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Journal Title: Proceedings of the National Academy of Sciences
Volume: Volume 115, Number 14
Publisher: National Academy of Sciences | 2018-04-03, Pages 3623-3627
Type of Work: Article | Final Publisher PDF
Publisher DOI: 10.1073/pnas.1711611115
Permanent URL: https://pid.emory.edu/ark:/25593/s93rr

Final published version: http://dx.doi.org/10.1073/pnas.1711611115

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Accessed December 15, 2018 12:07 AM EST
Behaviors, movements, and transmission of droplet-mediated respiratory diseases during transcontinental airline flights

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With over 3 billion airline passengers annually, the inflight transmission of infectious diseases is an important global health concern. Over a dozen cases of inflight transmission of serious infections have been documented, and air travel can serve as a conduit for the rapid spread of newly emerging infections and pandemics. Despite sensational media stories and anecdotes, the risks of transmission of respiratory viruses in an airplane cabin are unknown. Movements of passengers and crew may facilitate disease transmission. On 10 transcontinental US flights, we chronicled behaviors and movements of individuals in the economy cabin on single-aisle aircraft. We simulated transmission during flight based on these data. Our results indicate there is low probability of direct transmission to passengers not seated in close proximity to an infectious passenger. This data-driven, dynamic network transmission model of droplet-mediated respiratory disease is unique. To measure the true pathogen burden, our team collected 229 environmental samples during the flights. Although eight flights were during influenza season, all qPCR assays for 18 common respiratory viruses were negative.

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Significance

With over 3 billion airline passengers annually, the inflight transmission of infectious diseases is an important global health concern. Over a dozen cases of inflight transmission of serious infections have been documented, and air travel can serve as a conduit for the rapid spread of newly emerging infections and pandemics. Despite sensational media stories, risks of transmission of respiratory viruses in an airplane cabin are unknown. Movements of passengers and crew may facilitate disease transmission. On 10 transcontinental US flights, we chronicled behaviors and movements of individuals in the economy cabin on single-aisle aircraft. We simulated transmission during flight based on these data. This data-driven, dynamic network transmission model of droplet-mediated respiratory disease is unique.
single-aisle aircraft in the United States. We develop a network model of contacts that would enable infection transmission by large respiratory droplets, and we use a simulation model to determine the spread of a disease on this network. We also report on the prevalence of respiratory viral pathogens measured on these flights, and discuss the implications for disease transmission.

Results

Observations of Passenger and Crew Shedding. Our study team flew on 10 transcontinental flights, departing in the morning or afternoon, and of duration between 211 and 313 min. Seven flights had no unoccupied seats, while the others had 2, 3, and 17 unoccupied seats. On each flight our 10-member research team recorded the behaviors and movements of passengers seated and crew working in the economy class cabin on single-aisle aircraft. Only one passenger on one flight was observed to be coughing moderately and no passenger (of 1,540) was observed to be coughing severely. No crew member (of 41) was observed to be coughing.

Passenger and Crew Behaviors, Movements, and Close Proximity Contacts. We observed that 38% of passengers never left their seats during flight, 38% left once, 13% left twice, and 11% left more than two times. The median amount of time spent out of seat for each passenger who moved was 5.4 min, with an interquartile range (IQR) of 3.3–8.9. The proportion leaving their seat at least once varied by seating: 43% of passengers seated by a window (range: 29–62%), 62% of passengers seated in a middle seat (range: 47–72%), and 80% of passengers seated in the aisle (range: 75–85%) moved at least once during the flight. Half of the passengers did not use a lavatory during flight (range: 42–58%), 38% used it once (range: 34–53%), 9% used it twice (range: 4–13%), and 3% used it more than two times (range: 1–6%). The most common behaviors for passengers were waiting for, using, or exiting a lavatory [825 passengers, average time 4.3 min (IQR: 2.7–7.0)], and checking the overhead bin [135 passengers, average time 1 min (IQR: 0.4–2.0)]. The wait for the front lavatory was nearly twice as long as for the back lavatories (3.1 vs. 1.7 min) (IQR: 1.7–4.9 and 1.0–3.2). Over the course of an average flight (238 min of observation) (range: 196–290), each crew member was in contact with passengers for 239 min (IQR: 233–247) with other crew members is quite low, less than 0.03. On average, this manifests as 0.7 additional infected passengers per flight (IQR: 0.4–1.5). The results of simulations for other seats indicate, on average, at most two additional infected passengers per flight.

A crew member is not likely to come to work while being extremely sick. Even if she or he came to work, she or he would be more likely to take medication to reduce or eliminate coughing. For an infectious crew member, we use the conservatively low transmission rate of 0.0045, which is a quarter of what we used for infectious passengers. In Fig. 4 we present a heat map illustrating the probability that each passenger will have close contact with the infectious index passenger and the probability that an infectious index passenger will infect each of the other passengers. The 11 nearest neighbors have a high probability of becoming infected. However, the probability of transmission to each of the remaining passengers is quite low, less than 0.03. On average, this manifests as 0.7 additional infected passengers per flight (IQR: 0.4–1.5). The results of simulations for other seats indicate, on average, at most two additional infected passengers per flight.

Network-Based Transmission Model and Simulations. Based on these data and using the previously discussed 1-m transmission zone, we construct a dynamic-network model with which we simulate direct influenza transmission during flight. We consider two scenarios: the index passenger seated midcabin in 14C (14th row, aisle seat) and an infectious crew member.

For the infectious passengers, we use the conservatively high transmission rate of 0.018 per minute of contact, which is four times the transmission rate we estimate (16), which describes an incident in 1977 in which 38 of 54 passengers and crew became infected with influenza-like illness after waiting in an airplane on an airport tarmac for 4.5 h with no air circulation. This rate has been used in other transmission studies; see, for example, a simulation of influenza transmission in a high school in which contacts among students, faculty, and visitors were carefully quantified (17). In (Fig. 3) we present heat maps illustrating the probability that each passenger will have close contact with the infectious index passenger and the probability that an infectious index passenger will infect each of the other passengers. The 11 nearest neighbors have a high probability of becoming infected. However, the probability of transmission to each of the remaining passengers is quite low, less than 0.03. On average, this manifests as 0.7 additional infected passengers per flight (IQR: 0.4–1.5). The results of simulations for other seats indicate, on average, at most two additional infected passengers per flight.

Discussion

We present the results of a study to track behaviors, movements, and contacts between all individuals in the economy cabin on 10 transcontinental flights. We employ these data to quantify the likelihood of direct transmission of droplet-mediated respiratory infectious diseases during flight. We also present the results of qPCR panels assaying for 18 common respiratory viruses for 228 samples collected from the air and hard surfaces, and taken before, during, and after the 10 flights. Although eight flights were during influenza season in the northern hemisphere, all results were negative.
We documented many movements on each flight, leading to many close contacts beyond those induced by close seatmates (tribes). Most nontribe contacts were very brief. Our simulations using these data, unique in explicitly examining the role of movement of passengers and crew, indicate that a droplet-mediated respiratory infectious disease is unlikely to be directly transmitted beyond 1 m from the infectious passenger. Thus, transmission is limited to one row in front of or in back of an infectious passenger. This is more conservative than current public health guidance, calling for surveillance of passengers within two rows of an infectious passenger. Our simulations also indicate that an infectious flight attendant can generate several infections; thus, it is imperative that flight attendants not fly when they are ill.

Then how can we explain case reports documenting the over 40% of transmission of influenza and SARS to nontribe passengers? Some transmissions may have occurred while waiting in the airport, while boarding, or while deplaning. Alternatively, some passengers may have been infected by other sources before or after the flight. Three of the five flights in these case reports range from 9.5 to 14 h, providing many more opportunities for transmission. Other transmissions may have occurred via fomites. Flyers can protect themselves from fomite transmission by exercising careful hand hygiene. Finally, our model assumes that droplets are the main transmission route for influenza and SARS. This assumption is based on general public health agency guidance to health care providers, but it may not be true: significant transmission may also occur via smaller virus-laden particles (the smallest being aerosols), which have larger dispersion distances.

Unlike droplets that fall to the ground quickly, aerosols could remain suspended in cabin air until they are breathed or drawn into the heating, ventilation, and air conditioning system and putatively trapped by high-efficiency particulate air filters. Transmission via aerosols could also occur during the period between when the cabin door closes and take-off. Our model is not applicable to other aerosol-transmitted diseases, such as tuberculosis (18), varicella, and measles (19). Our model assumes omnidirectional transmission and does not take into account seat backs as barriers. Thus, our simulation results may be overestimating risk of direct droplet-mediated transmission. The movement of aerosols over long periods of time in an empty cabin, even without gaspers (the adjustable air outlet situated above each passenger seat), is extremely difficult to simulate with the fastest supercomputers. Such models require

**Fig. 2.** The number of nontribe contacts by row, for aisle, middle, and window seats for the Seattle outbound flight. Number of nontribe contacts increases with increasing length of observation period (which is very close to length of flight) for passengers who moved during the flight, regardless of their seat position. Similarly, the number of nontribe contacts increases with increasing length of observation period for passengers in aisle or middle seats who do not move during the observation period. There is no association between the number of nontribe contacts and length of observation for passengers in window seats who do not move during the observation period.

**Fig. 3.** (A) This seating heat map shows the probability of the passenger seated in 14C (triangle) being in contact with each infection target [other passengers (square) and crew members (circle)], as calculated by our simulation program. Contact is defined as being within a 1-m radius at least once during a flight. For each target, the probability of contact is calculated as number of flights with a contact per 1,000 flights. Only crew and passengers within two seats laterally or one row fore to aft are likely to be in contact with this passenger, and all other passengers are much less likely to have contact. Although we use seat 14C to illustrate this finding, outcomes are similar for an infectious passenger seated in any aisle seat except in the first or last row, for which no passengers forward or aft, respectively, are in contact. (B) This seating heat map shows the probability of the passenger seated in 14C (triangle) infecting each of the other passengers (squares) and crew members (circle) when the probability of infection is set at 0.018 per 1 min of contact. In this example, passengers seated within a 1-m radius are at highest risk, followed by crew members. Nonseatmates in window seats have the least risk of infection from this passenger. Although we use seat 14C to illustrate this finding, outcomes are similar for an infectious passenger seated in any aisle seat, except in the first or last row, for which no passengers forward or aft, respectively, are infected.
which is the hardest cabin airflow

Environmental samples were sent to a highly qualified

After each flight, the movement observations

This seating heat map shows the probability of an infectious crew

member infecting each of the other passengers (square) and crew members

circle when the probability of infection is set at 0.0045 per 1 min of contact.

In this example, other crew members are at highest risk, followed by pas-
sengers seated in aisle and middle seats.

simulations using a 3D Navier–Stokes equation. According to

Boeing engineers, airflow in an empty cabin lies on the

“boundary of turbulence,” which is the hardest cabin airflow

regime to simulate over long time periods. Previous transmission

models have employed approximations to the 3D Navier–Stokes

equation (20–23) (perhaps valid for short time intervals) or as-

sumed that the “droplets” or aerosols are well-mixed in cabin air.

In no case have previous investigators considered the effects of
cabin occupancy or gasper use in Navier–Stokes models. One
group conducted numerical simulations to study the effect of vortices generated by the continuous movement of a crew

member on the local dispersal of aerosols in a cabin (24). As-

suming that the cabin airflow is at steady state, they found a
decreased infection rate to the passengers but an increased in-
fec tion rate to the crew member.

Previous studies have employed cameras or real-time location-
sensing systems using technology, such as radio-frequency iden-
tification, ultrasound, and infrared, to quantify behaviors,
movements, and close contacts of individuals in various types of
buildings [schools (17), hospitals (25), and so forth]. However,
these devices cannot be employed in an airplane cabin during
flight. We tested extensively our observational protocol, which
uses paired observers seated every five rows, each using an iPad
app, and later aggregating these local zone-wise observations to
chronicle all movements. We found that a pair of trained ob-
servers could reliably determine and document (e.g., time-
stamp) the behaviors and movements of passengers and crew
within their row and the four to five rows in front of them. The
observers’ chronicling of times, which we used to reconstruct the
durations of movements and close contacts, were accurate to
within an order of seconds.

All 228 qPCR panels were negative for 18 common respiratory
viruses. There are two possible explanations. Of the 1,540 passengers
and 41 flight attendants, only one was observed to be coughing.

Thus, there was no obvious virus shedding into the cabin. Fur-
thermore, the airplane’s cabin-cleaning policy is to disinfect all hard sur-
faces whenever the plane “overnights,” and all surface samples were
taken from hard surfaces. Not all flights were the first of the day for
that plane. We chose to sample seat-belt buckles, believing that these
would be the most likely items to be touched and the least likely to
be thoroughly disinfected.

We caution about extrapolating these findings to short-hop
domestic flights, international flights, or flights on other airlines.
On our study flights, half of the passengers never left their seats
during flight. On short-hop flights, the amount of movement may
be much less. Conversely, on longer international flights, there
will be substantially more movement of passengers and crew,
leading to many additional close contacts. Our results also can-
not be extrapolated from single-aisle cabins to double-aisle
cabins commonly used for international flights. Different air-
lines will have different cabin-disinfection protocols and super-

vise their cabin-cleaning staff in different ways.

Methods

Data and Samples Collected on the Plane.

Passenger and crew movements. Our study team flew on 10 flights, mostly on
Boeing 757 aircraft, of 3.5–5 h duration between Atlanta and five des-
tinations on the US West Coast. Eight of the 10 flights occurred during the
traditionally recognized annual influenza season (October 2012 to March
2013), while two other flights occurred in May 2013. On each flight, 10 public
health and nursing graduate students recorded all movements of passengers
and crew in the economy cabin using a specially designed iPad app. The
graduate student researchers sat in paired aisle seats and were responsible for
recording the movement in their “virtual zone,” which consisted of their row
and the four rows in front of them. The Emory University Institutional
Review Board (IRB) determined that IRB review of this study was not
necessary.

Environmental sampling. Another member of our research team operated two
air-sampling pumps that sampled the cabin air in the back of the plane (the
“dirtiest air in the cabin” according to a Boeing engineer). One pump op-
erated continuously and the other operated during five 30-min intervals
(including boarding and deplaning). Both pumps sampled at 3.5 L/s, the
National Institute for Occupational Safety and Health protocol for stationary
sampling and approximately the normal breathing rate of adults. Other
members of our research team took swabs of the door handles (inside and
outside) of a randomly chosen aft lavatory, as well as swabs of the tray table
(both sides) and seat-belt buckle in two randomly chosen seats. All samples
were taken before passenger boarding and again after all passengers
had deplaned.

Movement Reconstruction. After each flight, the movement observations
were collated from the separate observation zones. Research assistants then
aggregated, cleaned, and prepared the data for analysis of behaviors,
movements, and ultimately time-delimited contact networks.

Laboratory Analysis. Environmental samples were sent to a highly qualified
molecular biology laboratory, which performed on all air samples a com-
prehensive qPCR respiratory virus panel assay for a broad range of respiratory
viruses and subtypes representing the majority of circulating respiratory
disease-causing pathogens. The panel consisted of tests for influenza A, in-
fluenza B, influenza A subtype H5N1, respiratory syncytial virus A, respiratory
syncytial virus B, parainfluenza virus 1, parainfluenza virus 2, parainfluen-
za virus 3, parainfluenza virus 4, rhinovirus F1, rhinovirus F2, coronavirus 229E,
coronavirus OC43, coronavirus NL63, human metapneumovirus, adenovirus
F1, and adeno virus F2.

More detail on the methods are given in SI Methods. Data and software
for the simulations are available at dx.doi.org/10.1513/ij3/OIOYETQ.

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