

I still think the discussion is too long and deals with a large of number of topics that are irrelevant to the data presented, being a clinically diagnosed first-time outbreak of HFMD in Bangladesh in a single hospital.

There is already a large body of available literature on HFMD. This manuscript adds the description of an outbreak or upsurge in Bangladesh. That is what needs to be described and interpreted / compared with other outbreaks. There is no need in this publication for the discussion section to provide a general review on HFMD or to provide extensive general recommendations on HFMD diagnosis, treatment and prevention.

The fourth paragraph of the discussion is an interpretation for which the authors present no data, this shouldn't be in a scientific publication. Sections on laboratory diagnosis, specific treatment and vaccination are not needed in this report. The list of principal findings should also be limited to findings from THIS study.

In the introduction, rephrase the sentence on "pollution free environment". HFMD prevention is through avoiding contact with infected persons and their secretions and excretions through hygiene/hand-washing and distancing (e.g. school closure or sending sick kids home).

Is the work clearly and accurately presented and does it cite the current literature?

Yes

Is the study design appropriate and is the work technically sound?

Yes

Are sufficient details of methods and analysis provided to allow replication by others?

Yes

If applicable, is the statistical analysis and its interpretation appropriate?
Yes

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Yes

**Competing Interests:** No competing interests were disclosed.

**Reviewer Expertise:** Clinical Microbiology

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

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**Version 1**

Reviewer Report 02 October 2018

https://doi.org/10.5256/f1000research.16525.r38927

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**H Rogier van Doorn**
Oxford University Clinical Research Unit, University of Oxford, Oxford, UK

The authors describe the results from a prospective observational study of children attending a single hospital in Bangladesh using WHO diagnostic criteria. If this is the first time HFMD has been described from Bangladesh, this is of major relevance locally and regionally.

I recommend the authors to use the STROBE guidelines/checkbox to verify whether all required data are included.

The main findings are that a number of cases of HFMD among young children was described from one hospital in Bangladesh, the symptom and age distribution are relatively similar to what is known from the region. Healthcare workers should be aware of this illness, its prevention and treatment and warning signs of severe illness.

I have made some comments and suggestions below, the most important being to shorten and bring more focus on the current data in the discussion.

Specific comments:

- Add this sentence on the aetiology, to replace the sentence in the second paragraph of the introduction: "HFMD is caused by several serotypes of Enterovirus A, the most common being Enterovirus A71 (EV-A71) and Coxsackievirus A16 (CV-A16) and more recently also CV-A6 and CV-A10. EV-A71 is associated with a higher proportion of severe illness."
- Please add the exact case definition that was used to enrol children.
• 143 children were included, how many children were eligible during the period of enrolment? How many were not enrolled because of exclusion criteria or otherwise, how many didn't consent?
• Can an epidemiological curve be added?
• Any further information on cases in the region, nearby hospitals?
• Were any warning signs detected during the study?
• Because of the epidemiology of HFMD, the preferred age stratification would be 0-6, 6-12, 12-24, 24-60 and >60 months or similar (e.g. Xing et al1)
• It is common to study the effects of precipitation allowing for a lag period of few days (incubation period)
• Reviews on the epidemiology, mortality and long-term outcome of HFMD have been published recently. These can be referenced in the discussion for clarity.
• The discussion deals with a broad spectrum of general topics. This is appropriate for a report to be circulated among local healthcare workers, but not for the current scientific publication. I would suggest to focus on the data from the current study for the discussion here, to broadly describe the findings and if there were any striking differences with what has been described from the region. The authors should not overinterpret the data from this relatively small sample size to look for potential associations.
• In the third paragraph of the discussion the authors state that outbreaks occurred in 1997 and 1998, despite forecasts. The referenced forecasts were derived from timeseries from Malaysia from 1998-2006 and could not have predicted the 1997-8 outbreaks. There are syndromic and serotype specific timeseries from Japan dating back to the 1980s that may have forecasted these, but to my knowledge no major HFMD outbreaks had occurred in Malaysia and Taiwan prior to these.
• In the laboratory diagnosis section, it is important to realise that diagnosis of EV-A71 as the main pathogen is important as it is associated with a higher proportion of severe illness.

References

Is the work clearly and accurately presented and does it cite the current literature?
Partly

Is the study design appropriate and is the work technically sound?
Yes

Are sufficient details of methods and analysis provided to allow replication by others?
Yes

If applicable, is the statistical analysis and its interpretation appropriate?
I cannot comment. A qualified statistician is required.

Are all the source data underlying the results available to ensure full reproducibility?
Yes

Are the conclusions drawn adequately supported by the results?
Partly
Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Clinical Microbiology

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Kazi Selim Anwar, Institute of Epidemiology, Disease Control and Research, Dhaka, Bangladesh

Comment specific response from the authors:
The authors thankfully appreciate the reviewer-1 for approving the paper with reservations and thank for the kind review and comments.

The followings remains the comment specific response from the authors:

Comment-1: The authors describe results from a prospective observational study of children attending a single hospital in Bangladesh using WHO diagnostic criteria. If this is the first time HFMD has been described from Bangladesh, this is of major relevance locally and regionally.
Reply-1: Yes, this observational study in our hospital remains the first report on HFMD from Bangladesh. We, therefore, thank you sincerely, for such an important comment…. “it remains of major relevance locally and regionally”.

Comment-2: I recommend the authors to use STROBE guideline/checkbox to verify if all required data included
Reply-2: Yes, agreed. We have uploaded STROBE guideline to verify our data in revised version.

Comment-3: The main findings that a number of cases of HFMD in young children was described from one hospital in Bangladesh, symptom & age distribution are relatively similar to what is known from the region.
Reply-3: Yes, we are glad to see your valuable comment that HFMD symptoms in younger children remain relatively similar with that of other reports from South/SE- Asian region.

Comment-4: Healthcare workers should be aware of this illness, its prevention and treatment and warning signs of severe illness
Reply-4: Yes, we appreciate your comment that healthcare workers must be aware of HFMD its prevention & treatment, particularly on warning signs of severe illness. Mentioned in 8th bullet point of “Insights on principal findings”.

Comment-5: I have made some comments and suggestions below, the most important being to shorten and bring more focus on the current data in the discussion.
Reply-5: Yes, agreeing to your most suggestion, shortened the discussion part focusing on current data-that really makes sense. Shortened discussion part as suggested

Comment-6: Add this sentence on the aetiology, to replace the sentence in 2nd para-graph of introduction ....“HFMD is caused by several serotypes…. with a higher proportion of severe illness.”
We thankfully agreed to replace it in the 2nd paragraph of introduction.. HFMD is caused by several serotypes of enterovirus A, the most common being enterovirus A71 (EV A71) and coxsackievirus A16 (CV-A16) and more recently, also (CV A-6, and CV A-10). EV-A71 is associated with a higher proportion of severe illnesses

Comment 7: Please add the exact case definition that was used to enroll children
Reply 7: Though it is mentioned in Fig.4, we have reemphasized the WHO recommended exact case definition of HFMD: having i) fever or history of fever, ii) papulovesicular rash on hand & foot iii) with or without oral ulcers.
Added this case definition in 2nd line of method and in clinical diagnostic tool, as well.

Comment 8: .... 143 children were included how many were eligible during enrolment period?
Reply 8: Since it was an outbreak situation, we had to enroll all 143 children attending our hospital from Sept. to Nov., 2017 with suspected HFMD cases (who met WHO criteria). Guardians of all children provided written consent to enroll.

Comment 9: Can an epidemiological curve be added?
Reply 9: Well yes, but we have described almost all epidemiological features in tables.

Comment 10: Any further information on cases in the region, nearby hospitals?
Reply 10: No. We explored to determine that among surrounding families, nurseries or kindergarten/primary schools, but none revealed any positive information.

Comment 11: Were any warning signs detected during the study
Reply 11: No, not as such. Of the 3 complications that we observed, only girl had onychomadesis, 1 child had pneumonia and the other had pyoderma. These may well be regarded as 'cautionary', if not 'warning' signs.

Comment 12: Because of the epidemiology of HFMD, the preferred age stratification would be 0-6, 6-12, 12-24, 24-60 and >60 months or similar (Xing et al)
Reply 12: Yes. But during that pocket outbreak our hospital team categorized the HFMD victimized children into two groups of <5 and >5 years only. Since 77% of them fell under <5 years it was further categorized into <3 years & 3.1 to <5 years. This age-stratification was done to fit aged-matched cases facilitating analysis.

Comment 13: It is common to study the effects of precipitation allowing for a lag period of few days (incubation period)
Reply 13: Yes. But we could not do that due to paying more attention in tackling/combating the on-going emergency of that pocket outbreak.

Comment 14: Reviews on the epidemiology, mortality and long-term outcome of HFMD have been published recently. These can be referenced in the discussion for clarity.
Reply 14: Well, yes. But we have described some of those in our discussion already.

Comment 15: The discussion deals with a broad spectrum of general topics. This is appropriate for a report to be circulated among local healthcare workers, but not for the current scientific publication.
I would suggest to focus on the data from the current study for the discussion here, to broadly
describe the findings and if there were any striking differences with what has been described from the region. The authors should not overinterpret the data from this relatively small sample size to look for potential associations.

Reply 15: Thanks for the good suggestions. We have shortened the discussion part, focused on our data from our current study and tried to describe the striking findings only that yielded some regional differences. And we also tried to avoid over-interpreting our data (relatively small sample size).

Comment 16: In the third paragraph of the discussion the authors state that outbreaks occurred in 1997 and 1998, despite forecasts. The referenced forecasts were derived from time series from Malaysia from 1998-2006 and could not have predicted the 1997-8 outbreaks. There are syndromic and serotype specific time series from Japan dating back to the 1980s that may have forecasted these, but to my knowledge no major HFMD outbreaks had occurred in Malaysia & Taiwan prior to these.

Reply 16: Thanks for pointing it out rightly. After cross checking on the contents of this sentence we have removed the following sentences 'Despite epidemiological forecasts that HFMD outbreaks occur in a 2–3-year cyclical pattern two large epidemics broke out in 2 consecutively years: one in Malaysia during 1997 and the other in Taiwan, the following year." Corrected this part as edited in the 2nd paragraph of ‘Potentials & dynamics of HFMD outbreak’.

Comment 17: In the laboratory diagnosis section, it is important to realise that diagnosis of EV-A71 as the main pathogen is important as it is associated with a higher proportion of severe illness.

Reply 17: Yes. Good point. We have added this point in lab diagnosis sect giving importance to diagnose EV-A71 as the main pathogen causing proportionately more severe cases of HFMD. It was reflected in 3rd paragraph of laboratory diagnosis, properly.

Finally the authors thank the reviewer-1 for his kind comments and suggestions once again.

Competing Interests: No competing interests were disclosed.
The following minor errors were corrected in abstract, including few in introduction but mostly in results section:

- The word ‘gross’ was removed from the 1st paragraph in abstract, page-4.
- The 1st sentence on Page-9 (Notably, HFMD cases…. first siblings (p <0.001) was amended.
- The word ‘papulovascular’ is replaced with ‘papulovesicular’ (last sentence of 2nd para, page-10).
- Rephrased the 1st sentence of 2nd para (The three major sign… recorded at 0.0 mm), page-12.
- A sentence ‘Time to recover from HFMD varies with age of patient’ was added on page-12.
- The last sentence on page-14 (‘However, we neither observed… or, rare’) was removed.
- To comply with reviewer’s opinion changed the 2nd sentence of 1st paragraph, Page-15).
- Removed the last phrase of 1st para on page-5.. “This observation led us to postulate…. others. reported high fever...” with a little modification keeping ref. 5, 8-9.
- Complying with reviewer’s comment, cited 4 references in 1st sentence of 2nd para, page-15.
- Removed the 2nd sentence of 2nd para on page-15 (“Since pain remains…. rational judgement)
- The 2nd sentence of 3rd par on p15 was altered a bit (However, the exact reason … remain unclear).
- The 1st sentence of 2nd para was replaced as suggested page-16 (discussion: Lab diagnosis).
- The 2nd paragraph of the manuscript on page-17 was taken out as commented.
- The 2nd sentence of 1st paragraph on page-18 was a bit changed following reviewer’s advice.


and, some information/data was included to discuss. The following minor errors were corrected in abstract, including few in introduction but mostly in results section:

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Competing Interests: No competing interests were disclosed.
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