SYSTEMATIC REVIEW

REVISED SARS-CoV-2 and the role of airborne transmission: a systematic review [version 2; peer review: 1 approved with reservations, 2 not approved]

Carl J. Heneghan ¹, Elizabeth A. Spencer ¹, Jon Brassey ², Annette Plüddemann¹, Igho J. Onakpoya¹, David H. Evans ³, John M. Conly⁴, Tom Jefferson¹

¹University of Oxford, Oxford, Oxfordshire, UK

²Trip Database, Trip, Bristol, UK

³Li Ka Shing Institute of Virology and Dept of Medical Microbiology & Immunology, University of Alberta, Alberta, Canada

⁴University of Calgary and Alberta Health Services, Calgary, Canada

v2 First published: 24 Mar 2021, 10:232
<https://doi.org/10.12688/f1000research.52091.1>

Second version: 06 Sep 2021, 10:232
<https://doi.org/10.12688/f1000research.52091.2>

Latest published: 19 Oct 2022, 10:232
<https://doi.org/10.12688/f1000research.52091.3>

Abstract

Background: Airborne transmission is the spread of an infectious agent caused by the dissemination of droplet nuclei (aerosols) that remain infectious when suspended in the air. We carried out a systematic review to identify, appraise and summarise the evidence from studies of the role of airborne transmission of SARS-CoV-2.

Methods: We searched LitCovid, MedRxiv, Google Scholar and the WHO Covid-19 database from 1 February to 20 December 2020 and included studies on airborne transmission. Data were dual extracted and we assessed quality using a modified QUADAS 2 risk of bias tool.

Results: We included 67 primary studies and 22 reviews on airborne SARS-CoV-2. Of the 67 primary studies, 53 (79%) reported data on RT-PCR from air samples, 12 (18%) report cycle threshold values and 18 (127%) copies per sample volume. All primary studies were observational and of low quality. The research often lacked standard methods, standard sampling sizes and reporting items. We found 36 descriptions of different air samplers deployed. Of the 42 studies conducted in-hospital that reported binary RT-PCR tests, 24 (57%) reported positive results for SARS-CoV-2 (142 positives out of 1,403 samples: average 10.1%, range 0% to 100%). There was no pattern between the type of hospital setting (ICU versus non-ICU) and RT-PCR positivity. Seventeen studies reported potential air transmission in the outdoors or in the community, of which seven performed RT-PCR sampling, and two studies reported weak positive RNA samples for 2

Open Peer Review

Approval Status

	1	2	3
version 3			
(revision)			
19 Oct 2022			
version 2			
(revision)
06 Sep 2021
version 1			
24 Mar 2021

1. David R. Tomlinson , University Hospitals Plymouth NHS Trust, Plymouth, UK
2. Nancy H. L. Leung , The University of Hong Kong, Hong Kong, Hong Kong
3. Maosheng Yao , Peking University, Beijing, China

Any reports and responses or comments on the article can be found at the end of the article.

or more genes (5 of 125 samples positive: average 4.0%). Ten studies attempted viral culture with no serial passage.

Conclusion: SARS-CoV-2 RNA is detected intermittently in the air in various settings. Standardized guidelines for conducting and reporting research on airborne transmission are needed. The lack of recoverable viral culture samples of SARS-CoV-2 prevents firm conclusions from being drawn about airborne transmission.

Keywords

SARs-CoV-2, transmission, COVID, Airborne

This article is included in the **Pathogens** gateway.

This article is included in the **Emerging Diseases** and **Outbreaks** gateway.

This article is included in the **Coronavirus** collection.

Corresponding author: Carl J. Heneghan (carl.heneghan@phc.ox.ac.uk)

Author roles: **Heneghan CJ:** Formal Analysis, Funding Acquisition, Investigation, Methodology, Writing – Original Draft Preparation, Writing – Review & Editing; **Spencer EA:** Data Curation, Formal Analysis, Investigation, Methodology, Project Administration, Writing – Review & Editing; **Brassey J:** Data Curation, Formal Analysis, Methodology, Writing – Review & Editing; **Plüddemann A:** Data Curation, Formal Analysis, Writing – Review & Editing; **Onakpoya IJ:** Data Curation, Formal Analysis, Methodology, Writing – Review & Editing; **Evans DH:** Data Curation, Formal Analysis, Supervision, Writing – Review & Editing; **Conly JM:** Formal Analysis, Investigation, Methodology, Supervision, Writing – Review & Editing; **Jefferson T:** Conceptualization, Formal Analysis, Funding Acquisition, Investigation, Methodology, Project Administration, Writing – Original Draft Preparation, Writing – Review & Editing

Competing interests: CH holds grant funding from the NIHR, the NIHR School of Primary Care Research, the NIHR BRC Oxford and the World Health Organization for a series of Living rapid review on the modes of transmission of SARs-CoV-2 reference WHO registration No2020/1077093. He has received financial remuneration from an asbestos case and given legal advice on mesh and hormone pregnancy tests cases. He has received expenses and fees for his media work including occasional payments from BBC Radio 4 Inside Health and The Spectator. He receives expenses for teaching EBM and is also paid for his GP work in NHS out of hours (contract Oxford Health NHS Foundation Trust). He has also received income from the publication of a series of toolkit books and for appraising treatment recommendations in non-NHS settings. He is Director of CEBM, an NIHR Senior Investigator and an advisor to Collateral Global. He is also an editor of the Cochrane Acute Respiratory Infections Group TJ was in receipt of a Cochrane Methods Innovations Fund grant to develop guidance on the use of regulatory data in Cochrane reviews (2015-018). In 2014–2016, he was a member of three advisory boards for Boehringer Ingelheim. TJ was a member of an independent data monitoring committee for a Sanofi Pasteur clinical trial on an influenza vaccine. TJ is occasionally interviewed by market research companies about phase I or II pharmaceutical products for which he receives fees (current). TJ was a member of three advisory boards for Boehringer Ingelheim (2014-16). TJ was a member of an independent data monitoring committee for a Sanofi Pasteur clinical trial on an influenza vaccine (2015-2017). TJ is a relator in a False Claims Act lawsuit on behalf of the United States that involves sales of Tamiflu for pandemic stockpiling. If resolved in the United States favor, he would be entitled to a percentage of the recovery. TJ is coholder of a Laura and John Arnold Foundation grant for development of a RIAT support centre (2017-2020) and Jean Monnet Network Grant, 2017-2020 for The Jean Monnet Health Law and Policy Network. TJ is an unpaid collaborator to the project Beyond Transparency in Pharmaceutical Research and Regulation led by Dalhousie University

and funded by the Canadian Institutes of Health Research (2018-2022). TJ consulted for Illumina LLC on next generation gene sequencing (2019-2020). TJ was the consultant scientific coordinator for the HTA Medical Technology programme of the Agenzia per i Servizi Sanitari Nazionali (AGENAS) of the Italian MoH (2007-2019). TJ is Director Medical Affairs for BC Solutions, a market access company for medical devices in Europe. TJ was funded by NIHR UK and the World Health Organization (WHO) to update Cochrane review A122, Physical Interventions to interrupt the spread of respiratory viruses. TJ is funded by Oxford University to carry out a living review on the transmission epidemiology of COVID-19. Since 2020, TJ receives fees for articles published by The Spectator and other media outlets. TJ is part of a review group carrying out Living rapid literature review on the modes of transmission of SARS-CoV-2 (WHO Registration 2020/1077093-0). He is a member of the WHO COVID-19 Infection Prevention and Control Research Working Group for which he receives no funds. He is also an editor of the Cochrane Acute Respiratory Infections Group. TJ is funded to co-author rapid reviews on the impact of Covid restrictions by Collateral Global Organisation. TJ is funded by Oxford University to carry out a living review on the transmission epidemiology of COVID-19 and provide consultancy services to the University. TJ's competing interests are also online <https://restoringtrials.org/competing-interests-tom-jefferson> DHE holds grant funding from the Canadian Institutes for Health Research and Li Ka Shing Institute of Virology relating to the development of Covid-19 vaccines as well as the Canadian Natural Science and Engineering Research Council concerning Covid-19 aerosol transmission. He is a recipient of World Health Organization and Province of Alberta funding which supports the provision of BSL3-based SARS-CoV-2 culture services to regional investigators. He also holds public and private sector contract funding relating to the development of poxvirus-based Covid-19 vaccines, SARS-CoV-2-inactivation technologies, and serum neutralization testing. JMC holds grants from the Canadian Institutes for Health Research on acute and primary care preparedness for COVID-19 in Alberta, Canada and was the primary local Investigator for a Staphylococcus aureus vaccine study funded by Pfizer for which all funding was provided only to the University of Calgary. He is a co-investigator on a WHO funded study using integrated human factors and ethnography approaches to identify and scale innovative IPC guidance implementation supports in primary care with a focus on low resource settings and using drone aerial systems to deliver medical supplies and PPE to remote First Nations communities during the COVID-19 pandemic. He also received support from the Centers for Disease Control and Prevention (CDC) to attend an Infection Control Think Tank Meeting. He is a member and Chair of the WHO Infection Prevention and Control Research and Development Expert Group for COVID-19 and a member of the WHO Health Emergencies Programme (WHE) Ad-hoc COVID-19 IPC Guidance Development Group, both of which provide multidisciplinary advice to the WHO, for which no funding is received and from which no funding recommendations are made for any WHO contracts or grants. He is also a member of the Cochrane Acute Respiratory Infections Group. JB is a major shareholder in the Trip Database search engine (www.tripdatabase.com) as well as being an employee. In relation to this work Trip has worked with a large number of organisations over the years, none have any links with this work. The main current projects are with AXA and Collateral Global. He worked on Living rapid literature review on the modes of transmission of SARS-CoV-2 (WHO Registration 2020/1077093-0) and is part of the review group carrying out a scoping review of systematic reviews and meta-analyses of interventions designed to improve vaccination uptake (WHO Registration 2021/1138353-0). AP is Senior Research Fellow at the Centre for Evidence-Based Medicine and reports grant funding from NIHR School of Primary Care Research (NIHR SPCR ESWG project 390 and project 461), during the conduct of the study; and occasionally receives expenses for teaching Evidence-Based Medicine. IJO and EAS have no interests to disclose.

Grant information: The review was funded by the World Health Organization: Living rapid review on the modes of transmission of SARS-CoV-2 reference WHO registration No 2020/1077093. CH, AP and ES also receive funding support from the National Institute of Health Research School of Primary Care Research Evidence Synthesis Working Group project 390 (<https://www.spcr.nihr.ac.uk/eswg>). *The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.*

Copyright: © 2021 Heneghan CJ *et al.* This is an open access article distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

How to cite this article: Heneghan CJ, Spencer EA, Brassey J *et al.* **SARS-CoV-2 and the role of airborne transmission: a systematic review [version 2; peer review: 1 approved with reservations, 2 not approved]** F1000Research 2021, 10:232 <https://doi.org/10.12688/f1000research.52091.2>

First published: 24 Mar 2021, 10:232 <https://doi.org/10.12688/f1000research.52091.1>

REVISED Amendments from Version 1

We have revised the introduction, added further details to the methods section and addressed all the review comments.

Any further responses from the reviewers can be found at the end of the article

Introduction

Airborne transmission is defined as the spread of an infectious agent caused by the dissemination of droplet nuclei (aerosols) that remain infectious when suspended in air over long distances and time¹. There are varied definitions of aerosols in the published literature. An aerosol is defined as a collection of particles (liquid or solid) with varying aerodynamic diameters, suspended in the air (gas) for a prolonged period of time. The size of the particles and the distance they may travel is highly variable and depends on many factors²⁻⁵. Droplet nuclei are airborne residue (with or without embedded pathogens) of a respiratory droplet containing non-volatile solutes, from which water has evaporated to the point of equilibrium with the defined ambient relative humidity⁶.

Transmission via droplet nuclei and aerosols in specific settings or situations may potentiate the spread of some viruses in humans, resulting in disease outbreaks that are difficult to manage. The results of several studies investigating human-to-human virus transmission have been largely inconclusive, and the evidence to inform such transmission in experimental studies is often not available^{7,8}. Among case clusters for which airborne transmission is hypothesised, published detailed investigations cannot rule out that droplet and fomite transmission could also explain human-to-human transmission⁹. Therefore, we aimed to systematically review the airborne transmission evidence for SARS-CoV-2.

Methods

We are undertaking a series of living systematic reviews investigating factors and circumstances that impact the transmission of SARS-CoV-2, based on our published protocol last updated on 1 December 2020 (archived protocol: *Extended data: Appendix 1*¹⁰). Briefly, this review aims to identify, appraise, and summarize the evidence (from studies peer-reviewed or awaiting peer review) relating to the role of airborne transmission of SARS-CoV-2 and the factors influencing transmissibility.

We searched four main databases: LitCovid, medRxiv, Google Scholar and the WHO Covid-19 database for COVID-19 using the terms Airborne: aerosol OR airborne OR airbourne OR inhalation OR air OR droplet) from 1 February 2020 up to 20 December 2020 (see *Extended data: Appendix 2* for the search strategies¹⁰). Searches were updated every two weeks. We aimed to include studies that sampled the air for the detection of SARS-CoV-2 in the populations under study or the environment. We primarily included studies that reported sampling for the detection of SARS-CoV-2. However, we also included

observational and randomised studies that investigated airborne transmission of SARS-CoV-2. Non-predictive and experimental studies were also considered for inclusion. Studies should include air sampling for the detection of SARS-CoV-2. Studies on factors influencing transmission were included, such as location, settings, meteorological and/or immunological factors. Studies incorporating models to describe observed data were eligible. Studies reporting solely predictive modelling were excluded. For relevant articles citation tracking was undertaken. We searched the included primary studies of all retrieved reviews and included them in the results section for reference.

We included field studies that included airborne sampling for SARS-CoV-2 in the population under study or the environment. JB performed the searches, TJ and ES performed the first screen and CH checked the initial screening of these studies. One reviewer (EAS) extracted data for each study, and a second reviewer (CH) independently checked the extractions. We extracted information on the study characteristics, the study population, setting and methods, and the main results from included studies. We also extracted data on the type of study, setting, sample source and methods, RT-PCR positive samples for SARS-CoV-2 RNA including cycle threshold (Ct) and copies per m³ of sampled air, viral culture methods and results, size of air particles (when reported) and proportion in the sample. We tabulated the data and summarised the data narratively by sample type. Because of substantial heterogeneity across the included studies, we did not perform a meta-analysis. We assessed quality using a modified QUADAS 2 risk of bias tool¹¹. We simplified the tool because the included studies were not designed as primary diagnostic accuracy studies, and there is a lack of high-quality data in published transmission studies¹². We gave particular importance to the description of methods for air sampling and the reporting of sufficient detail to enable replication of the study. We examined the following domains: (i) Source population – did the study authors adequately describe the source population? E.g. setting, severity of SARS-CoV-2, baseline demographics including concurrent respiratory infections or other comorbidities, distance between study subjects; (ii) Methods – did the study authors sufficiently describe the methods used to enable replication of the study? E.g. methods used for diagnosing SARS-CoV-2 in patients, procedure used for air sampling, time-point for sampling, number of samples per site, cycle thresholds, culture methods, airflow/ventilation settings, humidity; (iii) Sample sources – did the authors clearly describe the sources for the air samples? What was the volume of air in each sample? Was the period of sampling similar across various sites? (iv) Outcome reporting – was the reporting of the results consistent with the study outcomes? Was the analysis of the results appropriate – e.g., interval and time-point for testing study participants for potential transmission; (v) Follow-up – was the pattern and number of air samples sufficient to demonstrate airborne transmission – e.g. repeat sampling, serial air sampling? The risk of bias for each domain was rated “low”, “moderate” or “high” depending on the adequacy of reporting. One reviewer (CJH) assessed the risk of bias while a

second author (EAS) independently verified the risk of bias. Any disagreements were resolved through discussion. Where a consensus could not be reached, a third reviewer (IJO) arbitrated. We summarise data narratively and report the outcomes as stated in the paper, including quantitative estimates when reported and the detection of culture of SARS-CoV-2.

Results

We identified 89 studies (see [Figure 1](#); 19 full-text studies were excluded because they were not reviews or there was no SARS-CoV-2 airborne transmission outcome studied and we excluded four laboratory studies: see *Extended data: Appendix 3* for a list of excluded studies¹⁰). We included 67 primary studies and 22 systematic reviews (see *Extended data: Appendix 3* for references to included studies and [Table 1](#) and [Table 2](#) for the characteristics of the included studies¹⁰).

Reviews

We found 22 reviews on SARS-CoV-2: 16 reviews [Anderson EL 2020, Agarwal 2020, Bahl P 2020, Birgand G 2020, Carducci A 2020, Chen PZ 2020, Comber L 2020, Ekram W 2020, Ji B 2020, Mehraeen E 2020, Niazi S 2020, Noorimotlagh Z 2020, Rahmani 2020, Ren Y 2020, Singhal S 2020, and Wilson NM 2020] were about airborne transmission and prevention; three reviews on airborne transmission and procedures [Hussain A 2020, Kay JK 2020, and Schünemann HJ] and three on ventilation, air conditioning filtration and recirculation [Mousavi EH 2020, Chirico F 2020, and Correia G 2020] (see [Table 2](#)). The final search date of these reviews varied from April up to 27 October 2020. Only five reviews met

systematic review methods criteria that include systematically searching for all available evidence, appraising the quality of the included studies, and synthesising the evidence into a usable form¹³.

Quality of included primary studies (n=67)

All included primary studies were observational (some with experimental components) and low quality (see [Table 3](#)). We could not identify a published protocol for any of the studies. Most studies were based on convenience sampling. While the description of methods provided sufficient detail to replicate 91% of studies (see [Figure 2](#)), the research often lacked standard methods, standard sampling sizes and reporting. In 69% of the studies, the sample sources were clear, however, outcomes that aimed to demonstrate the detection of viable, replicable viruses were lacking. The variation in sample methods coupled with flaws in the reporting make it difficult to distinguish between aerosol and droplet nuclei transmission. Interpretation is further limited by the variability in reporting of patient distance from the sampler, use of protective or oxygen masks by patients, patient activities (coughing and sneezing during sampling time), air movement, air conditioning sampler type, sampling, storage and transfer conditions.

Primary studies

We included 67 primary studies, of which 53 (79%) reported binary data on RT-PCR air samples (see [Table 1](#)). All the studies were observational. Twelve studies (18%) reported Ct values and 18 studies report copies per sample volume (see [Table 4](#)). Two studies reported a Ct value < 25: Razzini K

Figure 1. Flow chart.

Table 1. Study characteristics: primary studies.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m ³ or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Ahn JY 2020	Hospital	China	Air (and surface) samples collected. Virus culture was attempted on PCR positive samples.	Air sampling at 1.2 m above floor level, 1.0 m from each patient, using an SKC BioSampler and a Swab sampler.	0/ (denominator unclear) samples	Not attempted.	N/A (no air samples positive)	N/A	Viral RNA was detected in the air outlet fan on the ceiling suggesting airborne contamination by aerosols. Only the outside surface of the endotracheal tubes in the area connected to the ventilator circuit tested positive for SARS-CoV-2. Viable viruses detected on the outside surface of the endotracheal tube and and seven sites in patient 3's room.
Bays D 2020	Healthcare setting	USA	Two detailed case studies	No sampling performed	Not attempted.	N/A	N/A	N/A	A total of 421 health care workers were exposed in total, and the results of the case contact investigations identified 8 secondary infections in health care workers. In all 8 cases, the staff had close contact with the index patients without sufficient personal protective equipment. Importantly, despite multiple aerosol generating procedures, there was no evidence of airborne transmission.
Binder 2020	Hospital	USA	Case series of 20 patients hospitalized with coronavirus disease	8 National Institute for Occupational Safety and Health (NIOSH) BC 251 Aerosol Samplers (Figure S3) were placed 1.5 m from the ground, at ~1 meter, ~1.4 meters, ~2.2 meters, and ~3.2 meters from the SARS-CoV-2 patient's head and subsequently run for ~4 hours. 195 air samples were collected	3/195 samples from 3 patients	0/3 viable virus	Sample at 1.4m, <4uM first PCR Ct 36.6, second PCR Ct 37.1 Sample at 2.2m, <4uM first PCR Ct 37.4, second PCR Ct 39.9 Sample at 2.2m, >4uM first PCR Ct 39.1, second PCR Ct 39.6	detected in aerosols particle size <4 µm	NIOSH sampler has roughly a 95% collection efficiency for aerosols with a diameter of 7 µm or less, which decreases to approximately 40% efficiency for aerosols ≥80 µm in diameter. Dry cyclone aerosol samplers, which are not as well-suited for viable virus collection when compared to liquid collection medium-based bioaerosol samplers
Charlotte N 2020	Choir practice	France	Follow-up of a choir practice: 27 participants, including 25 male singers, a conductor and an accompanist attended a choir practice on 12 March 2020.	No sampling performed. The choir rehearsal room was not ventilated.	Not attempted.	Not attempted.	N/A	N/A	70% of the participants (19/27) were diagnosed with COVID-19 from 1 to 12 days after the rehearsal (median 5.1 days).
Cheng VCC 2020a	Hospital	China	Air sampling: 6 patients' air sampled, and 5 positive controls	The air sampler was perpendicularly positioned 10 cm away from the patient's chin, collecting at a rate of 50 L/minute. An air tent was used to increase the proportion of exhaled air collected. Participants sneezed directly onto gelatin filter and spit saliva droplets onto gelatin filter.	0/6	Not attempted.	N/A (no air samples positive)	N/A	Infection isolation rooms had 12 air changes per hour. 5% surface samples were found to be PCR-positive.
Cheng VCC 2020b	Hospital	China	Air sampling using ISO 180 model 86834 air sampler was performed in the room of a patient.	Air samples were collected 10 cm from the one patient's chin. The patient performed 4 different manoeuvres (normal breathing, deep breathing, speaking "1, 2, 3" continuously, and coughing continuously) while putting on and removing the surgical mask.	0/8	Not attempted.	N/A (no air samples positive)	N/A	SARS-CoV-2 was identified in 1 of 13 environmental surface samples of the patient's room.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m ³ or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Chia PY 2020	Hospital	Singapore	Air (and surface) sampling surrounding 61 hospitalized COVID-19 patients in airborne infection isolation rooms	Air sampling was performed in three of the 27 airborne infection isolation rooms (AIRs). Bioaerosol samplers used to collect air samples, set at a flow-rate of 3.5 L/min and run for four hours, collecting a total of 5,040 L of air from each patient's room.	2/3	Not attempted.	Total SARS-CoV-2 concentrations in air ranged from 1.84×10 ³ to 3.38×10 ³ RNA copies per m ³ air sampled.	positive particles of sizes >4µm and 1–4µm detected in two rooms	Patient 1 intermittently faced the samplers seated 1m from the 1st tripod and 2.1m from the 2nd. In the rooms of Patients 2 and 3, three NIOSH samplers were attached to each of two tripod stands at 1.2m, 0.9m, and 0.7m height. Patients 2 & 3 remained in bed within 1 m from all 6 air samplers. Patient 3 was also talking on the phone for much of that time.
Chirizzi D 2020	Outdoor	Italy	Study of the outdoor concentrations and size distributions of virus-laden aerosol simultaneously collected, in May 2020, in northern (Veneto) and southern (Apulia) regions of Italy.	Genetic material of SARS-CoV-2 (RNA) was determined, using both real time RT-PCR and ddPCR, in air samples collected using PM10 samplers and cascade impactors able to separate 12 size ranges from nanoparticles (diameter D < 0.056 µm) up to coarse particles (D > 18 µm).	Outdoor atmospheric concentrations of SARS-CoV-2 were very small (<0.8 copies m ⁻³)	Not attempted.	SARS-CoV-2 concentrations were <0.8 copies m ⁻³ for each size range.	(D < 0.056 µm) up to coarse particles (D > 18 µm)	It is possible to conclude that outdoor air in residential and urban areas was generally not infectious and safe for the public in both northern and southern Italy, with the possible exclusion of very crowded sites (See Liu 2020)
Dedementi M 2020	Hospital	Italy	Air sampling to assess environmental contamination in a COVID-19 non-intensive Care Unit. Two patients admitted to the hospital rooms were positive for COVID-19 for more than a week.	8 air samples were collected before and after the application of two different sanitization devices. Pumps were placed in 4 sites: patient 1 room, patient 2 room, an empty room nearby patients' rooms, corridor outside the rooms. Pumps (47 mm filter cassettes and 0.45 µm filters in polytetrafluoroethylene-PFTE) positioned 1 meter above the floor for 340 minutes at 15 L/min.	0/8	Not attempted.	N/A (no air samples positive)	N/A	Surface samples collected before and after sanitization (n=24) were all negative. Patient 1 rhinopharyngeal swab was positive while patient 2 rhinopharyngeal swab was negative (Table 2).
De Man P 2020	Care home	The Netherlands	Case series. Responding to an outbreak in a care home, the ventilation system of the outbreak ward was investigated in addition to routine source and contact tracing	No air samples collected.	Not attempted.	N/A	N/A	N/A	The ventilation system allowed recirculation of air below a certain CO2 limit. The outbreak ward was additionally cooled by 2 air conditioning units, which recirculated air through a 1-mm mesh dust filter. The other 6 wards (no outbreak) were ventilated with outside air.
Di Carlo P 2020	Inside a bus	Italy	Observational measurements were carried out across the last week of the lockdown and the first week when, gradually, all travel restrictions were removed. 12 to 22 May 2020 in Chieti, Italy.	Samples of air inside the bus were taken every day of the two observational weeks, excluding weekends. Two microbiological gelatine membrane sample filters of 80 mm diameter were installed on board: one close to the ticket machine, the other on the rear part of the bus. All the air samples were gathered during the 6.5 hours daily operation of the bus.	0/14	Not attempted.	N/A (no air samples positive)	N/A	During the whole observation period about 1100 passengers travelled on the trolleybus. Hand sanitizing was a strict requirement to get on the bus, and rule of wearing a facial mask during travel, and the recommendation to keep the windows open to allow high air ventilation.
Ding Z 2020	Hospital	China	Sampling, including of air, within and around 4 isolation rooms each with 3 patients. Other areas in the hospital and its roof air-exhausts were also sampled.	46 air samples, two exhaled condensate samples, and two expired air samples (also 47 surface samples) were collected within and beyond the 4 three-bed isolation rooms.	1/46 air samples weakly positive. Both exhaled condensate samples negative. Both expired air samples negative.	Not attempted.	RNA copies for weakly positive sample not calculated.	NR	The toilet area was the area most contaminated by SARS-CoV-2 RNA as detected by PCR. Two exhaled condensate samples and the two expired air samples were negative.
Dohia M 2020	Quarantined households	Germany	Study of 43 adults and 15 children living in 21 households; air (also surface and wastewater) samples taken.	Air samples obtained using Coriolis Micro-sampler; air collectors were positioned in the middle of the room used most frequently by the residents (usually the living room or kitchen) - no rooms had ventilation equipment. Close contact to the air sampler was avoided (e.g. speaking in a range below 2 m but not above 3 m).	0/15	Infectious virus could not be isolated in Vero E6 cells from any environmental sample.	N/A (no air samples positive)	N/A	26 of all 43 tested adults were positive by RT-PCR. 10 of 66 wastewater samples and 4/119 surface swab samples were positive for SARS-CoV-2

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m ³ or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Dumont-Leblond N 2020	Hospital	Canada	Air sampling in acute care hospital rooms over the course of nearly two months	100 air samples in acute care hospital rooms hosting 22 patients using three different air sampling protocols. Two conductive plastic Institute of Occupational Medicine (IOM) samplers with 3 µm gelatine filters or one IOM and a 37 mm cassette with 0.8 µm polycarbonate filters.	11/100 from 6 patient rooms	Viral cultures were negative	Among 11 positives for N gene target: Ct ranged from 36.46 to 39.8, mean 37.99. Among 8 positives for ORF1b target: Ct ranged from 32.07 to 35.15, mean 33.69. Among the 8 positive for both N and ORF1b, viral concentrations ranged from 9.86 to 514.17, mean 201.64 genomes /m ³	NR	Even when the IOM and cassette were positive (patient D), SARS-CoV-2 could not be recovered in the air using the SAS-63100 according to the protocol. 7/11 positive air samples collected using IOMs. When both IOMs and cassettes were used, cassettes lead to positive results more often than IOMs (5/5 vs. 3/5) and higher concentrations overall. "No live virus was isolated from air samples, either due to viral inactivation through the sampling process or the true absence of whole, infectious virions."
Faridi S 2020	Hospital	Iran	Air sampling in wards of Covid-19 patients with severe and critical symptoms.	10 air samples were collected into the sterile standard midjet impingers containing 20 mL DMEM with 100 µg/mL streptomycin, 100 U/mL penicillin and 1% antifungal reagent for 1 h. Air samplers placed 1.5 to 1.8 m above the floor and approximately 2 to 5 m away from the patients' beds. Some patients coughed during the sample collection.	0/10	Not attempted.	N/A (no air samples positive)	N/A.	Air samples which were collected 2 to 5 m from the patients' beds
Feng B 2020	Hospital	China	Environmental contamination investigated around 21 COVID-19 patients in the later stage of infection	For sampling of isolation room air, a NIOSH sampler was placed on a tripod 1.2 m in height and 0.2 m away from the bed at the side of the patient's head. The sampling duration was 30 min, and a total of 105-L room air was sampled. 19 Exhaled Breath (EB) samples, 8 Exhaled Breath Condensate (EBC) samples, 12 bedside air samples	0/14 EB 2/8 EBC 1/12 room air	Not attempted.	RNA detected in air sample, with virus concentrations of 1111 copies/m ³ and 744 copies/m ³ in the <1 µm and >4 µm fractions, respectively	RNA detected in air sample in <1 µm and >4 µm fractions.	An exhaled aerosol collection system was developed and the patients were asked to breathe normally through a mask for 30 min and asked to perform 10 forced coughs during this time.
Ge XY 2020	Hospital	China	Environmental, air samples from 6 different sites of 3 hospitals	Air samples were collected for 30 min using the National Institute for Occupational Safety and Health (NIOSH) bioaerosol sampler (BC251) with air pumps (K65000, SKC). The stream of air has been set to 3.5 L / minute.	ICU 3/3 Haemodialysis clinic 0/12 fever clinic 0/12 respiratory ward 0/6	Not attempted.	ICU: Ct 36.5 - 37.8	NR	
Günther T 2020	Meat Processing Plant	Germany	Staff tested based on self-reported symptoms, possible contacts to other infected persons, returning to work after more than 96 h absence from work	Eight air conditioning units placed near the ceiling in the proximal half of the room constantly cool the air. Fans project the air in a lateral direction, either directly from frontal openings in the unit or via perforated hoses mounted underneath the ceiling	Not attempted	Not attempted.	N/A	N/A.	Low temperature, low air exchange rates, and constant air recirculation, together with relatively close distance between workers and demanding physical work, may have promoted efficient aerosol transmission.
Guo ZD 2020	Hospital	China	Air (and surface) samples of ICU and Covid-19 wards.	Indoor air and the air outlets were sampled to detect aerosol exposure. Air samples were collected by using a SAS-2300 Wetted Wall Cyclone Sampler at 300 L/min for 30 min. Samples were tested for the open reading frame 1 ab and nucleoprotein (N) genes of SARS-CoV-2 by qRT-PCR	Air samples: 14/40 ICU* 2/16 General Ward Air outlet swab samples: 8/12 for ICUs 1/12 for GWs.	Not attempted.	Indoor air near the air outlet: Ct 35.7, 3.8/L Indoor air near the patients: Ct 44.4, 1.4/L Indoor air near the doctor's office area: Ct 12.5, 0.52/L	NR	*ICU high-risk area was the patient care and treatment area, where rate of positivity was 40.6% (13/32). The low-risk area was the doctor's office area, where rate of positivity was 12.5% (1/8).
Hammer L 2020 and Miller SL 2020	Choir Practice	USA	Follow up of choir practice attendees	In total, 78 members attended the 3rd March 2020 practice, and 61 attended the 10th March 2020 practice. Overall, 51 (65.4%) of the 3rd March practice attendees became ill; all but one of these persons also attended the 10th March practice. Among 60 attendees at the 10th March practice (excluding the patient who became ill 7th March, who also attended), 52 (86.7%) choir members subsequently became ill. 32 were confirmed and 20 probable secondary COVID-19 cases occurred.	Not attempted.	Not attempted.	N/A	N/A	Attendees had a 15-minute break, during which cookies and oranges were available at the back of the large room. No one reported physical contact between attendees. The seating chart was not reported because of concerns about patient privacy. One hour of the practice occurring outside of the seating arrangement.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/mL or copies/L or Cycle threshold (Ct)	Size of air particles and proportion in sample	Notes
Hernández JL 2020	Hospital	Mexico	Air samples of Emergency areas and Covid-19 patients rooms.	Air sampled in three areas: Emergency area (Clinic A), Internal medicine (Clinic A), COVID-19 patient area (Clinic A), and COVID-19 patients care room (Clinic B). Sampling in all areas was accomplished in 3 h. Filters of 25 mm diameter with 0.22 µm pores were utilized (Millipore, AAWP02500), placed in a sterilized filter holder (Millipore, SWINNX) coupled to a vacuum system through a previously disinfected plastic hose, filtering the air with a flow of 9.6 L/min in each filter holder.	3/15	Not attempted.	Not reported	filtration through 0.22 µm pores.	All three positive samples were in COVID-19 patient area (Clinic A)
Horve PF 2020	Hospital	USA	Air handling units (AHUs) sampled, including the pre-filters, final filters, and supply air dampers.	Samples were collected using Puritan Puriflock Ultra swabs and swabs were taken in triplicate at each AHU location from the left, middle, and right side of each area along the path of airflow. Swabs were pre-moistened using viral transport media. Swabbing occurred for 20 seconds on an area approximately 20 X 30 cm at each location and swabs were immediately placed into 15 mL conical tubes (Cole-Parmer, catalog #UX-06336-89) containing 1.5 mL viral transport media and stored on ice for transport to a BSL-2 laboratory with enhanced precautions (BSL2+) lab for processing, which typically occurred within two hours after collection.	14 out of 56 samples	Not attempted.	The highest abundance sample (~245 gene copies) was found on the pre-filters, where outside air mixes with recirculated building air. [Other copy number data not found in report.]	NR	Highest abundance sample (~245 gene copies) was found on the pre-filters, where outside air mixes with recirculated building air. Of the samples collected, 35% (7/20) of samples at the pre-filters, 16.67% (2/12) of samples at the final filter, and 20.8% (5/24) of samples at the supply air dampers contained detectable SARS-CoV-2 RNA
Hu J 2020	Hospital	China	Indoor and outdoor air samples in ICUs and CT rooms	Aerosol samples were collected over 30 min intervals with the use of a centrifugal aerosol-to-hydrosol sampler (WA-400, Beijing Dingbule Technology Co., Ltd., China). Twenty-three masks from patients and 24 swabs from surfaces in ICUs were also collected and analyzed. Ten 3M™ Versaflo™ IR-600 respirator filters and 40 masks from healthy workers in the P3 lab of Wuhan Institute of Virology were collected for viral RNA detection. The airflow rate of the respiratory filters was 190 L/min and the surface area was ~30 cm². All viral RNA positive aerosol samples were subjected to cell culture. All viral RNA positive aerosol samples were subjected to cell culture to determine whether viable virus could be recovered from them.	Aerosol samples 8/38 from ICUs 1/6 from CT rooms samples from medical staff rest areas and corridors, were all negative (denominator not clear)	All positive aerosol samples were negative after three passages of Vero-E6 cells inoculated in a blind test.	The range of virus concentrations in the positive aerosol samples was 1.11 x 10³ to 1.12 x 10⁴ RNA copies m⁻³. In 10% of the outdoor air samples collected 10 m from the doors of inpatient and outpatient buildings, respectively, viral concentrations ranged from 0.89 to 1.65 x 10³ RNA copies m⁻³.	NR	5 surface swabs (cabinet, patient bed rail, door handle, and patient monitor) out of 24 from the ICU were positive for SARS-CoV-2, with viral RNA. After rigorous disinfection, no viral RNA was detected in a second batch. Positive rates for the mask samples were relatively high compared with the aerosol or surface samples. All positive masks were subjected to cell culture and inoculated with Vero-E6 cells after blind passage for three generations. One mask from a critically ill patient detected positive.
Jiang Y 2020	Hospital	China	Indoor air samples from Covid-19 isolation ward	Air was collected by two methods: natural sedimentation and a microbial air sampler (MAS-100 ECO), for which the stream of air was set to exactly 100 liters/minute (Merck, Germany).	1/28 air samples	Not attempted.	Not reported	NR	The isolation ward with an ICU patient was positive. Based on the original 24 hours of UV air filtering and 1000-2000 mg/L chlorine-containing disinfectant for ambient air and floor disinfection, the frequencies and duration times of air disinfectants were extended. Key surfaces such as computer keyboards easily overlooked were clearly noted and carefully disinfected. The samples from the positive area and indoor air were collected 24 hours later, and the test results were negative.
Jin T 2020	Hospital	China	Air and surface samples of ICU of one Covid-19 patient.	Two hours after routine cleaning, high-volume air samples were taken 0.5m from the patient bed and in the staff PPE dressing room, using a WA 400 Portable viral aerosol sampler at 400 L/min for 15 min at 1.5m height, while the patient was present and was not wearing a mask.	Air sample: 0/1 staff PPE dressing room 1/1 ICU patient isolation room	Not attempted.	Not reported	NR	All surface samples tested negative. The concentration of airborne SARS-CoV-2 was not quantified. The aerodynamic size distribution of SARS-CoV-2 aerosols was not evaluated.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m3 or copies/L or cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Kang M 2020	Block of flats	China	Air (and surface) sampling, and experimental air flow study.	Air samples from 11 of the 83 flats in the building, public areas, and building drainage systems. Investigated gas flows and dispersion as an indicator of the movement of virus-laden droplets in the drainage system, tracer gas (ethane) was released into bathrooms. The hydraulic interactions of toilet wastewater and the stack were observed.	0/11 air samples	Not attempted.	N/A (no air samples positive)	N/A	Virus-containing fecal aerosols may have been produced during toilet flushing by index cases. The infected families lived in 3 vertically aligned flats connected by drainage pipes in the master bedrooms. There were 9 infected patients, 193 other residents of the building, and 24 members of the building's management staff.
Kenarkoohi A 2020	Hospital	Iran	Air sampling through hospital wards indoor air by confirmed COVID-19 patients on 7th May 2020.	A liquid impinger biosampler calibrated for a flow rate of 12 L min ⁻¹ at 1.5 m above ground floor and at least 2 m away from the patient beds was used to take fourteen air samples in different wards of the indoor air of the hospital: ICU entrance hall, hospital entrance hall, laboratory ward, CT scan, radiology, men internal ward, woman internal ward and emergency ward.	2/14 air samples (both in ICU)	Not attempted.	Cycle threshold (CT) values were around 38 and 35 for ORF1ab and nucleoprotein gene, respectively.	The particulate matter PM1, PM2.5 and PM10 concentrations during the air sampling in the hospital wards was reported but no RNA samples	Two of 14 air samples contained SARS-CoV-2 RNA. Droplet vs air borne could not be distinguished.
Kim UJ 2020	Hospital	Korea	Surface and air sampling.	The rooms of 8 COVID-19 patients in four hospitals. On days 0, 3, 5, and 7 of hospitalization, the surfaces in the rooms and anterooms were swabbed and air samples were collected 2 m from the patient and from the anterooms.	0/52 air samples positive for SARS-CoV-2 RNA	Not attempted.	N/A (no air samples positive)	N/A	All 52 air samples from 8 COVID-19 patients' rooms were negative for SARS-CoV-2 RNA. Surface contamination with SARS-CoV-2 RNA was widespread; negative after disinfectant cleaning.
Kwon KS 2020	Community	Korea	Investigation was implemented based on personal interviews and data collection on closed-circuit television images, and cell phone location data.	A total of 39 environmental samples of inlets and outlets of air conditioners, table seat of Case A, and nearby tables and chairs in consideration of air flow direction were collected on June 23 for testing of SARS-CoV-2 in the environment and were analyzed by RT-PCR test. Air speed and direction at several specified positions were precisely measured using a portable anemometer	0/39 positive	Not attempted.	N/A (no air samples positive)	N/A	Maximum air flow velocity of 1.2 m/s was measured between the injector and infectee in a restaurant equipped with ceiling-type air conditioners. Environmental samples were collected at 11 days after the inspector visit.
Lednický JA 2020a	Hospital	USA	Air samples collected, and virus culture attempted	VIVAS air samples from the room of two COVID-19 patients were set up 2m to 4.8m away from the patients. Three serial 3-hr air samples were collected. For each sample, the second of the three samplings was performed with a high efficiency particulate arrestance (HEPA) filter affixed to the inlet tube, a process to reveal whether virus detected in consecutive samplings reflect true collection and not detection of residual virus within the collector.	4/4 air samples without a HEPA filter 0/2 samples using a HEPA filter	Virus-induced CPE were observed for 4/4 RNA-positive air samples.	Four positive samples estimated to contain: 2.82E+03, 9.12E+02, 1.15E+03, 4.68E+02 genome equivalents/ 25 µL, with Cycle quantification (Cq) values 36.02, 37.69, 37.42, 38.69, respectively (mean Cq 37.46)	NR	No other respiratory virus was identified in the samples using a BioFire FilmArray Respiratory 2 Panel. The amount of airborne virus detected per liter of air was small. Plaque assays could not be performed due to a nationwide non-availability of some critical media components (due to COVID-19 pandemic-related temporary lockdown of production facilities), so TCID50 assays were performed in Vero E6 cells to estimate the percentage of the collected virus particles that were viable. Estimates ranged from 2 to 74 TCID50 units/L of air
Lednický JA 2020b	Student Healthcare centre	USA	Air samples collected, and virus culture attempted	The air sampling device was placed in a hallway along which potential Covid-19 cases walked, wearing a mask, to reach clinical evaluation rooms. The air inlet was approximately 1.5m above floor level.	1/2	General virus-induced cytopathic effects were observed within two days post-inoculation	0.87 virus genome equivalents L ⁻¹ of air; Ct value 39.13	NR	The amount of virus present in 350 L of sampled air was low (approximately 340 virus genome equivalents). PCR tests for SARS-CoV-2 vRNA from cell culture were negative. Three respiratory viruses were identified using the BioFire RVP: Influenza A H1N1, Influenza A H3N2, and Human coronavirus OC-43

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/mL or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Lei H 2020	Hospital	China	Air and surface samples from the intensive care unit (ICU) and an isolation ward for COVID-19 patients.	Air samples were collected with a two-stage cyclonic bioaerosol sampler (NIOH) and an aerosol particle liquid concentrator, between 8am and 12 noon. The NIOH sampler was placed on a tripod at the head of the bed within 1 m of the patient's head at a height of 1.3 m. In the isolation ward the sampler was also used in the bathroom by mounting it on an infusion support near the sink, < 1 m from the toilet.	Surface and air: 1/218 ICU samples 2/182 Isolation ward samples	Not attempted.	near the head of the patient Ct 41.25.	NR	The number of air samples is unclear. One air sample collected using the Dingle sampler placed near the head of the patient in bed 14 showed amplification at cycle threshold (Ct) 41.25. The detection of viral RNA was also in the air samples in the bathroom.
Li YH & Fan YZ 2020	Hospital	China	Aerosol samples & surface samples collected in a hospital for severe COVID-19 patients	Aerosol samples collected by an impingement air sampler BIO-Capturer-6. 135 135 aerosol samples from 45 locations taken from the ICU ward, general isolation wards, fever clinic, storage room for medical waste, conference rooms and the public area.	0/135	Not attempted.	N/A (no air samples positive)	N/A	The ICU ward has 12 air inlets with 16 discharges per hour. Isolation room 8 air inlets with 12 discharges per hour. COVID-19 patients in a ward were separated by a minimum of 1.5 m. Air was cleaned with 4-time-daily air disinfection using a plasma air steriliser, with the exception of two samples from a COVID-19 patient's mask, all 90 environmental surfaces sampled were negative for SARS-CoV-2.
Li Y & Qian H 2020	Restaurant	China	Observational and experimental. Data from a video record and a patron seating arrangement from the restaurant in Hong Kong were collected. Secondly, the dispersion of a warm tracer gas was assessed, as a surrogate for exhaled droplets	No sampling performed	Not attempted.	N/A	N/A	N/A	Analysed outbreak using computer models and experiments based on airflow dynamics
Lin G 2020	Block of flats	China	Case series: Nine COVID-19 cases in one community in Guangzhou who lived in three vertically aligned units of one building sharing the same piping system.	Given that all the cases occurred in the same unit and that these households shared a common pipe system, we therefore conducted a tracer-gas experiment to simulate the process of potential transmission through air	Not attempted.	N/A	N/A	N/A	Airflow detection and simulation experiment revealed that flushing the toilets could increase the speed of airflow in the pipes and transmitted the airflow from Apartment 15-b to 25-b and 27-b. Reduced exhaust flow rates in the infected building might have contributed to the outbreak.
Liu Y & Ning Z 2020	Hospital and public spaces	China	Measured SARS-CoV-2 RNA in air samples from 2 Covid-19 hospitals, and quantified the copy counts using a droplet digital PCR-based detection method	Over a 2 week period: 30 aerosol samples of total suspended particles collected on 25-mm-diameter filters loaded into syringe filter cassettes (SKC) by sampling air at a fixed flow rate of 5.0 l min ⁻¹ using a portable pump (APB2, Casella). Three size-segregated aerosol samples collected using a miniature cascade impactor (Sioutas Impactor, SKC) that separated aerosols into five ranges (>2.5 µm, 1.0 to 2.5 µm, 0.50 to 1.0 µm and 0.25 to 0.50 µm on 25-mm filter substrates, and 0 to 0.25 µm on 37-mm filters) at a flow rate of 9.0 l min ⁻¹ . Two aerosol deposition samples collected using 80-mm-diameter filters packed into a holder with an effective deposition area of 42.0 cm ² , filters were placed intact on the floor in two corners of an ICU for 7 days.	ICU, 2/3 positive 15/22 Isolation wards & ventilated rooms 4/11 public areas	Not attempted.	ICU - 31 & 113 copies m ³ Isolation wards & ventilated rooms (concentrations very low: <43 m ⁻³ public areas (very low concentrations <11 m ⁻³)	NR	Negatively pressurized isolation and high air exchange rates were inside the intensive care units, coronary care units and ward room. Reported values are virus aerosol deposition rates in copies m ⁻² h ⁻¹ . Very low or undetectable concentrations of airborne SARS-CoV-2 were found in most of the patient areas of Renmin Hospital. The authors suggest that the negatively pressurized isolation and high air exchange rate inside the intensive care units, coronary care units and ward room of Renmin Hospital are effective in limiting the airborne transmission of SARS-CoV-2.
Lu J 2020	Restaurant	China	Study of an outbreak apparently centred on a restaurant; air flow studied & surface samples taken	Air samples not taken. 6 smear samples taken from the air conditioner (3 from the air outlet and 3 from the air inlet)	Not attempted. Air-conditioned 5-floor building without windows	N/A	N/A	N/A	0/6 smear samples tested positive by PCR.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m3 or copies/L or Cycle threshold (Ct)	Size of air particles and proportion in sample	Notes
Luo K 2020	Bus trip	China	Case study of a SARS-CoV-2 outbreak event during bus trips of an index patient in Hunan Province, China.	No sampling performed	Not attempted.	N/A	N/A	N/A	Could not verify transmission via fomites as no environmental samples were collected; (2) the SAR was likely overestimated as it is solely based on a single large cluster; (3) there might be recall bias because the information (including the seat number) was collected retrospectively; (4) no viral genetic sequence data were available from these cases to prove linkage; and (5) some of the secondary and tertiary cases could have been exposed to unknown infections
Ma J 2020	Hospital and quarantine hotel	China	Exhaled breath condensate (EBC) samples were collected from 20 imported COVID-19 cases, 29 local cases and 15 healthy controls.	EBC samples were collected using a BioScreen device developed by Peking University. 242 surface swabs from quarantine hotels and hospitals or from personal items of COVID-19 patients were obtained using wet cotton swabs	14/52 EBC sample positive; 1/26 air samples positive	Not attempted.	EBC samples, 14 positive: Ct values 35.54 ± 3.14 were obtained for each positive. The breath emission rate was estimated to be from 1.03×10^5 to 2.25×10^7 viruses per hour. The positive air sample was estimated to contain 6.07×10^3 viruses/m ³ .	NR	In the ward of patient C, the virus was present on the surface of an air ventilation duct entrance that was located below the patient's bed. Cycle threshold range (N or ORF1a/b) for EBC samples 35.5 ± 3.1 and air samples $CT = 38.4$. 1 sample (air-1) from an unventilated quarantine hotel toilet room was positive SARS-CoV-2 emission does not continue at the same rate but rather is a sporadic event. For example, 2 EBC samples (EBC-1, EBC-2) collected from patient E but on different dates and using the same method returned different test results
Marchetti R 2020	Hospital	Italy	Air sampling in three different hospitals in Milan, Italy.	For particles' sampling the AEROTRAK™ Portable Airborne Particle Counter was used for cleanroom particles classification. For microbiological air sampling, the SAS Super IAQ Surface Air System (model 90593), which conveys a known volume of air during a fixed period on Petri Plates filled with Standard Plate Count Agar (PCA) was used. Ten Alltel units per hospital were placed in three different hospitals in Milan, Italy. In total 68 samples were processed in three distinct test sessions between April and June 2020, using the QIAGEN Rotor-Gene thermal cycler.	E gene 19/68 samples, ORF1ab + N detected in 7/68 samples.	Not attempted.	Not reported	NR	The result of the RT-PCR showed a marked presence of the target β -coronavirus E gene for 19 of the 68 samples, while the target ORF1ab + N was detected in 7 samples. In particular at Sacco Hospital, the test results show the detection of ORF1ab + N and/or E gene in 15 samples out of 40.
Masoumbeigi H 2020	Military hospital	Iran	Random air sampling with continuously sterilised sample equipment	All patients aged 55-65 were either incubated or had severe symptoms. Sampling of 100-1000 l for 20 mins in two randomly chosen stations 0.5 metres from the beds. RT-PCR performed at 42 cycles. Air sampling was done (n=31) on selected wards including Emergency 1, Emergency 2, bedridden (4-B, 10-D), ICU 2, ICU 3, CT-SCAN, and laundry.	0/31	Not attempted.	N/A (no air samples positive)	N/A	Cycle threshold for detection used = 42
McGain F 2020	Hospital	Australia	Case report of a tracheostomy procedure; air samples were collected throughout	Two spectrometers to measure aerosol particles: the portable Mini Wide Range Aerosol Sizer 1371 (MiniWRAS) and the Aerodynamic Particle Sizer (APS). During the procedure, the aerosol detector inlet was positioned 30 cm directly above the patient's neck, representing the surgeon's breathing air space	Not attempted.	Not attempted.	N/A	APS detected larger aerosols (> 0.37 mm) and MiniWRAS smaller particles (0.01-0.35 mm).	Maximum aerosol particles were generated during diathery, but overall low levels. It is unlikely that viruses will survive the high temperature of diathery.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m3 or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Moreno T 2020	Buses and Subway Trains	Spain	75 samples from buses and 24 from subway trains, collected from surfaces using swabs (78 samples), from ambient air (12 samples), and from air-conditioning filters (9 samples)	Air sampling in the subway took place June 17-19, 2020 on three consecutive days. Six samples of particulate matter with a diameter of <2.5 µm (PM2.5) were collected inside 6 trains using 47 mm Teflon filters with PEM (Personal Environmental Monitor) equipment. The sampling of the buses took place between 20:00 and 03:00 on the night of May 25-26, 2020 in one of the four main bus depots in Barcelona. After sampling, the bus was disinfected.	1/6 air samples on buses gave weak positive result 2/6 subway trains	Not attempted.	Bus: Positive sample genome count values ranged between 14 to 446/m2 for IP2, 9 to 490/m2 for IP4 and 5 to 378/m2 for E. Subway: first positive sample estimated viral load 23.4 GC/m3, second positive sample the amplified target gene regions were IP2 (18.8 GC/m3) and the envelope protein E (5.6 GC/m3).	NR	Only fragments of 1 or 2 gene targets were identified, not an infectious virus, and furthermore, even if they were infectious viruses, it is estimated that only one particle in 10 million would be able to produce an infectious cycle. Bus calculated viral load (supposing that RNA represents the unlikely worst situation of being representative of infective virus load) of 1.44 GC/m3. 6 PM2.5 samples collected in ambient air (first case the target gene region identified was IP2, with a figured viral load of 23.4 GC/m3. In the second case the amplified target gene regions were IP2 (18.8 GC/m3) and the envelope protein E (5.6 GC/m3)
Morioka S 2020	Hospital	Japan	2 case reports	Air was sampled using an MD8 airscan sampling device and sterile gelatin filters. Air was sampled twice at a speed of 50 L/minute for 20 minutes in the negative-pressure rooms of two patients and its associated bathrooms.	0/2 patient 1 0/2 patient 2	Not attempted.	N/A	N/A	Intubation was performed for patient 1 three days before the sampling. Patient 2 was asymptomatic when the sampling was conducted.
Mponponsuo K 2020	Hospital	Canada	Epidemiological study investigating airborne versus droplet transmission of SARS-CoV-2	Air samples not taken. From 5 HCWs with positive SARS-CoV-2 tests and Covid-19 symptoms, no onward transmission was observed from 72 exposures	Not attempted.	Not attempted.	N/A	N/A	No transmission from multiple high-risk exposures from 5 COVID-19 HCWs to either patients or other staff.
Nakamura K 2020	Hospital	Japan	Nasopharyngeal, environmental and air samples from patients	11 air samples in three negative pressure bays (Bay 1 to Bay 3), a single negative pressure room in a general ward (Room 1) and a single negative pressure room in an isolation ward (Room 2) using an MD8 airscan sampling device (Sartorius, Goettingen, Germany) and sterile gelatin filters (80 mm diameter and 3 µm pores; Sartorius). We placed the device on the floor about 1.5 meters-2 meters away from the patient's head. Air was sampled twice, at a speed of 50 L/minute for 20 minutes, in the negative pressure rooms and its associated restrooms	0/11	Not attempted.	N/A (no air samples positive)	N/A (no air samples positive)	47/41 swab samples collected from the three bays and two single rooms were positive
Nissen K 2020	Hospital	Sweden	Observational: surface swabs and fluid samples collected, and experimental: virus culture was attempted.	In a Covid-19 ward, surface samples were taken at air vent openings in isolation rooms and in filters. Fluid sample collections were done in the ventilation system, separate HEPA filter systems, distance measured to between 49 and 56 meters. Admitted patients in the ward were between day 5 and 23 after symptom onset	7/19 room vents 11 days later, 47/9 for both genes. 8/9 main exhaust filters +ve for both genes.	No significant CPE was seen after three passages on Vero E6 cells from samples retrieved from ward vent openings or central ventilation ducts or filters	Petri dishes Ct values 35.32 and 33.16 for N and E genes respectively. Ward 1 +ve specimen had Ct value 33.00, for E gene only.	NR	Cycle threshold (Ct) values varied between 35.3 and 39.8 for the N and E gene. Virus culture was attempted: RNA detected in sequential passages but CPE not observed. Petri dishes of cell medium, placed in inspection hatches in the central ventilation system prior to the exhaust filters, were +ve for both N and E genes. 1/3 specimens from ward 1 contained only the E gene.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m ³ or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Ogawa Y 2020	Hospital	Japan	Observational study of 15 HCP who had contact exposures (15/15) and aerosol exposures (7/15) to a hospitalized Covid-19 patient who re-tested positive 18 days after initial negative PCR.	Air sampling not performed, All PCR tests performed on exposed HCVs using a nasopharyngeal swab obtained on the 10th day after the exposure were negative, and the results of the tests for IgG antibodies to SARS-CoV-2 on the specimens collected approximately 20 days after exposure were also negative.	Not attempted.	N/A	N/A	N/A	Due to sudden change in symptoms, the patient underwent nasopharyngeal and sputum PCR testing for SARS-CoV-2 again; the results were re-positive. Due to this, several HCP who had interacted with this patient had to be marked for active isolation. The core issue is determining whether the patients whose PCR test results are re-positive are infectious. A low probability of infection from a re-positive case.
Ong SWX 2020	Hospital	Singapore	Air surface and PPE swab samples collected for 3 hospitalized Covid-19 patients.	Air sampling was done on 2 days using SKC Universal pumps (with 37-mm filter cassettes and 0.3-µm polytetrafluoroethylene filters for 4 hours at 5 L/min) in the room and anteroom and a Sartorius M88 microbiological sampler (with gelatin membrane filter for 15 minutes at 6 m ³ /h) outside the room. Supplemental file Blue (containing A to E indicate the position of the air samplers within the room (A to C), anteroom (D), and common corridor (E)).	0/5	Not attempted.	N/A (no air samples positive)	N/A	Surface contamination with SARS-CoV-2 RNA was widespread but undetectable after cleaning; swabs taken at air outlets tested positive suggesting droplet deposition; all air samples were negative.
Orenes-Piñero E 2020	Hospital	Spanish	Study of COVID-19 traps to measure the capacity of SARS-CoV-2 aerosol transmission.	"COVID-19 traps" were placed only in the rooms of patients with a confirmed positive diagnostic. Interestingly, the rooms where COVID-19 patients were isolated had a ventilation rate of 1800 m ³ /h. 6 different surfaces trapped in boxes with plastic, protective grids to avoid that samples could be touched by the patient or by the healthcare personnel. The different surfaces were: polypropylene (PP), glass, polyvinyl chloride (PVC), methacrylate, agar medium and carbon steel. PP surfaces were obtained from PP black panels and had a semi-gloss finish with a thickness of 2 mm.	0/18 ICU "traps" 2/18 Covid wards "traps"	Not attempted.	Ct from positive surfaces were more than 10 cycles after than those obtained from the patient, indicating that the viral load was lower in the room environment.	NR	No-one could touch the surfaces of the "traps" and patients were isolated in their rooms. RNA was found in two different surfaces at 72 h in the room of a patient with a nasal cannula. No positives were found at 24 or 48 h on the same surfaces. The rest of surfaces, placed in rooms with patients with no respiratory support, were not positive.
Razzini K 2020	Hospital	Italy	Observational, 5 air (& 37 surface) samples collected in the ICU for Covid-19 patients.	Air samples done using an MD8 Airport Portable Air Sampler with gelatine membrane filters, 1 filter for each monitored area. Each aspiration cycle was 40 min with a flow of 50 l/min. The detector was positioned 1.5 m above the floor. Air (n = 5) samples were collected from three zones classified as contaminated (corridor for patients and ICU), semi-contaminated (undressing room) and clean areas (lockers and passage for the medical staff and a dressing room).	20/20 from the contaminated area 0/8 semi-contaminated 0/9 clean areas.	Not attempted.	Mean Ct for ICU air samples 22.6 Mean Ct for corridor air samples 31.1	NR	Surface contamination with SARS-CoV-2 RNA in Covid-19 wards was widespread, but not found in hospital "clean" areas. A total of 37 swab samples were collected within the five areas and 24% were positive for viral. Air samples collected from ICU and corridor for patients were positive for viral RNA with mean concentrations of 22.6 and 31.1 Ct value, respectively. In the present study the correlation between the virus concentration and the distance from patients was also evaluated. The Spearman coefficient suggests that there may be a moderate correlation and that the viral load of the surfaces increases with the patient proximity.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m3 or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Santarpia JL 2020a	Hospital	USA	Size-fractionated aerosol samples collected; virus culture was attempted.	Air samplers were placed in various places in the vicinity of the patient, including over 2m distant. Personal air sampling devices were worn by study personnel on two days during sampling. Measurements were made to characterize the size distribution of aerosol particles, and size-fractionated, aerosol samples were collected to assess the presence of infectious virus in particles sizes of >4.1 µm, 1-4 µm, and <1 µm in the patient environment. An Aerodynamic Particle Sizer Spectrometer was used to measure aerosol concentrations and size distributions from 0.542 µm up to .20 µm. A NIOSH BC251 sampler was used to provide size segregated aerosol samples for both RT-PCR and culture analysis.	6/6 patient rooms.	In 3 aerosol samples of size <1 µm, cell culture resulted in increased viral RNA. Viral replication of aerosol was also observed in the 1 to 4 µm size but did not reach statistical significance.	Most RNA was identified in <1 microm particles (rather than 1-4 microm or >4.1 microm); concentrations up to around 7.5 TCID 50 / m3 of air.	Two of 1-4 µm samples demonstrated viral growth, between 90% and 95% confidence	Western blot assay was done using the antibody against SARS-CoV N protein, in cell supernatant samples with statistically significant evidence of replication. The presence of SARS-CoV-2 was reported to be observed via western blot for all but one of the samples (<1 µm, Room 7B) with statistically significant evidence of replication by RT-PCR (figure of replication by RT-PCR (figure 2). Inactivated virus was reported to be observed via TEM in the submicron sample from Room 5, and reported as "indicating active viral replication in that sample."
Santarpia JL 2020b	Healthcare centre	USA	High-volume (50 Lpm) and low-volume (4 Lpm) personal air samples (& surface samples) collected from 13 Covid-19 patients; virus culture was attempted.	We initiated an ongoing study of environmental contamination obtaining surface and air samples in 2 NBU hospital and 9 NBU residential isolation rooms housing individuals testing positive for SARS-CoV-2. Samples were obtained in the NBU on days 5-9 of occupancy and in the NBU on Day 10	63% of in-room air samples positive (denominator unclear)	Cultivation of virus was not confirmed in these experiments. Authors suggest this was due to the low concentrations recovered in the samples.	Concentration of gene copies present in the recovered liquid sample (copies/µL); generally low and highly variable from sample to sample ranging from 0 to 1.75 copies/µL with the highest concentration recovered from an air handling grate in the NBU.	NR	Aerosol samples were analyzed by RT-PCR targeting the E gene of SARS-CoV-2. Partial evidence of virus replication from one air sample. In the NBU, for the first two sampling events performed on Day 10, the sampler was placed on the window ledge away from the patient, and was positive for RNA (2.42 copies/L of air). On Day 18 in NBU Room B occupied by Patient 3, one sampler was placed near the patient and one was placed near the door greater than 2 meters from the patient's bed while the patient was receiving oxygen (1L) via nasal cannula. Both samples were positive by PCR, with the one closest to the patient indicating a higher airborne concentration of RNA (4.07 as compared to 2.48 copies/L of air). Samples taken outside the rooms in the hallways were 58% positive. Between 5 and 16 samples were collected from each room, with a mean of 7.35 samples per room and a mode of 6 samples per room. *In two of the samples, cell culture indicated some evidence for the presence of replication competent virus
Setti L 2020	Outdoor sampling	Italy	Observational study of particulate matter collected in industrial area of Bergamo over a continuous 3-week period	Particulate matter was collected using fiber filters by using a low-volume gravimetric air sampler (38.3 l/min for 24 h), compliant with the reference method EN12341:2014 for PM10 monitoring. This sampling procedure allows collection of aerosol and bioaerosol, by filtering 55 m3 per day, in a wide dimensional range; an approach considered suitable for sentinel and surveillance purposes.	20/34 PM samples positive for one gene 4/34 positive for 2 genes	Not attempted.	Not reported.	PM reported	particulate matter in defined conditions of atmospheric stability and high concentrations of PM10;
Seyyed Mahdi SM 2020	Hospital	Iran	Cross-sectional study in the Covid-19 ICU ward.	Air and surface sampling; impinger method was applied for air sampling; at a distance of 1.5 to 1.8 meters from the ground, the air of the ICU ward was passed through a sampling pump with an flow rate of 1.5 l/min into the porous midjet impeller-30 ml containing 15 ml of virus transmission medium (PVTM) for 45 minutes.	6/10 air samples	Not attempted.	Highest RNA concentrations observed at the point between beds 6 and 7 (3913 copies per ml)	NR	Highest RNA concentrations observed at the point between beds 6 and 7 (3913 copies per ml). Most of the reported negative air samples were from the middle of the ward, which was further away from the patients beds. ten samples taken from different surfaces of the ward, 4 samples were positive (40%) and the highest concentration (8318 copies per ml) was related to the table next to bed number 3.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m ³ or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Shen Y 2020	Community including transport on buses	China	Observational epidemiology; cohort of 128 individuals.	128 individuals travelled on 1 of 2 buses to attend a worship event in Eastern China. Those who rode a bus with air recirculation and with a patient with COVID-19 had an increased risk of SARS-CoV-2 infection compared with those who rode a different bus.	Not attempted.	Not attempted.	N/A.	N/A.	Fomites and droplet transmission can not reasonably be excluded.
Song Z 2020	Public Health Clinical Center	China	Observational surveillance to evaluate the risk of viral transmission in AIIRs with 115 rooms in three buildings at the Shanghai Public Health Clinical Center, Shanghai during the treatment of 334 patients infected with SARS-CoV-2.	In patient rooms, an air sampler was placed on the ground with a distance of about 1.0 m from patient's bed. In changing rooms, it was located between air supply outlet and air exhaust to capture particles from the unidirectional airflow. In addition, HEPA filters of air exhaust outlet in AIIRs in building 2 were collected.	0/7 ICU air samples 0/2 non-ICU buildings.	Not attempted.	N/A (no air samples positive)	N/A.	We collected air samples from 15 AIIRs, including 7 ICU-AIIRs in building 3 and 8 non-ICU AIIRs in buildings 1 and 2. Two of the samples were collected in the ICU-AIIR of building 3 when tracheotomy surgery was performed. Directional airflow and strong environmental hygiene procedures were in place. None of 290 HCWs was infected when working in the AIIRs at this hospital. Additionally, testing of all surface samples from air exhaust and HEPA filters failed to detect any viral RNA.
Tan L 2020	Hospital	China	Observational study of air and surface samples collected from isolation wards and ICU for 15 COVID-19 patients.	Air samples were obtained by placing an air sampler within 1 m of the patient's head; this continuously filtered air at a speed of 5 l/min and trapped small virus particles on a membrane. After 1 h the membrane was removed and cut into small pieces to be stored in VTM prior to further testing. The air sampler was placed at the same height as (or slightly lower than) an electronic fan installed on top of the windows to expel the air from the wards to the outside. Air samples were obtained from patient rooms, the corridor outside the patient rooms, and in the nearby nursing stations.	1/29 0/17 clean areas 1/12 patient rooms*	Not attempted.	Not attempted.	NR	*Only one sample was positive for SARS-CoV-2, which was collected within 10 cm of a female patient who was undergoing endotracheal intubation for massive mechanical ventilation. SARS-CoV-2 RNA was not detected on any of the 36 surgical masks from 18 patients (14 mild and four severe/critical), although some of the patients had worn the same mask for 24 h. Most patients were 20 days post symptom onset, and 10/24 (42%) tested positive for SARS-CoV-2 by throat swab on the day of sampling.
Wei L 2020 (a)	Hospital	China	Sampled the surroundings and air of 6 negative-pressure non-ICU rooms	In a designated isolation ward occupied by 13 COVID-19 patients, including 2 asymptomatic patients. Air was sampled between 10:30 am and 13:00pm during the routine medical activities using an air sampler (FSC-1V; Hongrui, Suzhou, China) with 0.22-µm-pore-size filter membranes for 15 min at 100 l/min. The air sampler was placed about 0.6 m away from each patient and 1 m above the floor in each room. The filter membranes were wiped by the use of pre moistened sterile swabs (Copan).	0/6 room air samples	Not attempted.	N/A (no air samples positive)	NR	3/6 of samples from air exhaust outlets in three rooms were positive for SARS-CoV-2. It appears that the patient surroundings in rooms with a SARS-CoV-2-positive air exhaust outlet are usually extensive contaminated (26.7% to 95.7%). It is possible that small virus-laden particles may be displaced by airflows and deposited on patient surroundings as suggested previously. 44/112 surface samples tested positive.

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m3 or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Wei L (2020 (b))	Hospital	China	Observational study in patient surroundings and on PPE in a non-ICU isolation ward	The air from rooms for nine COVID-19 patients with illness or positive PCR >30 days, before and after nasopharyngeal oropharyngeal swabbing and before and after nebulization treatment. Air sampling was performed using an air microbiological sampler (FSC-1V; Hongui, Suzhou, China) with 0.22 µm filter membranes on a nutrient agar plate for 15 min at 100 L/min, which was placed about 2 m away from patient and 1.1 m above the ground. Air was also sampled before and after performing nebulization treatment for all patients required (n=4 on March 4 and n=2 on March 12, 2020). After air sampling, the filters and the surface of agar were wiped using sterile swabs.	0/34 room air samples	Not attempted.	N/A (no air samples positive)	N/A	Environmental sampling was not performed at the early stage of COVID-19 when viral load in upper respiratory tract is higher. SARS-CoV-2 was not detected at distances > 1 m away from patients with a SARS-CoV-2 positive swab (n=5 for nasopharyngeal and n=2 for oropharyngeal) when collecting swabs nor after nebulization for patients with positive respiratory samples
Wong JCC 2020	Home residence	Singapore	Observational study of environmental contamination of SARS-CoV-2 in non-24 healthcare settings and assessed the efficacy of cleaning and disinfection in removing SARS-CoV-2 contamination.	Air samples were collected (n=4) in an accommodation room (occupied by Case 1) that was thought to be poorly ventilated and another 2 samples were collected right outside the room entrance. All samples were taken after the infected persons vacated the sites and have been isolated in healthcare facilities.	0/6 home residence samples	Not attempted.	N/A (no air samples positive)	N/A	Half of the surface swab and air samples were taken before the cleaning and disinfection and the other half was taken after the disinfection procedure, performed by third party commercial companies
Wong SCY 2020	Hospital	China	Case report and contact tracing and testing outbreak investigation of a patient in with COVID-19 who was nursed prior to Covid diagnosis in an open cubicle of a general hospital ward, Hong Kong.	Samples not collected.	Not attempted.	Not attempted.	N/A	N/A	Findings suggest that SARS-CoV-2 is not spread by an airborne route. A total of 71 staff and 49 patients were identified from contact tracing, 7 staff and 10 patients fulfilled the criteria of 'close contact'. After 28-day surveillance, 76 tests were performed on 52 contacts and all were negative, including all patient close contacts and 6/7 staff close contacts. The remaining contacts were asymptomatic throughout the surveillance period. Evidence against airborne transmission: no positive test among close contacts up to 28 days. The patient could not wear a surgical mask as she was on oxygen therapy through a simple facemask.
Wu S 2020	Hospital	China	Observational study of air and surface samples in hospital including rest rooms	Air samples from medical areas were collected through natural precipitation according to the Hygienic Standard for Disinfection in Hospitals 9. All samples were collected under emergency conditions around 8:00 AM before routine cleaning and disinfection	0/44 0/13 ICU 0/13 Wards 0/18 fever clinic	N/A	N/A	N/A	The positive rates in 200 environmental surface samples in medical areas (24.83%) was higher than that in living quarters (3.64%), with a significant difference (p < .05).

Authors	Setting	Country	Method	Samples source	Air Samples PCR positive for SARS-CoV-2 RNA (unless otherwise stated)	Viral culture	Viral concentrations copies/m ³ or copies/L or Cycle threshold (Ct)	size of air particles and proportion in sample	Notes
Yuan XN 2020	Hospital	China	Observational study of the contaminated area in COVID-19 wards	Air samples from the clean area, the buffer room and the contaminated area in the COVID-19 wards using a portable bioaerosol concentrator WA-15.	0/90	Not attempted.	N/A (no air samples positive)	N/A	The 38 high-frequency contact surfaces samples of the contaminated area and 16 surface samples of medical staff's protective equipment including outermost gloves and isolation clothing were all negative.
Zhang D 2020	Outdoor environment of 3 hospitals	China	Air (and wastewater and soil samples) collected from the surroundings of a Covid-19 hospital.	73 air and wastewater samples from the environment of three hospitals in Wuhan treating Covid-19 patients.	3/16	Not attempted.	SARS-CoV-2 RNA found in aerosols ranged from 285 to 1,130 copies/m ³ . Inside the adjusting tank of Hospital 1 and Hospital 2, respectively, SARS-CoV-2 in aerosols was found at a level of 285 copies/m ³ and 603 copies/m ³ . Aerosols collected 5 m away from Hospital 1 outpatient building were 1130 copies/m ³ , whereas undetected in aerosols collected 5 m away from the inpatient building.	N/A	SARS-CoV-2 RNA found in a range of samples adjacent to hospitals. Inside the adjusting tank of Jinyintan Hospital and Huoshenshan Hospital, SARS-CoV-2 in aerosols was found at a level of 285 copies/m ³ and 603 copies/m ³ . Outside patient departments of Jinyintan Hospital, SARS-CoV-2 in the aerosols collected 5 m away from outpatient building were 1130 copies/m ³ , whereas undetected in aerosols collected 5 m away inpatient building.
Zhou J 2020	Hospital	UK	Observational: (air & surface) samples collected from a hospital with a high number of Covid-19 inpatients.	In the Emergency Department, dedicated for patients with confirmed or suspected COVID-19, two of the cubicles were occupied and one patient was in the ambulatory wait area at the time of sampling. These areas were disinfected daily using a combined chlorine-based detergent/disinfectant (Actichlor Plus, Ecolab), with an additional twice daily disinfection of high touch surfaces using the same detergent/disinfectant. In each of these clinical areas, four air samples were collected (five air samples were collected in the Emergency Department, and three in public areas of the hospital). Air sampling was performed using a Coriolis µ air sampler (referred to as Coriolis hereafter) (Bertin Technologies), which collects air at 100–300 litres per minute (LPM). After 10 min sampling at 100 LPM, a total of 1.0 m ³ 1.47 air was sampled into a conical vial containing 5 mL Dulbecco's minimal essential medium (DMEM).	2/31 air samples positive 1/31 suspected	0/14	10 ¹ to 10 ³ copies/m ³ of SARS-CoV-2 RNA were detected in all air samples; no significant difference between sample areas.	NR	We defined samples where both air or surface sample detected SARS-CoV-2 RNA as positive, and samples where one of the two PCRs performed from an air or surface sample detected SARS-CoV-2 RNA as suspected
Zhou L 2020	Hospital	China	Study of collected samples of exhaled breath of patients ready for discharge and air samples.	The 13 patients in 4 hospitals were aged 70+ years. 10 were recovered Covid-19 patients ready for discharge; 3 were patients recovered from influenza who tested negative for SARS-CoV-2. Air (& surface) samples were collected. Exhaled breath condensate of 500–500 L was collected from each patient: a long straw was used to allow the patient to breathe into a tube that was electrically cooled. 44 air samples were taken, from corridors, hospital waste storage rooms, ICU rooms (5 samples), toilets, medical preparation rooms, clinical observation rooms, and general wards. Two impinger samplers were used: WA-15 sampled at a flow rate of 15 L/min, while the WA-400 sampled at 400 L/min.	0/44	Not attempted.	N/A (no air samples positive)	Not attempted.	1.3% of surface swab samples tested positive. 20% of Covid-19 patients, who were ready for a hospital discharge based on current guidelines, had SARS-CoV-2 in their exhaled breath (~105 RNA copies/m ³). They were estimated to emit about 1400 RNA copies into the air per minute.

Table 2. Study characteristics: reviews.

Study (n=22)	Fulfills systematic review methods	Research question (search date up to)	No. included studies (No. participants)	Main results	Key conclusions
Airborne transmission and its prevention (n=14)					
Anderson EL 2020	no	What are the scientific uncertainties and potential importance of aerosol transmission of SARS-CoV-2. (search methods and date not clear)	unclear	Limited evidence reports that SARS-CoV-2 can remain active in aerosol for at least 3 hours, although its concentration decreases over time.	Further data collection required assessment under differing conditions of temperature and humidity. Such research should be relatively low cost and results available in a short time.
Agarwal 2020	yes	To summarize the evidence for the efficacy, safety, and risk of aerosol generation and infection transmission during high-flow nasal cannula (HFNC) use among patients with acute hypoxemic respiratory failure due to COVID-19 (search conducted to 14 May)	Four studies evaluating droplet dispersion and three evaluating aerosol generation and dispersion.	Two simulation studies and a crossover study showed mixed findings regarding the effect of HFNC on droplet dispersion. Two simulation studies reported no associated increase in aerosol dispersion, and one reported higher flow rates were associated with increased regions of aerosol density (evidence rated as very low certainty).	High-flow nasal cannula may reduce the need for invasive ventilation and escalation of therapy
Bahl P 2020	No	To review the evidence supporting the rule of 1-meter (=3 feet) horizontal separation for droplet precautions in the context of guidelines issued by the WHO, CDC, and European Centre for Disease Prevention and Control (ECDC) for HCWs on respiratory protection for COVID-19. (open search to March 2020)	10 studies	"... the evidence base for current guidelines is sparse... the available data do not support the 1- to 2-meter (=3-6 feet) rule of spatial separation. Of 10 studies on horizontal droplet distance, 8 showed droplets travel more than 2 meters (=6 feet), in some cases up to 8 meters (=26 feet). Several studies of... SARS-CoV-2 support aerosol transmission, and 1 study documented virus at a distance of 4 meters (=13 feet) from the patient."	"The weight of combined evidence supports airborne precautions for the occupational health and safety of health workers treating patients with COVID-19."
Birgand G 2020 and Birgand G 2020 JAMA	no	Evidence for airborne contamination of SARS-CoV-2 in hospitals (search conducted to 21 July) repeated on October 27, 2020 for JAMA publication)	17 articles JAMA Dec: 24 cross-sectional observational studies	68/247 (28%) of air sampled from close patients environment were positive for SARS-CoV-2: no difference according to the setting (ICU: 27/97, 27.8%; non-ICU: 41/150, 27.3%; p=0.93), or the distance from patients (<1 metre: 1/64, 1.5%; 1 to 5 metres: 4/67, 6%; p=0.4), 3/78 (4%) viral cultures performed in three studies were positive (all were samples from close to patients). JAMA: A total of 81 viral cultures were performed across 5 studies, and 7 (8.6%) from 2 studies were positive, all from close patient environments.	In hospital, the air near and away from COVID-19 patients is frequently contaminated with SARS-CoV-2 RNA, with however, rare proofs of their viability. JAMA in this systematic review, the air close to and distant from patients with coronavirus disease 2019 was frequently contaminated with SARS-CoV-2 RNA; however, few of these samples contained viable viruses. High viral loads found in toilets and bathrooms, staff areas, and public hallways suggest that these areas should be carefully considered.
Carducci A 2020	no	To describe the state of the art of coronavirus airborne transmission (search conducted 5 June)	64 papers classified into three groups: laboratory experiments (12 papers), air monitoring (22) and epidemiological and airflow model studies (30)	Airborne transmission of SARS-CoV-2 was suggested by studies across the three groups, but methods were not standardised.	No studies had sufficient confirmatory evidence, and there is only a hypothesis to support airborne transmission
Chen PZ 2020	yes	To develop a comprehensive dataset of respiratory viral loads (rvLs) of SARS-CoV-2, SARS-CoV-1 and Influenza A(H1N1)pdm09 (search conducted to 7 Aug)	64 studies (n = 9,631 total specimens)	Modelling of the likelihood of respiratory particles containing viable SARS-CoV-2. When expelled by the mean COVID-19 case during the infectious period, respiratory particles showed low likelihoods of carrying viable SARS-CoV-2. Aerosols (equilibrium aerodynamic diameter [da] ≤ 100 µm) were ≤0.69% (95% CI: 0.43-0.95%) likely to contain a virion. Droplets also had low likelihoods: at an equilibrium aerodynamic diameter = 330 µm,	Aerosols (≤100 µm) can be inhaled nasally, whereas droplets (>100 µm) tend to be excluded. For direct transmission, droplets must be sprayed ballistically onto susceptible tissue. Hence, droplets predominantly deposit on nearby surfaces, potentiating indirect transmission. Aerosols can be further categorized based on typical travel characteristics: short-range aerosols (50–100 µm) tend to settle within 2 m; long range ones (10–50 µm) often travel beyond 2 m based on emission force; and buoyant aerosols (≤10 µm) remain suspended and travel based on airflow profiles for minutes to many hours

Study (n=22)	Fulfills systematic review methods	Research question (search date up to)	No. included studies (No. participants)	Main results	Key conclusions
Comber L 2020	yes	To synthesise the evidence for the potential airborne transmission of SARS-CoV-2 via aerosols. (Searches 1 Jan up to 27 July 2020)	28 studies (8 epidemiological case series of SARS-CoV-2 clusters or outbreaks; 16 air sampling studies, and 4 virological studies)	10/16 air sampling studies detected SARS-CoV-2 ribonucleic acid; however, only three of these studies attempted to culture the virus with one being successful in a limited number of samples. Two of four virological studies using artificially generated aerosols indicated that SARS-CoV-2 is viable in aerosols.	The results of this review indicate there is inconclusive evidence regarding the viability and infectivity of SARS-CoV-2 in aerosols. Epidemiological studies suggest possible transmission, with contextual factors noted. However, there is uncertainty as to the nature and impact of aerosol transmission of SARS-CoV-2, and its relative contribution to the Covid-19 pandemic compared with other modes of transmission.
Ekram W 2020	no	To summarize the ways in which SARS-CoV-2 is transmitted (Searches Dec 28, 2019 up to July 31 2020)	unclear	Evidence-based hypotheses support the possibility of SARS-CoV-2 airborne transmission due to its persistence in aerosol droplets in a viable and infectious forms.	Aerosolized transmission is likely the dominant route for the spread of SARS-CoV-2, particularly in healthcare facilities. Although SARS-CoV-2 has been detected in non-respiratory specimens, including stool, blood and breast milk, their role in transmission remains uncertain.
Jl B 2020	no	To reviews the information from published papers, newsletters and large number of scientific websites to profile the transmission characteristics of the coronaviruses in water, sludge, and air environment, (search methods and date not clear)	There is a paucity of scientific information regarding the infectivity and load of SARS-CoV-2 in the air. Emerging evidence suggests that SARS-CoV-2 could be transmitted via airborne routes.		There is limited evidence supporting airborne transmission of SARS-CoV-2.
Mehraeen E 2020	no	To review the current evidence of COVID-19 transmission modes. (Searches Dec 2019 to April 2020)	36 studies including 31 articles (11 reports, eight reviews, seven letters to the editor, two modeling, one perspective, and two experimental studies) and five clinical trials.	Identified five potential transmission modes of COVID-19 including airborne, droplet, contact with contaminated surfaces, oral and fecal secretions.	Droplet and contact with contaminated surfaces were the most frequent transmission modes of COVID-19. Fecal excretion, environmental contamination, and fluid pollution might contribute to a viral transmission
Niazi S 2020	no	To evaluate the mechanisms of generation of human pathogenic coronaviruses, evaluating these viruses in the air/field studies and available evidence about their seasonality patterns. (searches no restriction on year up to July 31, 2020)	total unclear (8 Studies of air sampling; 6 Sars-CoV-2)	Evidence exists for respirable-sized airborne droplet nuclei containing viral RNA, although this does not necessarily imply that the virus is transmissible, capable of replicating in a recipient host, or that inoculum is sufficient to initiate infection. However, evidence suggests that coronaviruses can survive in simulated droplet nuclei for a significant time (>24 h). Nevertheless, laboratory nebulized virus-laden aerosols might not accurately model the complexity of human carrier aerosols in studying airborne viral transport	Human respiratory activities generate respirable sized aerosols that are of adequate size to support an infectious virus. Knowledge of the properties of respiratory aerosols and their effects on the viability of viruses remains incomplete. Environmental factors could directly affect the viability of virus on the embedded viruses in aerosols. There is disagreement on whether wild coronaviruses can be transmitted via an airborne path. Further studies are required to provide supporting evidence for the role of airborne transmission.
Noorimotlagh Z 2020	no	To review studies on airborne transmission of SARS-CoV-2 in indoor air environments.(search methods and date not clear)	14 studies	11 studies were experimental and reported different findings on positive or negative detection of SARS-CoV-2 airborne transmission in indoor air. Among them, three studies indicated that all indoor air samples in the hospital were negative, thus concluding that there is no evidence that SARS-CoV-2 is transmitted by air (Faridi <i>et al.</i> , 2020; Kim <i>et al.</i> , 2020; Masoumbeigi <i>et al.</i> , 2020). the other included experimental studies reported positive results that confirmed transmission of the virus through the air.	There is a possibility of airborne transmission of SARS-CoV-2 in indoor air environments.
Rahmani 2020	no	A review of methods used for sampling and detection of SARS like viruses in the air. (search methods and date not clear)	not clear	Factors that limit the interpretation included variable patient distance from the sampler, use of protective or oxygen masks by patients, patient activities, coughing and sneezing during sampling time, air movement, air conditioning, sampler type, sampling conditions, storage and transferring conditions.	Most studies are not able to discriminate between airborne or respiratory droplet transmission.

Study (n=22)	Fulfills systematic review methods	Research question (search date up to)	No. included studies (No. participants)	Main results	Key conclusions
Ren SY 2020	No	This review aims to summarize data on the persistence of different coronaviruses on inanimate surfaces. (search date unclear)	unclear	Viruses in respiratory or fecal specimens can maintain infectivity for quite a long time at room temperature. Absorbent materials like cotton are safer than unabsorbent materials for protection from virus infection. The risk of transmission via touching contaminated paper is low. Preventive strategies such as washing hands and wearing masks are critical to the control of coronavirus disease 2019.	Viruses in respiratory or fecal specimens can maintain infectivity for quite a long time at room temperature. Absorbent materials like cotton are safer than unabsorbent materials for protection from virus infection. The risk of transmission via touching contaminated paper is low.
Singhal S 2020	no	To focus on different modes of transmission of this virus, comparison of this virus with previous similar analogy viral diseases like SARS and MERS. (Searches Jan 1 to 29 April 2020)	unclear	SARS-CoV-2 is highly contagious and spreads through air, droplets, close contact, through fomites. SARS-CoV-2 can also spread via aerosol in surroundings with high aerosol generating procedures only.	Social distancing, isolation of symptomatic patients and respiratory hygiene will be effective in SARS-CoV-2 infection control
Wilson NM 2020	no	To assess the airborne transmission of severe acute respiratory syndrome coronavirus-2 to healthcare workers (search methods and date not clear)	unclear	Evidence largely from low-quality case and cohort studies where the exact mode of transmission is unknown as aerosol production was never quantified. The mechanisms and risk factors for transmission were also largely unconfirmed.	Limited evidence suggests aerosol generating procedures cause an increase in airborne healthcare worker transmission. Further research is required.
Airborne transmission and procedures (n=3)					
Hussain A 2020	no	Extent of infectious SARS-CoV-2 aerosolisation as a result of oesophagogastroduodenoscopy or colonoscopy (search conducted up to 5 June)	26 studies	The aerosolisation and infectious extent of SARS-CoV-2 cannot be accurately measured, and no clinical studies have confirmed aerosol infection of SARS-CoV-2.	Aerosol-generating procedures carry a high risk of SARS-CoV-2 transmission via direct contact, droplets in air and on surfaces.
Kay JK 2020	yes	What is the evidence for minimizing the use of flexible laryngoscopy during the coronavirus disease 2019 pandemic? (search conducted up to April 2020)	No studies provided data for SARS-CoV-2 transmission during flexible laryngoscopy.	A paucity of data regarding the risks of SARS-CoV-2 aerosolization and transmission during endoscopic procedures of the aerodigestive tract	More research is needed.
Schünemann HJ	yes	To review multiple streams of evidence regarding the benefits and harms of ventilation techniques for coronavirus infections, including that causing COVID-19 (search conducted up to 1 May) .	123 eligible studies (45 on COVID-19)	Evidence suggests an increased risk for transmission of coronaviruses with invasive procedures. An additional 34 studies in COVID-19 patients were found, by their methods and reporting were too poor to synthesize data appropriately.	Direct studies in COVID-19 are limited and poorly reported.
Ventilation, air conditioning filtration and recirculation (n=3)					
Mousavi EH 2020	no	What is the safety of air filtration and air recirculation in healthcare premises. (search methods and date not clear)	109 documents categorized into five levels	Evidence to support current practice is very scarce. No randomized trials were retrieved and most experiments were designed to try to prove airborne transmission as opposed to test the null hypothesis. Observational evidence and animal studies showed contaminated air can result in disease spread, and the combination of air filtration and recirculation can reduce this risk.	There is a need for a rigorous and feasible line of research in the area of air filtration and recirculation in healthcare facilities.
Chirico F 2020	no	What is the impact of heating, ventilation and air conditioning systems (HVAC) on transmission of coronaviruses (search conducted 11 July)	Six studies on SARS-CoV-2	In three of six studies of SARS-CoV-2, the heating and ventilation system was suspected to aid transmission; in two studies the data did not support such an effect, and in one study only modelling suggested an impact	The differences in HVAC systems prevent generalization of the results. The few investigations available do not provide sufficient evidence that SARS-CoV-2 can be transmitted by HVAC systems.
Correia G 2020	no	What is the impact of HVAC in hospitals or healthcare facilities on the spread of the virus. (search methods and date not clear)	Unclear. Theoretical possibility that aerosolized particles containing SARS-CoV-2 could contribute to sporadic cases of COVID-19 infection.		The authors speculate that incorrect use of HVACs might contribute to the transmission of the virus.

Table 3. Quality of included studies.

Study	Is the source popn adequately described	Description of methods and sufficient detail to replicate	Samples sources clear and quantified	Analysis & reporting outcomes appropriate	Was follow up sufficient
Ahn JY 2020	Yes	Yes	No	Unclear	Not Applicable
Bays D 2020	Yes	Yes	Not Applicable	Yes	Yes
Binder 2020	Yes	Yes	Yes	Yes	Yes
Charlotte N 2020	Yes	Unclear	Not Applicable	Unclear	Yes
Cheng VCC 2020a	Yes	Yes	Yes	Yes	Not Applicable
Cheng VCC 2020b	Unclear	Yes	Yes	Unclear	Not Applicable
Chia PY 2020	Yes	Yes	Yes	Yes	Not Applicable
Chirizzi D 2020	Not Applicable	Yes	Yes	Yes	Not Applicable
Declementi M 2020	Yes	Yes	Yes	Yes	Not Applicable
De Man P 2020	Unclear	Yes	Not Applicable	Unclear	Not Applicable
Di Carlo P 2020	Not Applicable	Yes	Yes	Yes	Not Applicable
Ding Z 2020	Yes	Yes	Yes	Unclear	Not Applicable
Döhla M 2020	Unclear	Yes	Yes	Unclear	Not Applicable
Dumont-Leblond 2020	Yes	Yes	Yes	Yes	Not Applicable
Faridi S 2020	Yes	Yes	Yes	Yes	Not Applicable
Feng B 2021	Yes	Yes	Yes	Yes	Not Applicable
Ge XY 2020	Yes	Unclear	Yes	Unclear	Not Applicable
Günther T 2020	Yes	Yes	Yes	Unclear	Yes
Guo ZD 2020	Yes	Yes	Yes	Yes	Not Applicable
Hamner 2020 and Miller SL 2020	Yes	Yes	Not Applicable	Unclear	Yes
Hernández JL 2020	Unclear	Yes	Yes	Yes	Not Applicable
Horve PF 2020	Yes	Yes	Yes	Yes	Not Applicable
Hu J 2020	Yes	Yes	Yes	Unclear	Not Applicable
Jiang Y 2020	Yes	Yes	Unclear	Unclear	Not Applicable
Jin T 2020	Yes	Yes	Yes	Yes	Not Applicable
Kang M 2020	Yes	Yes	Unclear	Unclear	Not Applicable
Kenarkoohi A 2020	Yes	Yes	Yes	Unclear	Not Applicable
Kim UJ 2020	Yes	Yes	Yes	Yes	Not Applicable
Kwon KS 2020	Yes	Yes	Not Applicable	Yes	Yes
Lednický JA 2020a	Yes	Yes	Yes	Unclear	Not Applicable
Lednický JA 2020b	Yes	Yes	Yes	Unclear	Not Applicable
Lei H 2020	Yes	Yes	Yes	Yes	Not Applicable
Li Y & Qian H 2020	Yes	Yes	Not Applicable	Yes	Yes
Li YH & Fan YZ 2020	Yes	Yes	Yes	Yes	Not Applicable
Lin G 2020	Yes	Yes	Not Applicable	Yes	Not Applicable
Liu Y, Ning Z 2020	Yes	Yes	Yes	Yes	Not Applicable

Study	Is the source popn adequately described	Description of methods and sufficient detail to replicate	Samples sources clear and quantified	Analysis & reporting outcomes appropriate	Was follow up sufficient
Lu J 2020	Yes	Unclear	Not Applicable	Unclear	Not Applicable
Luo K 2020	Yes	Yes	Not Applicable	Yes	Yes
Ma J 2020	Yes	Yes	Yes	Yes	Not Applicable
Marchetti 2020	Yes	Yes	Unclear	Unclear	Not Applicable
Masoumbeigi 2020	Yes	Yes	Yes	Yes	Not Applicable
McGain F	Yes	Yes	Unclear	Unclear	Not Applicable
Moreno 2020	Not Applicable	Yes	Yes	Yes	Not Applicable
Morioka S 2020	Yes	Yes	Not Applicable	Unclear	Not Applicable
Mponponsuo K 2020	Yes	Yes	Not Applicable	Yes	Yes
Nakamura K 2020	Yes	Yes	Yes	Yes	Not Applicable
Nissen K 2020	Yes	Unclear	Yes	Unclear	Not Applicable
Ogawa Y 2020	Yes	Yes	Yes	Yes	Yes
Ong SWX 2020	Yes	Yes	Yes	Yes	Not Applicable
Orenes-Piñero E 2020	Yes	Yes	Not Applicable	Yes	Not Applicable
Razzini K 2020	Yes	Yes	Yes	Yes	Not Applicable
Santarpia JL 2020a	Yes	Yes	Yes	Unclear	Not Applicable
Santarpia JL 2020b	Yes	Yes	Yes	No	Not Applicable
Setti L 2020	Not Applicable	Yes	Yes	Yes	Not Applicable
Seyyed Mahdi SM 2020	Yes	Yes	Yes	Unclear	Not Applicable
Shen Y 2020	Unclear	Yes	Not Applicable	No	Unclear
Song Z 2020	Unclear	Yes	Yes	Yes	Not Applicable
Tan L 2020	Yes	Yes	Yes	Unclear	Not Applicable
Wei L 2020a	Yes	Yes	Yes	Yes	Not Applicable
Wei L 2020b	Yes	Yes	Yes	Yes	Not Applicable
Wong JCC 2020	Yes	Yes	Unclear	Yes	Not Applicable
Wong SCY 2020	Yes	Yes	Not Applicable	Yes	Yes
Wu S 2020	Yes	Unclear	Yes	Unclear	Not Applicable
Yuan XN 2020	Unclear	Unclear	Unclear	Unclear	Not Applicable
Zhang D 2020	Yes	Unclear	Yes	Unclear	Not Applicable
Zhou J 2020	Yes	Yes	Yes	Yes	Not Applicable
Zhou L 2020	Yes	Yes	Yes	Yes	Not Applicable
Total	56	60	46	39	11
	67	67	67	67	67
	83.6%	89.6%	68.7%	58.2%	16.4%

Figure 2. Risk of bias (n=67).

Table 4. Concentrations of PCR samples recovered (n=25).

Study (n=64)	Cycle Threshold (Ct)	Copies per m ³ (or L)
Binder 2020	Sample at 1.4m, <4μM: 1st 36.6; 2nd 37.1 Sample at 2.2m, <4μM: 1st 37.4, 2nd 39.9 Sample at 2.2m, >4μM: 1st 39.1, 2nd 39.6	
Chia PY 2020		range 1.84 × 10 ³ to 3.38 × 10 ³ RNA copies/m ³
Chirizzi D 2020		<0.8 copies/m ³ for each size range.
Ding Z 2020		RNA copies for weakly positive sample not calculated.
Dumont-Leblond N 2020	N gene (range 36.5 to 39.8) mean 38.0 ORF1b gene (32.1 to 35.2) mean 33.7	8 positives for both N and Orf1b (range 9.9 to 514.2) mean 201.6 genomes /m ³
Feng B 2020		<1 μm: 1,111 copies/m ³ >4 μm: 744 copies/m ³
Ge XY 2020	ICU: Ct 36.5 - 37.8	
Guo ZD 2020	Indoor air near air outlet: Ct 35.7, Near patients: Ct 44.4. Near the doctor's office area: Ct 12.5	Indoor air near the air outlet: 3.8/L near the patients: 1.4/L near the doctor's office area: 0.52/L
Horve PF 2020		The highest abundance sample (~245 gene copies) found on the pre-filters,
Hu J 2020		range 1.11 × 10 ³ to 1.12 × 10 ⁴ copies/m ³ In 10% of outdoor air samples, 10 m from the doors of inpatient & outpatient buildings range 0.89 to 1.65 × 10 ³ copies/m ³
Kenarkoohi A 2020	Ct around 38 for ORF1ab Ct around 35 for n gene	

Study (n=64)	Cycle Threshold (Ct)	Copies per m ³ (or L)
Lednický JA 2020a	Ct 36.0, 37.7, 37.4, 38.7, respectively (mean Cq 37.5)	Four positives contain: 2.82E+03, 9.12E+02, 1.15E+03, 4.68E+02 genome equivalents/25 µL,
Lednický JA 2020b	Ct 39.1	0.87 virus genome equivalents L ⁻¹
Lei H 2020	Near the head of the patient Ct 41.25.	
Liu Y & Ning Z 2020		ICU: range- 0 -113 copies/m ³ Patient areas 0 -19 copies/m ³ Medical Staff Areas 0 – 42copies/m ³ Public areas: 0 -11copies/m ³
Ma J 2020	Exhaled Breath Samples, 14 positives: Ct 35.5 ± 3.14	Breath emission rate estimate: 1.03 × 10 ⁵ to 2.25 × 10 ⁷ viruses per hour. Air sample estimate 6.1 × 10 ³ viruses/m ³
Moreno T 2020		genome count range 14 to 446/m ² for IP2, 9 to 490/m ² for IP4 and 5 to 378/m ² for E. Subway: 1st sample estimate 23.4 GC/m ³ , 2nd amplified target gene IP2 (18.8 GC/m ³) & protein E (5.6 GC/m ³).
Nissen K 2020	Ct N gene: 35.3 Ct E gene 33.2 Ward 1 specimen Ct 33.0 for E gene only.	
Orenes-Piñero E 2020	Ct from surfaces > 10 cycles of those obtained from the patient, indicating viral load was lower in the room environment.	
Razzini K 2020	ICU: Mean Ct 22.6 Corridor: Mean Ct 31.1	
Santarpia JL 2020a		concentrations up to around 7.5 TCID ₅₀ / m ³ of air.
Santarpia JL 2020b		gene copies generally low and highly variable from sample to sample ranging from 0 to 1.75 copies/µL
Seyyed Mahdi SM 2020		Highest RNA concentrations observed between beds 6 and 7 (3,913 copies per ml)
Zhang D 2020		Range 285 to 1,130 copies/m ³ . Inside adjusting tank 285 copies/m ³ and 603 copies/m ³ . 5 m from Hospital outpatient building 1,130 copies/m ³ , 5 m from the inpatient building undetected
Zhou J 2020		101 to 103 copies/m ³ of SARS-CoV-2 RNA in all air samples; no significant difference between sample areas.

2020 *et al.* reports in the intensive care unit the mean Ct was 22.6, and Guo ZD 2020 *et al.* report a Ct of 12.5 near the doctor's office area. Ten studies report Ct values > 35; two [Guo ZD 2020, Lei H 2020] report Ct > 40, and three studies [Dumont-Leblond 2020, Kenarkoohi 2020, Nissen 2020] report the detection of single genes.

Table 5 shows eight studies reporting the size of detectable particles containing RNA [Binder 2020, Chia PY 2020, Chirizzi D 2020, Feng B 2020, Hernández JL 2020, Liu Y & Ning Z 2020, McGain F 2020, and Santarpia 2020a]. Overall, the methods used for air sampling were heterogeneous across the studies. SARS-CoV-2 RNA was detectable in a

range of air sample sizes from <1 µm through to >18 µm. Seven studies detected particles below <4 µm, and Chirizzi D 2020 *et al.* reported on coarse particles up to diameter > 18 µm. In one study, different samplers detected different size particles: McGain F 2020 *et al.* reported that the APS detected larger aerosols (> 0.37 µm) and MiniWRAS smaller particles (0.01–0.35 µm) (see Figure 3).

We found 36 different descriptions of air samplers deployed: the two most used samplers were the MD8 sampler, Sartorius, Goettingen, Germany (n=7 studies) and the National Institute for Occupational Safety and Health (NIOSH) BC 251 Aerosol sampler (n=6 studies) (see Extended data: Appendix 4¹⁰). One study

Table 5. The size of air particles in the sample (n=8).

Study (n=64)	Samples Source	Size of air particles
Binder 2020	8 National Institute for Occupational Safety and Health (NIOSH) BC 251 Aerosol Samplers (Figure S3) were placed 1.5m from the ground, at ~1 meter, ~1.4 meters, ~2.2 meters, and ~3.2 meters from the SARS-CoV-2 patient's head and subsequently run for ~4 hours. 195 air samples were collected	detected in aerosols particle size <4 µm
Chia PY 2020	Air sampling was performed in three of the 27 airborne infection isolation rooms (AIIRs). Bioaerosol samplers used to collect air samples, set at a flow-rate of 3.5 L/min and run for four hours, collecting a total of 5,040 L of air from each patient's room.	positive particles of sizes >4µm and 1–4µm detected in two rooms
Chirizzi D 2020	The genetic material of SARS-CoV-2 (RNA) was determined, using both real-time RT-PCR and ddPCR, in air samples collected using PM10 samplers and cascade impactors able to separate 12 size ranges from nanoparticles (diameter D < 0.056 µm) up to coarse particles (D > 18 µm).	(D < 0.056 µm) up to coarse particles (D > 18 µm)
Feng B 2020	For a sampling of isolation room air, a NIOSH sampler was placed on a tripod 1.2 m in height and 0.2 m away from the bed at the side of the patient's head. The sampling duration was 30 min, and a total of 105-L room air was sampled. (9 Exhaled Breath (EB) samples, 8 Exhaled Breath Condensate (EBC) samples, 12 bedside air samples)	RNA detected in the air sample in <1 µm and >4 µm fractions,
Hernández JL 2020	Air sampled in three areas: Emergency area (Clinic A), Internal medicine (Clinic A), COVID 19 patient area (Clinic A), and COVID-19 patients care room (Clinic B). Sampling in all areas was accomplished in 3 h. Filters of 25 mm diameter with 0.22 µm pores were utilized (Millipore, AAWP02500), placed in a sterilized filter holder (Millipore, SWINNX) coupled to a vacuum system through a previously disinfected plastic hose, filtering the air with a flow of 9.6 L/min in each filter holder.	filtration through 0.22 µm pores.
Liu Y & Ning Z 2020	Over a 2-week period: 30 aerosol samples of total suspended particles collected on 25-mm-diameter filters loaded into styrene filter cassettes (SKC) by sampling air at a fixed flow rate of 5.0 l min ⁻¹ using a portable pump (APEX2, Casella). Three size-segregated aerosol samples collected using a miniature cascade impactor (Sioutas Impactor, SKC) that separated aerosols into five ranges (>2.5 µm, 1.0 to 2.5 µm, 0.50 to 1.0 µm and 0.25 to 0.50 µm on 25-mm filter substrates, and 0 to 0.25 µm on 37-mm filters) at a flow rate of 9.0 l min ⁻¹ . Two aerosol deposition samples collected using 80-mm-diameter filters packed into a holder with an effective deposition area of 43.0 cm ² ; filters were placed intact on the floor in two corners of an ICU for 7 days.	SARS-CoV-2 aerosols one in the submicrometre region (dp between 0.25 and 1.0 µm) and the other in supermicrometre region (dp > 2.5 µm). Aerosols in the submicrometre region were found with peak concentrations of 40 and 9 copies m ³ in the 0.25–0.5 µm and 0.5–1.0 µm range, respectively.
McGain F 2020	Two spectrometers to measure aerosol particles: the portable Mini Wide Range Aerosol Sizer 1371 (MiniWRAS) and the Aerodynamic Particle Sizer (APS). During the procedure, the aerosol detector inlet was positioned 30 cm directly above the patient's neck, representing the surgeon's breathing air space	APS detected larger aerosols (> 0.37 mm) and MiniWRAS smaller particles (0.01–0.35 mm).

Study (n=64)	Samples Source	Size of air particles
Santarpia JL 2020a	Air samplers were placed in various places in the vicinity of the patient, including over 2m distant. Personal air sampling devices were worn by study personnel on two days during sampling. Measurements were made to characterize the size distribution of aerosol particles, and size-fractionated, aerosol samples were collected to assess the presence of infectious virus in particles sizes of >4.1 μm , 1-4 μm , and <1 μm in the patient environment. An Aerodynamic Particle Sizer Spectrometer was used to measure aerosol concentrations and size distributions from 0.542 μm up to 20 μm . A NIOSH BC251 sampler ¹⁸ was used to provide size segregated aerosol samples for both rRT-PCR and culture analysis.	Two of the 1-4 μm samples demonstrated viral growth, between 90% and 95% confidence

Figure 3. The relative size of particles.

used four different methods [Ding Z 2020], and in seven studies the sampler used was unclear [Hernández JL 2020, Horve PF 2020, Kang M 2020, Kwon KS 2020, Seyyed Mahdi SM 2020, Tan L 2020 and Zhang D 2020].

Hospital/Health Center. There were 50 studies conducted in healthcare settings: 45 studies included binary RT-PCR air samples: 42 hospitals, 1 hospital outdoor environment, 1 hospital indoor and outdoor environment and 1 student healthcare centre): 45 studies included binary RT-PCR air samples (42 hospitals, 2 outdoors and 1 student healthcare centre).

Of the 42 studies that reported air sampling RT-PCR data within a hospital/healthcare environment, 24 (57%) reported

positive samples (142 positives out of 1,403 samples: average 10.1%). Samples taken per study varied from 2 to 135. In two studies [Ahn 2020 and Santarpia JL 2020b] the denominator was unclear. There was no pattern observed in terms of the type of hospital setting (ICU versus non-ICU) and RT-PCR positivity. Three studies involving ICUs reported 0% of samples were positive [Ma J, Song Z, Wu S] (see Figure 4).

Two studies conducted in hospitals also sampled other spaces. Liu Y & Ning Z *et al.* reported 4/13 public areas were RT-PCR positive; Ma J *et al.* reported 1 positive sample from an unventilated quarantine hotel toilet room out of 26 samples taken. Zhang D *et al.* sampled the outdoor environment of three

Figure 4. Percentage hospital air samples positive for SARS-CoV-2 RNA (n=42). Red bars indicate studies sampling ICUs.

hospitals and reported 3/16 samples were RT-PCR positive. Lednicki JA 2020b sampled in a respiratory infection evaluation area of a student healthcare center and reported one positive sample with a CT of 39 (virus genome equivalent of 0.87 virus genomes L^{-1} air).

Two studies reported on Exhaled Breath Condensate (EBC). Ma J *et al.* reported 14/52 EBC samples as RT-PCR positive and Feng B *et al.* reported 2/8 positive EBC samples. Five studies conducted in hospitals did not attempt RT-PCR air sampling [Bays D 2020; McGain F 2020; Mponponsuo K 2020; Ogawa Y 2020 and Wong SCY 2020]. In Lei H *et al.*, it was not possible to separate air from surface sample results.

Community. Seventeen studies reported data in community settings (see Figure 1). Of these studies, 15 were conducted in indoor settings: choir practice (2), care home (1), inside a bus (3), quarantine households (1), meat processing plant (1), block of flats (2), restaurant (3), buses and subway trains (1), and home residence (1); three studies were conducted in outdoor settings: public places (1), industrial outdoor (1) and outdoor in a working/residential area (1).

Seven of these studies undertook RT-PCR sampling [Di Carlo P 2020: inside a bus; Dohla M 2020: quarantined households; Kang M 2020: a block of flats; Kwon KS 2020: the community; Moreno T 2020: buses and subway trains; Setti L 2020: outdoor sampling; and Wong JCC 2020: in the home residence], and one Chirizzi D 2020 sampled atmospheric concentrations.

Of the eight studies, two reported positive RT-PCR samples (5 of 125 samples positive for 2 or more genes, average 4.0%), and one Chirizzi 2020 *et al.* found outdoor atmospheric concentrations of SARS-CoV-2 RNA at low levels <0.8 copies m^{-3} . Moreno 2020 *et al.* sampled on buses and subway trains in Barcelona, and reported samples were mainly positive for only 1 of the 3 RNA targets, and Setti *et al.*, in a study of outdoor sampling, reported 20/34 (59%) Particulate Matter (PM) samples were RNA positive for one gene, and 4/34 (11.8%) were positive for two genes (see Table 1). Five studies found no positive samples [Di Carlo P 2020; Dohla M 2020; Kang M 2020, Kwon KS 2020 and Wong JCC 2020].

Indoor. Three studies reported on two choir practices and potential air transmission. Charlotte N *et al.* followed-up a

choir practice in France with 27 participants who attended a choir practice on 12 March 2020. Two separate publications [Hamner L 2020 and Miller SL 2020] published on the same Choir Practice Skagit County, Washington, USA. In total, 78 members attended two practices: 87% of choir members subsequently became ill (32 confirmed cases and 20 probable secondary cases).

Viral culture. Ten studies attempted viral culture [Binder 2020, Dohla M 2020, Dumont-Leblond N 2020, Hu J 2020, Lednický JA 2020a, Lednický JA 2020b, Nissen K 2020, Santarpia JL 2020a, Santarpia JL 2020b, Zhou J 2020]. In seven of the ten studies, infectious virus could not be isolated and cytopathic effects could not be observed [Binder 2020, Dohla M 2020, Dumont-Leblond N 2020, Hu J 2020, Nissen K 2020, Santarpia JL 2020b and Zhou J 2020] (see [Table 6](#)).

Of the remaining three studies, Lednický JA 2020b reported that general virus-induced cytopathic effects were observed within two days post-inoculation. The amount of virus present in 390 L of sampled air was low (approximately 340 virus genome equivalents). RT-PCR for SARS-CoV-2 RNA from the cell culture were negative, and three other respiratory viruses were identified: Influenza A H1N1, Influenza A H3N2, and human coronavirus OC43.

Lednický JA 2020a observed presumed virus-induced CPE for 4/4 RNA-positive hospital air samples. The authors report that plaque assays could not be performed due to a nationwide non-availability of some critical media components in the USA. They also report that it took 6 to 11 days post-inoculation before rounding of the cells was observed with material collected by the air sampler and there is no report of a serial subculture of the positive air samples to demonstrate propagation of a competent replicating virus.

Santarpia JL 2020a reported 3/39 aerosol samples (particle size <1 µm) that cell culture resulted in increased viral RNA at very low levels. An intact virus was observed via transmission electron microscopy in the submicron sample from one room. This study was published as a preprint (checked 5 March 2021) and is subject to methodological criticisms. Serial RT-PCR of cell culture supernatant was unclear and incongruent with the statement that some increase in viral RNA may have occurred. No size-fractionation techniques were used to determine the size range of SARS-CoV-2 droplets and particles. ([Table 7](#) sets out several methodological issues relating to viral culture).

Discussion

We identified 67 primary studies, all were observational and of low quality. The results show that RT-PCR RNA can be detected sporadically in airborne samples in a variety of settings. About half the studies did not detect RNA positivity. Some of the reasons for this may be methodological weaknesses in the study design, the lack of validated methods and the location and variable distance of the sampling methods. We have proposed a framework for reporting studies

that assess causality that we believe could help strengthen the methods used for conducting and reporting respiratory virus transmission research¹⁴. There was no clear relationship between the type of setting and positivity of sampling or detectable viral RNA concentrations. The reporting of viral RNA concentrations was very heterogeneous as were the sampling methods.

Past attempts to detect infectious particles have proved difficult: aerosols are dilute and culturing fine particles is problematic. In a NEJM editorial, Roy *et al.*, report ‘the only clear proof that any communicable disease is transmitted by aerosol came from the famous experiment by Wells, Riley, and Mills in the 1950s, which required years of continual exposure of a large colony of guinea pigs to a clinical ward filled with patients who had active tuberculosis¹⁵’. A 2019 review reported that viral RNA or DNA, depending on the virus, could be found in the air near patients with influenza, respiratory syncytial virus, adenovirus, rhinovirus, and other coronaviruses but rarely reported viable viruses¹⁶. For coronaviruses, previous review evidence supporting the airborne route of transmission is weak¹⁷; however, it should be noted that this review was published before the COVID-19 pandemic.

Several studies included in our systematic review and reported in the tables, do not support the airborne transmission hypothesis. An included US study performed active case finding from two index patients and 421 exposed HCWs [Bays D 2020]. Eight secondary infections in HCWs were reported, but despite multiple aerosol-generating procedures, there was no evidence of airborne transmission. No transmission events were found in multiple high-risk exposures from five symptomatic COVID-19 health care workers with low Ct values [Mponponsuo K 2020]; Wong SCY *et al.* reported none of 120 contacts of a patient with initially undetected COVID-19 subsequently became infectious, and Kim UJ *et al.* reported that all 52 air samples were negative for SARS-CoV-2 RNA.

Strengths and limitations

There is a current lack of well-conducted studies addressing airborne transmission: only nine studies identified during the search period reported air sampling outdoors and in the environment, outside of hospitals. The findings of our review are limited by the low-quality included studies that lack standardised methods, reporting and outcomes. The small sample sizes, the absence of study protocols and the lack of replication further undermine the findings. Sporadic isolation of viral RNA may be due to problems with sampling techniques. Lack of quality is noted across several of the airborne reviews. Furthermore, while our search was comprehensive, it is likely there are studies that we have missed. We excluded study designs/settings that attempted to detect SARS-CoV-2 via other methods apart from air sampling, e.g., virus stability, outbreak reports, aircraft outbreaks, non-pharmaceutical intervention, experimental infection, air tracer studies and computational modelling/simulation. Our continual updating and scoping of the literature mean we intend to update this review as more studies and evidence become available.

Table 6. Viral culture methodological issues.

Study	Methodological
Binder 2020	This study separated particles by three sizes: >4 µm, 1–4 µm, and <1 µm and used multiple sampling sites which is a robust sampling methodology. The median day's post symptom was reported as 10 with a range of 1 to 34 days, and only one patient had a cycle threshold for the N gene < 20. This limits the finding of any cultivatable virus and the conclusions.
Hu J 2020	All positive masks were subject to cell culture and inoculated with Vero-E6 cells after blind passage for three generations which is a robust approach. One mask from a critically ill patient was positive for the virus but no details on which passage and at what quantitative burden. The masks could have been contaminated by saliva or nasal secretions and the conclusion stated that masks blocked the release of viable virus in the air exhaled from the patient cannot be confirmed.
Lednický 2020a	The authors reported that plaque assays could not be performed due non-availability of the components which make up the culture media in the USA at the time of the study. Three serial 3-hr air samplings were performed. Over the 9 hours, it is likely patients would have moved about and may have been in close proximity to the samplers. The method does not mention particle sizing for the sampler (ie < or > 5 microns) and the sampled particles could be any size and hence it is difficult to state they were true aerosols. No data are provided about health workers who may have been in the room and might have handled the air samplers. Samples were not done at 0.5 m to 1 metre to see if there was a gradient effect. It was noted it took 6 to 11 days post-inoculation before rounding of the cells with material collected by the air sampler and there is no report of a serial subculture of the positive air samples to demonstrate a healthy and propagating virus. Nothings is presented about testing the air sampling isolates in susceptible animal models.
Santarpia JL 2020a and b	<p>For Santarpia 2020 a we could only find a preprint publication. A large number of samples were collected. Serial PCR of cell culture supernatant was unclear and incongruent with the statement that some increase in viral RNA may have occurred. Increased viral RNA presence is a surrogate and subject to many interpretations and should not be considered equal to the cultivation of replication and infection competent virus on cell culture which was not identified. Western blot assay was not done in cell supernatant samples with non-statistically significant evidence of replication, which would have acted as a control to ensure the findings were not spurious. Western blots are very weak, with no positive control or size markers and the signal doesn't necessarily come from a replicating virus, there's no "before culture" analysis.</p> <p>The presence of virus-like particles on TEM is not proof that these are replicating viruses or necessarily even SARS-CoV-2. No comparisons to control TEM photomicrographs of the live virus from fresh Vero cells are presented to discuss.</p> <p>No information is provided about activity by either patients or the doffing by health workers which may have contributed to hallway air samples being PCR positive. The contamination identified may have accumulated over the extended periods of occupancy and may represent the high frequency of reported PCR positive sites, Floor samples were most heavily reported which supports this finding. The numbers don't match up, Ct values were converted to pseudo TCID50 values based on an equation that obscures what Cts were actually recorded. Reporting 100% or 200% increases in RNA levels is actually only 2–3 fold, and not the way viruses replicate (i.e. exponentially).</p> <p>Neither plaque assay nor serial passage was attempted in the study. Statistical inferences are very difficult to interpret in Figure 1 based on the error bars. The broad sweeping conclusions that SARS-CoV-2 RNA exists in respired aerosols less than 5 µm in diameter; that aerosols containing SARS-CoV-2 RNA exist in particle modes that are produced during respiration is difficult to justify based on the findings presented.</p> <p>In Santarpia 2020 b here are "six patients in five rooms in two wards on three separate days in April of 2020" reported in the text. Table S1 reports are 6 rooms (2 are 7A and 7B and 4 are 5A-D). The abstract reports SARS-CoV-2 RNA was detected in all six rooms – It is therefore not clear whether there are 6 rooms or 5 – One room had 2 patients so the total could be 7 not 6 patients</p> <p>There is no information in the patients and sampling is done 2–24 days post the 1st COVID-19 test and looks like 4 were sampled less than 3 days post first covid test but there is no information of symptom onset. No ct values were provided on the testing of the pts when first done. A Ct of 45 for E gene is not considered a usual standard and much higher than what most labs use and accept and a lot of background "noise" as a result</p> <p>It is likely an equation as used to calculate the concentration of the virus, however, it is more robust to measure the virus directly than use an equation. EM also does not confirm live virus and does not indicate active viral replication as the authors suggest – where are the comparisons to control EM photomicrographs.</p>
Zhou J 2020	No indication any particle size-fractionation techniques were used to determine the size range of droplets and particle differentiation in air sampling. No information on patients is provided and it is possible they were in the later stages of illness when no virus could be reliably cultivated. All surface and air samples from the hospital environment had a Ct value >30, in a range where it is extremely difficult to cultivate the virus. No attempt was made to ensure the sampler was placed at a specific distance from the individuals.
(Wang W, Xu Y 2020 and (Xiao F, Sun J 2020)	Electron microscopy alone does not proof of an infectious virus. Inactivated particles would look the same, and images weren't provided in these studies.

Table 7. Live culture results (n=10).

Study (n=64)	Setting	Method	Air Samples positive n/d for SARS-CoV-2 RNA	Live culture	Notes
Binder 2020	Hospital	An observational case series of 20 patients hospitalized with coronavirus disease	3/195 samples from 3 patients	0/3 viable virus	
Dohla M 2020	Quarantined households	An observational study of 43 adults and 15 children living in 21 households; air (also surface and wastewater) samples taken.	0/15	The infectious virus could not be isolated in Vero E6 cells from any environmental sample.	26 of all 43 tested adults were positive by RT-PCR. 10 of 66 wastewater samples and 4/119 surface swab samples were positive for SARS-CoV-2
Dumont-Leblond N 2020	Hospital	An observational study in acute care hospital rooms over the course of nearly two months	11/100 from 6 patient rooms	Viral cultures were negative	
Hu J 2020	Hospital	An observational study: indoor and outdoor air samples in ICUs and CT rooms	aerosol samples 8/38 from ICUs 1/6 from CT rooms samples from medical staff rest areas and corridors were all negative (denominator not clear)	All positive aerosol samples were negative after three passages of Vero-E6 cells inoculated in a blind test.	All positive masks were subjected to cell culture and inoculated with Vero-E6 cells after blind passage for three generations. One mask from a critically ill patient detected positive.
Lednicky JA 2020a	Hospital	Observational: air samples collected, and virus culture attempted	4/4 air samples without a HEPA filter 0/2 samples using a HEPA filter	Virus-induced CPE was observed for 4/4 RNA-positive air samples.	No other respiratory virus was identified in the samples using a BioFire FilmArray Respiratory 2 Panel. The amount of airborne virus detected per litre of air was small. Plaque assays could not be performed due to a nationwide nonavailability of some critical media components (due to COVID-19 pandemic-related temporary lockdown of production facilities), so TCID50 assays were performed in Vero E6 cells to estimate the percentage of the collected virus particles that were viable. Estimates ranged from 2 to 74 TCID50 units/L of air
Lednicky JA 2020b	Student Healthcare centre	Observational, air samples collected, and virus culture attempted	1/2 air samples	General virus-induced cytopathic effects were observed within two days post-inoculation	Estimated concentration of 0.87 virus genomes L ⁻¹ air. The amount of virus present in 390 L of sampled air was low (approximately 340 virus genome equivalents). PCR tests for SARS-CoV-2 vRNA from cell culture were negative. Three respiratory viruses were identified using the Biofire RVP: Influenza A H1N1, Influenza A H3N2, and Human coronavirus OC43

Study (n=64)	Setting	Method	Air Samples positive n/d for SARS-CoV-2 RNA	Live culture	Notes
Nissen K 2020	Hospital	Observational: surface swabs and fluid samples collected, and experimental: virus culture was attempted.	7/19 filter were positive 11 days later, 4/19 were positive for both genes.	No significant CPE was seen after three passages on Vero E6 cells from samples retrieved from ward vent openings or central ventilation ducts or filters	Cycle threshold (Ct) values varied between 35.3 and 39.8 for the N and E gene. Virus culture was attempted: RNA detected in sequential passages but CPE not observed.
Santarpia JL 2020a	Hospital	Observational: size-fractionated aerosol samples collected; experimental: virus culture was attempted.	6/6 patient rooms.	In 3 aerosol samples size <1 µm, cell culture resulted in increased viral RNA. Viral replication of aerosol was observed in the 1 to 4 µm size but did not reach statistical significance.	The presence of SARS-CoV-2 was observed via western blot for all but one of the samples (<1 µm, with statistically significant evidence of replication, by rRT-PCR. The intact virus was observed via TEM in the submicron sample from Room.
Santarpia JL 2020b	Healthcare centre	Observational: high-volume (50 Lpm) and low-volume (4 Lpm) personal air samples (& surface samples) collected from 13 Covid-19 patients; experimental: virus culture was attempted.	63% of in-room air samples positive (denominator unclear)	Due to the low concentrations recovered in the samples cultivation of the virus was not confirmed in these experiments. *	Partial evidence of virus replication from one air sample. In the NBU, for the first two sampling events performed on Day 10, the sampler was placed on the window ledge away from the patients and was positive for RNA (2.42 copies/L of air). On Day 18 in NBU Room B occupied by Patient 3, one sampler was placed near the patient and one was placed near the door greater than 2 meters from the patient's bed while the patient was receiving oxygen (1L) via nasal cannula. Both samples were positive by PCR, with the one closest to the patient indicating a higher airborne concentration of RNA (4.07 as compared to 2.48 copies/L of air).
Zhou J 2020	Hospital	Observational: (air & surface) samples collected from a hospital with a high number of Covid-19 inpatients.	2/31 air samples positive 12/31 suspected	0/14	We defined samples, where both of the PCRs performed from an air or surface sample, detected SARS-CoV-2 RNA as positive, and samples where one of the two PCRs performed from an air or surface sample detected SARS-CoV-2 RNA as suspected

Evidence from the referenced systematic reviews noted the need to improve the quality of evidence. Anderson *et al.* reported the need for further data collection under differing conditions of temperature and humidity¹⁸. Carducci *et al.* considered no studies had sufficient confirmatory evidence, and only a hypothesis supports airborne transmission¹⁹. Schünemann *et al.* noted direct studies in COVID-19 are limited and poorly reported²⁰, and Mousavi *et al.* noted the need for rigorous and feasible lines of research in the area of air filtration and recirculation in healthcare facilities²¹.

Future studies are warranted to verify findings (particularly including viral culture) before conclusions can be reached about a mode of transmission and important knowledge such as infectious dose. Because of the heterogeneity of the settings, the case-mix limitations, the sampling techniques used, the lack of clear descriptions and variable study protocols, it is difficult to make meaningful comparisons of air sampling positivity or viral concentrations between settings. Many factors including relative humidity, temperature, aerosolization medium, exposure period, the chemical composition of the air, seasonality, sampling methods, and ultraviolet light exposure can affect the potential infectivity of airborne viruses. While sampling techniques have improved greatly over time, the lack of standardization requires addressing as it limits the development of general recommendations for the sampling of airborne viruses²².

One essential question is whether observed epidemiologic associations are causal^{23,24}. Establishing transmission modes requires integrated epidemiological and mechanistic approaches to narrow uncertainty⁹. Transmission evidence should be context-specific to particular settings (i.e., indoor or outdoor), environment-specific (i.e., the presence of UV light, ventilation etc.) and should ensure that there is evidence of exposure to a transmissible agent. Identifying those circumstances that promote transmission using all relevant evidence that would be more likely to promote viral transmission is important, as well as for identifying interventions. Any study based on epidemiological associations necessitates confirmation from whole genome sequencing. Sequencing has repeatedly shown that outbreaks initially thought to share a single origin were, in fact, the product of multiple independent infection events.

Methodological issues of the culture methods used, as well as knowledge of the infectiousness of the patient hinder interpretation and suggest that the results should be interpreted with caution. The detection of SARS-CoV-2 RNA in the air cannot presume transmission, since only infectious virions can cause disease. None of the included studies definitively demonstrated that SARS-CoV-2 can be recovered in the air, which offers the most robust evidence of transmissibility²⁵. CPE alone cannot be relied upon to establish SARS-CoV-2 replication and additional methods are required, including demonstration of viral growth on

permissive cell lines, immunofluorescence staining, and confirming the exclusion of other pathogens or contaminants with sequence confirmation. General virus-induced cytopathic effects were observed in one study, however, RT-PCR tests for SARS-CoV-2 were negative while three other respiratory viruses were identified²⁶.

Conclusion

SARS-CoV-2 RNA can be detected intermittently by RT-PCR in the air in a variety of settings. A number of studies that looked for viral RNA in air samples found none, even in settings where surfaces were found to be contaminated with SARS-CoV-2 RNA. The lack of recoverable viral culture samples of SARS-CoV-2 prevents firm conclusions to be drawn about airborne transmission. The current evidence is low quality, and there is an urgent need to standardise methods and improve reporting.

Data availability

Underlying data

All data underlying the results are available as part of the article and no additional source data are required.

Extended data

Figshare: SARS-CoV-2 and the Role of Airborne Transmission: Systematic review, <https://doi.org/10.6084/m9.figshare.14248055.v2>¹⁰.

This project contains the following extended data:

- Appendix 1: Updated protocol
- Appendix 2: Search strategy
- Appendix 3: References of included studies
- Appendix 4: Sampling methods

Reporting guidelines

Figshare: PRISMA checklist for 'SARS-CoV-2 and the role of airborne transmission: a systematic review', <https://doi.org/10.6084/m9.figshare.14248055.v2>¹⁰.

Data are available under the terms of the [Creative Commons Attribution 4.0 International license](#) (CC-BY 4.0).

Acknowledgements

This work was commissioned and paid for by the World Health Organization (WHO). Copyright on the original work on which this article is based belongs to WHO. The authors have been given permission to publish this article. The author(s) alone is/are responsible for the views expressed in the publication. They do not necessarily represent views, decisions, or policies of the World Health Organization.

References

- WHO: **Transmission of SARS-CoV-2: implications for infection prevention precautions.** Scientific Brief. [Reference Source](#)
- Hinds WCJ: **Aerosol Technology.** John Wiley and Sons. 1982; 424.
- Tellier R: **Aerosol transmission of influenza A virus: a review of new studies.** *J R Soc Interface.* 2009; **6 Suppl 6**(Suppl 6): S783–S790. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- World Health Organization: **Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care.** [Reference Source](#)
- Xie X, Li Y, Chwang AT, *et al.*: **How far droplets can move in indoor environments—revisiting the Wells evaporation-falling curve.** *Indoor Air.* 2007; **17**(3): 211–25. [PubMed Abstract](#) | [Publisher Full Text](#)
- Wells WF: **ON AIR-borne infection: study II. Droplets and droplet nuclei.** *Am J Epidemiol.* 1934; **20**(3): 611–618. [Publisher Full Text](#)
- Kutter JS, Spronken MI, Fraaij PL, *et al.*: **Transmission routes of respiratory viruses among humans.** *Curr Opin Virol.* 2018; **28**: 142–151. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Tellier R, Li Y, Cowling BJ, *et al.*: **Recognition of aerosol transmission of infectious agents: A commentary.** *BMC Infect Dis.* 2019; **19**(1): 101. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Transmission of SARS-CoV-2: implications for infection prevention precautions. [Reference Source](#)
- Heneghan C, Spencer E, Plüddemann A, *et al.*: **SARS-CoV-2 and the Role of Airborne Transmission: Systematic review.** *figshare.* Dataset. 2021. <http://www.doi.org/10.6084/m9.figshare.14248055.v2>
- Whiting PF, Rutjes AW, Westwood ME, *et al.*: **QUADAS-2: a revised tool for the quality assessment of diagnostic accuracy studies.** *Ann Intern Med.* 2011; **155**(8): 529–36. [PubMed Abstract](#) | [Publisher Full Text](#)
- Savvides C, Siegel R: **Asymptomatic and presymptomatic transmission of SARS-CoV-2: A systematic review.** *medRxiv.* 2020; 2020.06.11.20129072. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Mahtani KR, Jefferson T, Heneghan C, *et al.*: **What is a 'complex systematic review'? Criteria, definition, and examples.** *BMJ Evid Based Med.* 2018; **23**(4): 127–130. [PubMed Abstract](#) | [Publisher Full Text](#)
- Jefferson T, Heneghan C, Spencer E, *et al.*: **A Hierarchical Framework for Assessing Transmission Causality of Respiratory Viruses.** *Preprints.* 2021; 2021040633. [Publisher Full Text](#)
- Roy CJ, Milton DK: **Airborne transmission of communicable infection—the elusive pathway.** *N Engl J Med.* 2004; **350**(17): 1710–1712. [PubMed Abstract](#) | [Publisher Full Text](#)
- Shiu EYC, Leung NHL, Cowling BJ: **Controversy around airborne versus droplet transmission of respiratory viruses: implication for infection prevention.** *Curr Opin Infect Dis.* 2019; **32**(4): 372–379. [PubMed Abstract](#) | [Publisher Full Text](#)
- Herfst S, Böhrringer M, Karo B, *et al.*: **Drivers of airborne human-to-human pathogen transmission.** *Curr Opin Virol.* 2017; **22**: 22–29. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Anderson EL, Turnham P, Griffin JR, *et al.*: **Consideration of the Aerosol Transmission for COVID-19 and Public Health.** *Risk Anal.* 2020; **40**(5): 902–07. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Carducci A, Federigi I, Verani M: **Covid-19 Airborne Transmission and Its Prevention: Waiting for Evidence or Applying the Precautionary Principle?** *Atmosphere.* 2020; **11**(7): 710. [Publisher Full Text](#)
- Schünemann HJ, Khabsa J, Solo K, *et al.*: **Ventilation techniques and risk for transmission of coronavirus disease, including COVID-19: a living systematic review of multiple streams of evidence.** *Ann Intern Med.* 2020; **173**(3): 204–216. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Mousavi ES, Kananizadeh N, Martinello RA, *et al.*: **COVID-19 Outbreak and Hospital Air Quality: A Systematic Review of Evidence on Air Filtration and Recirculation.** *Environ Sci Technol.* 2021; **55**(7): 4134–4147. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Verreault D, Moineau S, Duchaine C: **Methods for sampling of airborne viruses.** *Microbiol Mol Biol Rev.* 2008; **72**(3): 413–44. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Howick J, Glasziou P, Aronson JK, *et al.*: **The evolution of evidence hierarchies: what can Bradford Hill's 'guidelines for causation' contribute?** *J R Soc Med.* 2009; **102**(5): 186–94. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Hill AB: **The Environment and Disease: Association or Causation?** *Proc R Soc Med.* 1965; **58**(5): 295–300. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Jefferson T, Spencer EA, Brassey J, *et al.*: **Viral cultures for COVID-19 infectious potential assessment - a systematic review.** *Clin Infect Dis.* 2020; ciaa1764. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)
- Lednicky JA, Shankar SN, Elbadry MA, *et al.*: **Collection of SARS-CoV-2 Virus from the Air of a Clinic within a University Student Health Care Center and Analyses of the Viral Genomic Sequence.** *Aerosol Air Qual Res.* 2020; **20**(6): 1167–1171. [PubMed Abstract](#) | [Publisher Full Text](#) | [Free Full Text](#)

Open Peer Review

Current Peer Review Status:

Version 2

Reviewer Report 05 October 2021

<https://doi.org/10.5256/f1000research.77065.r93516>

© 2021 Yao M. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Maosheng Yao

College of Environmental Sciences and Engineering, Peking University, Beijing, China

I just read their responses to my comments. First, a thank you to the authors for taking their valuable time to respond. Unfortunately, I found none of my critiques have been adequately answered. Thus, I feel that I do not need to further comment this paper. It seems to me that the authors are reluctant to revise their paper as commented. For most of my comments, the authors said they are out of scope of their paper, although they state that their paper is a “systematic” review. If they state many things, despite vital to the review, are out of the scope of the paper, they should at least change their paper title to something: a mini review, not a systematic review. Overall, I am not satisfied with any responses to my comments.

It is unusual to see that they refused to change their conclusion even the WHO has officially recognized the aerosol transmission of COVID-19. As another reviewer pointed out they performed a biased review. It would be very harmful if misleading statements or documents are endorsed by influential authors from prestigious institutions on a public domain especially in face of the disastrous pandemic. I think if the authors were right with their position of the COVID-19 transmission, the pandemic would already have been well under control since disinfection and 1-meter distancing were all in place across the world since March 2020. However, the reality is that the pandemic is still ravaging the world.

It is important that the paper be revised according to the comments raised by many online authors and reviewers in order to avoid causing further confusion and misleading the public on combating the pandemic. This is what I, as a reviewer, can write and can do regarding this matter.

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: I obtained a PhD in conducting bioaerosol related studies from Rutgers University; and did postdoc training at Yale in the same field. I am currently a Professor from Peking University, and has been working in bioaerosol field for about 20 years. My expertise ranges from bioaerosol sampling and detection to air pollution health effects and particulate

matter toxicity.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

Reviewer Report 16 September 2021

<https://doi.org/10.5256/f1000research.77065.r93514>

© 2021 Tomlinson D. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

David R. Tomlinson

University Hospitals Plymouth NHS Trust, Plymouth, UK

Dear Professor Heneghan and team,

Thank you for responding to my submitted comments following my review of version 1 'SARS-CoV-2 and the role of airborne transmission: a systematic review'. I hope that my responses herein to your comments and manuscript changes are of use to you and your team.

1. Re: my request for a revision to the stated definition of an aerosol.

Thank you for revising the stated definition.

Note: This additional section has been pasted into your response, but I believe this relates to comments made by reviewer 3 and was in error?

"There are varied definitions of aerosols in the published literature. An aerosol is defined as a collection of particles (liquid or solid) with varying aerodynamic diameters, suspended in the air (gas) for a prolonged period of time. The size of the particles and the distance they may travel is highly variable and depends on many factors, (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2843947/>; https://apps.who.int/iris/bitstream/handle/10665/112656/9789241507134_eng.pdf;jsessionid=41AA684FB64571CE8D...)"

Consider to add this reference Xie X, Li Y, Chwang AT, Ho PL, Seto WH. How far droplets can move in indoor environments--revisiting the Wells evaporation-falling curve. Indoor Air. 2007 Jun;17(3):211-25. doi: 10.1111/j.1600-0668.2007.00469.x. PMID: 17542834

2. Re: my request for you to address evidence of plagiarism in paragraph 2 of the introduction (55% match to text from Kutter *et al.* (2018), your original reference 4, now reference 7).

Thank you for making changes. However, the first sentence of the new text you have provided in your response does not match that of version 2 manuscript:

Your response to my review: *"Transmission via droplets and aerosols in specific settings or situations may potentiate the spread of some viruses in humans, resulting in disease outbreaks that are difficult to manage."*

Version 2 manuscript: "Transmission via **droplet nuclei** and aerosols in specific settings or situations may potentiate the spread of some viruses in humans, resulting in disease outbreaks that are difficult to manage."

I would be grateful if you could clarify which of these is the correct and final version, please. Thank you.

3. Re: my request to provide objective methodological descriptors of factors employed to determine the selection of included studies (i.e., concerns over terms including 'adequately', 'sufficient' and 'clearly defined') and assess their quality.

Thank you for providing a response to this together with my point 6: a request for 'objectively defined descriptions of 'Quality of included studies' in 'your table 3'.

You have provided a far clearer description of the methods used here and I am pleased to see your qualifying statement regarding the use of the 'QUADAS 2 risk of bias tool' towards **quality reporting** [my term], since QUADAS 2 was never intended to be used to assess study quality. Instead, it was devised towards 'more transparent rating of bias and applicability of primary diagnostic accuracy studies'¹. However, again there are differences in the text between the 'tracked changes' version 2 manuscript submitted to the F1000 editorial office, and the text in your response to my comments, as follows:

Your response: *"We assessed quality using a modified QUADAS 2 risk of bias tool⁸. We simplified the tool as the included studies were not designed as primary diagnostic accuracy studies and the quality of transmission studies is known to be low⁹."*

Version 2 manuscript: "We assessed quality using a modified QUADAS 2 risk of bias tool¹¹. We simplified the tool **because** the included studies were not designed as primary diagnostic accuracy studies, and **there is a lack of high-quality data in published transmission studies.**"

I would be grateful if you could clarify which of these is the correct and final version, please. Thank you.

In your extended description of the methods here, you have provided useful insights into how study quality was assessed, thank you. However, this new description of 'quality reporting' [my term] scoring - i.e., low / moderate / high - remains importantly imprecise. For example, under point (ii) you state:

"Methods – did the study authors sufficiently describe the methods used to enable replication of the study? E.g. methods used for diagnosing SARS-CoV-2 in patients, procedure used for air sampling, time-point for sampling, number of samples per site, cycle thresholds, culture methods, airflow/ventilation settings, humidity".

From this total of eight factors, how many of these would constitute your scoring of low vs moderate vs high quality? Similarly, under each point you have not clarified how each of the multiple stated 'quality factors' [my term] was used to achieve your final 'quality reporting'. Therefore, for your newly described study methods to be considered reproducible, these points require further clarification please. In so doing, this will also help provide assurance to readers that study quality assessment processes were without important bias. Thank you.

You later state:

"The risk of bias for each domain was rated "low", "moderate" or "high" depending on the adequacy of reporting. One reviewer (CJH) assessed the risk of bias while a second author (EAS) independently verified the risk of bias."

I believe these are typographical errors, since you had modified the QUADAS 2 risk of bias tool to assess **study quality**, not bias. I would be grateful if you would correct these sentences accordingly, please. Thank you.

One further important methodological point arises here from review of some of the new text provided in which you state:

"(v) Follow-up – was the pattern and number of air samples sufficient to demonstrate airborne transmission - e.g. repeat sampling, serial sampling?"

This newly clarified list of 'quality indicators' suggests that you consider a **single** air sample demonstrating live SARS-CoV-2 to be insufficient evidence towards airborne transmission of SARS-CoV-2. Whatever the argument regarding the purely circumstantial level of evidence afforded by air sampling studies (Kutter *et al*, your reference 7), please could you provide justification for this requirement for repeated findings of this nature? Thank you.

4. Re: my concerns over inappropriately narrow study selection criteria towards assessing the evidence base for SARS-CoV-2 airborne transmission (e.g., exclusion of laboratory studies of SARS-CoV-2 aerosol viability, animal models of transmission within controlled environmental conditions).

My concern over the difference in methodology comparing the 'Protocol for a living evidence review (Version 3: 1 December 2020)' and this present manuscript (i.e. the former stated under 'Study inclusion and exclusion': "Eligible studies should include sampling for the detection of SARS-CoV-2 in the population or the environment on any potential mode of transmission..." whereas the latter states: "We included field studies that included airborne sampling for SARS-CoV-2 in the population under study or the environment."). The former methodology permits the inclusion of studies that have formed the historical basis for investigations into the transmission routes of many human pathogens (e.g. outbreak reports within households, hospitals and/or aircraft), including the demonstration that measles is transmitted via the airborne route, whereas the latter does not).

In your response, you have not explained why you changed the protocol from that originally outlined in your online protocol and nor have you provided clarification of this methodological change in the final manuscript. I would be grateful if you could include this point in your final

manuscript, please. Thank you.

Thank you for including this sentence in version 2, study limitations:

"We excluded study designs/settings that attempted to detect SARS-CoV-2 via other methods apart from air sampling, e.g., virus stability, outbreak reports, aircraft outbreaks, non-pharmaceutical intervention, experimental infection, air tracer studies and computational modelling/simulation."

However, from a 'scientific' perspective this statement alone is insufficient: given that you have chosen to exclude methods which represent the foundational approach to historical studies towards understanding routes of pathogen transmission, you must provide a valid scientific argument for excluding each of these experimental types. Moreover, you must provide an explanation of how any resulting narrow methodological search strategy remains a valid indicator of 'real world' SARS-CoV-2 transmission characteristics, particularly since Kutter *et al.* (your reference 7) correctly state that air sampling studies – your current restricted study inclusion criterion – only provide circumstantial evidence towards airborne transmission.

Furthermore, if animal transmission studies remain excluded from your final manuscript, you must explain the scientific validity of this decision, particularly considering that transmission in animal models represents one of the 10 foundational methods employed by the Centers for Disease Control and Prevention (CDC) in its Influenza Risk Assessment Tool (IRAT) – as you know, an 'assessment tool developed by the CDC and external influenza experts that assesses the potential pandemic risk posed by influenza A viruses that currently circulate in animals but not in humans.' (source, <https://www.cdc.gov/flu/pandemic-resources/national-strategy/risk-assessment.htm>)

In addressing my concerns over the exclusion of airborne viability experiments conducted in March 2020, you state:

"Laboratory studies such as the one quoted provide insights into the stability of the virus in airborne suspensions but provide no insights into whether there exist ordinary biological mechanisms capable of generating such high-titer aerosols in the first place. The fact that one can put humans into orbit, doesn't mean it is an easily achieved or common task. It simply says humans can survive in orbit."

Thank you for clarifying your views. However, considering this explanation, your newly included reference 4 – used to better define the meaning of the term 'aerosol' – states: *"Aerosols are produced when an air current moves across the surface of a film of liquid, generating small particles at the air-liquid interface. The particle size is inversely related to the velocity of air."* (Annex A, first sentence of body text, page 37/156).

May I respectfully remind you and your co-authors that during every respiratory cycle – an 'ordinary biological mechanism' – in mammals, air currents move across the surface of a film of liquid (respiratory fluid) lining the endothelium of the respiratory tract. It is self-evident that humans create aerosols during tidal breathing. Furthermore, in experimental studies of human subjects during influenza infection dating back as far as 1966, sufficient quantities of influenza virus aerosols have been demonstrated to be released during coughing, to result in levels of environmental air contamination necessary to sustain transmission via the airborne route (Couch RB *et al.*, (1966)².

Also, a 2013 investigation of children and adults during respiratory virus infection², referenced by World Health Organisation COVID-19 Infection Prevention and Control Scientific Brief authors, July 2020 in their discussion of possible airborne transmission of SARS-CoV-2 (<https://www.who.int/news-room/commentaries/detail/transmission-of-sars-cov-2-implications-for-infection-prevention-precautions>), stated:

*"The simultaneous detection of viral RNA in small, airborne-sized (<4.7 mm) and large, droplet-sized (≥4.7 mm) particles produced on breathing and coughing by children and adults with symptomatic respiratory infections was observed in this study. Viruses detected included hRV, Influenza A virus, Parainfluenza 1 and 3 viruses and RSV"*². Using the PubMed search criteria 'cough' AND 'aerosol' demonstrates 1,392 published manuscripts since 1967-2020 inclusive.

I hope there is no further need for me to reference this extensive literature for you and your co-authors to accept that abundant aerosol release occurs during 'ordinary biological' activities including breathing, speaking, singing, coughing, and sneezing. Accordingly, it is a biological inevitability that any pathogen contained within fluid lining the respiratory tract and which demonstrates aerosol viability, has the potential for airborne transmission when the time course of its airborne viability exceeds a critical threshold. Considering that the aerosol viability experiments conducted by Van Doremalen *et al.*³ demonstrated SARS-CoV-2 survival for hours, clinically important airborne / aerosol transmission of SARS-CoV-2 is inevitable, according to these universally applicable physical laws. It will therefore probably come as no surprise to learn of more recent data from humans with COVID-19, demonstrating that: "fine aerosols [<5µm diameter) constituted 85% of the SARS-CoV-2 viral load emitted during singing, talking, or breathing."³ In short, just like SARS Coronavirus [1], SARS-CoV-2 is airborne.

Now considering your review comment:

"The inclusion of laboratory studies was not a part of our protocol but could be included as a part of a separate review but is outside the scope of our study."

This present study protocol is simply not fit for purpose when it comes to addressing the stated objective in your online Web appendix 1 Protocol for a living evidence review (Version 3: 1 December 2020): *"to provide a rapid summary and evaluation of **relevant data** [my emphasis] on transmission of SARS-CoV-2..."*. You have provided no scientifically valid justification for such a limited study protocol in your responses, and as such your study protocol must be changed to include **all** studies of relevance, i.e., as stated in my original response, virus stability, outbreak reports, aircraft outbreaks, non-pharmaceutical intervention, experimental infection, air tracer studies and computational modelling/simulation. Thank you.

5. Re: my concern over your questioning the occurrence of airborne transmission of SARS-CoV-2 according to first principles of similarity in biological properties of closely related viruses (i.e., my statement that SARS Coronavirus was proven to be airborne (2003), so SARS-CoV-2 will be airborne too).

The principle of 'concordant' biological properties of closely related viruses can be found in the 'WHO Ebola 2014 IPC guideline', which is why I included this reference in my comments. In responding to this point, you cast doubt on the proven airborne transmission of SARS

Coronavirus. I was hoping that I had perhaps misinterpreted your reply, but this statement in the discussion of your present manuscript is concerning:

"For coronaviruses, previous review evidence supporting the airborne route of transmission is weak (reference cited: Herfst et al 2017)".

Searching this quoted reference for evidence in support of this statement reveals the following (first paragraph, page 27):

'Furthermore, for some microorganisms, for example, for coronaviruses, epidemiological or experimental evidence that transmission of the pathogens via the airborne route is successful or even contributes importantly to epidemic or pandemic spread of the agent remains weak.' - Astonishingly, Herfst et al. (2017) provide no reference in support of this assertion, so this statement lacks scientific validity.

I am surprised that you were not aware of this fact, since the Herfst et al. manuscript was your choice of reference to support your assertion against airborne transmission of SARS Coronavirus. Furthermore, given some of your fellow contributing authors' expert standing in the infectious diseases / infection prevention and control community, they must be aware of the WHO declaration that 'SARS is an airborne virus' (https://www.who.int/health-topics/severe-acute-respiratory-syndrome#tab=tab_1). Accordingly, please would you explain: (1) why you have denied airborne transmission of SARS Coronavirus, given the international consensus on the existence and clinical importance of this transmission route? (2) Why did you try to support your statement by using a manuscript whose authors failed to provide a reference to support their statement: 'epidemiological or experimental evidence that transmission of the pathogens [i.e., coronavirus] via the airborne route is successful or even contributes importantly to epidemic or pandemic spread of the agent remains weak'? Thank you.

6. Re: my comment, 'your chosen methods are so importantly flawed that the present manuscript should be completely re-written using methods with greater scientific validity and including the whole range of available data towards SARS-CoV-2 transmission, as described.'

You respond as follows:

"We already have a published protocol that has been used to conduct our series of systematic reviews of studies investigating transmission dynamics of COVID-19."

As described in detail above, you have importantly deviated from this original protocol without providing suitable justification on scientific grounds. Furthermore, the objectives of this present systematic review (i.e., 'to provide a rapid summary and evaluation of relevant data on transmission of SARS-CoV-2', from the Web Appendix 1, Protocol for a living evidence review Version 3: 1 December 2020) cannot be met using such restricted study inclusion criteria.

You continue:

"However, our research is ongoing, the quality of the evidence and methods have changed over time and we make necessary adjustments to improve the robustness of the evidence as more studies (and

evidence) become available (and examined)."

I am glad that your team's research is ongoing, since this meets your stated aim: *'there is a need to continuously and systematically conduct reviews of publicly available studies with the latest knowledge from publications to inform WHO recommendations using the most up-to-date information.'* (Web Appendix 1, Protocol for a living evidence review (Version 3: 1 December 2020). However, it is surprising that despite previously undertaking an updated literature review every 2 weeks between 1st February and 20th December 2020 for version 1, the time-period for included literature in this present version 2, has not been extended beyond December 2020. In short, why not? Why would any research team with a stated protocol aim *'to provide a rapid summary and evaluation of relevant data on transmission of SARS-CoV-2'*, fail to update their manuscript in the 6 months since its first release?

Furthermore, I am sure there would be huge benefit in extending the date range for your search, not least in view of your repeated criticism of methods and stating:

"Standardized guidelines for conducting and reporting research on airborne transmission are needed", the February 2021 manuscript of Borges JT *et al.* is likely to be of great interest to you *'SARS-CoV-2: a systematic review of indoor air sampling for virus detection'*⁴. But this is just one of very many published studies which demonstrate conclusively that SARS-CoV-2 transmission occurs via the airborne route. Indeed, taking a simple mathematical approach to assess the probability of aerosol inhalation versus large droplet-based SARS-CoV-2 transmission between humans, led me to the figure of 56 million to one in favour of aerosol inhalation. I'd be keen to know whether you agree with my logic (<https://twitter.com/DRTomlinsonEP/status/1436214995239456769?s=20>).

Thank you again for responding to my comments. I hope you find my responses useful towards your stated aim: *"to provide a rapid summary and evaluation of relevant data on transmission of SARS-CoV-2"*.

References

1. Whiting PF, Rutjes AW, Westwood ME, Mallett S, et al.: QUADAS-2: a revised tool for the quality assessment of diagnostic accuracy studies. *Ann Intern Med.* 2011; **155** (8): 529-36 [PubMed Abstract](#) | [Publisher Full Text](#)
2. Couch RB, Cate TR, Douglas RG, Gerone PJ, et al.: Effect of route of inoculation on experimental respiratory viral disease in volunteers and evidence for airborne transmission. *Bacteriol Rev.* 1966; **30** (3): 517-29 [PubMed Abstract](#) | [Publisher Full Text](#)
3. Coleman K, Wen Tay D, Tan K, Xiang Ong S, et al.: Viral Load of SARS-CoV-2 in Respiratory Aerosols Emitted by COVID-19 Patients while Breathing, Talking, and Singing. *medRxiv.* 2021. [Publisher Full Text](#)
4. Borges JT, Nakada LYK, Maniero MG, Guimarães JR: SARS-CoV-2: a systematic review of indoor air sampling for virus detection. *Environ Sci Pollut Res Int.* 2021; **28** (30): 40460-40473 [PubMed Abstract](#) | [Publisher Full Text](#)

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: My regular daytime job since 2009 has been as Consultant Cardiologist and Electrophysiologist - perhaps an unlikely job title for anyone reviewing this manuscript. However,

as MedRxiv Affiliate since June 2019, I have been exposed to and performing 'release review' of a constant stream of early published works on SARS-CoV-2 - something which has catalysed my interest in this field. I am also experienced in assessing the validity of experimental methods chosen (please see my recent peer reviewed publications and/or preprints) and believe my background allows me to approach this topic without risk of anchoring bias towards one or other mode of respiratory viral transmission. My interest in this area can be further affirmed by evidence of my 'peer review' of the WHO SARS-CoV-2 IPC Scientific Briefing July 2020, assessing the validity of the chosen references *against* airborne transmission of SARS-CoV-2 (my pinned tweet @DRTomlinsonEP). I mention this to illustrate the breadth and depth of my reading and background on this subject, which may otherwise be assumed to be insufficient for someone in my professional role. I hope this is acceptable and that you are able to consider my comments constructively - since this is my intention. Thank you.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

Version 1

Reviewer Report 05 May 2021

<https://doi.org/10.5256/f1000research.55319.r82052>

© 2021 Yao M. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Maosheng Yao

College of Environmental Sciences and Engineering, Peking University, Beijing, China

Review for Heneghan *et al.* (2021), SARS-CoV-2 and the role of airborne transmission: a systematic review, F1000Research 2021, 10:232 .

First, I have to declare that this review is provided solely based on scientific evidence and reasoning without any discipline preferences or conflicting interests. Despite not being exhaustive, I have to greatly applaud the efforts of all the authors for developing this review, especially the compiling of relevant COVID-19 aerosol related articles. However, to me this review serves as a perfect piece for evidence compiled for probable airborne transmission of COVID-19 if the biased discussion and preferences of content inclusion are eliminated/avoided. Thus, I feel this review, if to be indexed, needs to completely change the tone, and better suited for an article with a title like: Evidences for probable aerosol transmission of COVID-19: a systematic review. For its current form, there are many problematic issues with this review, and the discussion is also biased.

Major comments are listed below:

1. This review is commissioned and supported by the WHO (World Health Organization) which has clearly stated in March 2020 that COVID-19 is not airborne. An effort supported by the WHO is hardly believed to use to overturn its own statements or harm its authority. Thus, the authors should provide documents that can demonstrate such potential conflicting interests can be sufficiently cleared. Otherwise, I can only say that this review just serves as a proxy of the WHO for its statements with a biased science provided.

2. The aerosol definition was not effectively or properly communicated. For example, in the Introduction, they state that "aerosol particle ranges from 0.001 μm to over 100 mm". Are they sure that there are 10 cm (100 mm) aerosol particles in the air? In case they mistyped the unit, e.g., 100 μm should be used. Experimental data in many studies (they did not cite) show that major fraction of exhaled particles during breathing or speaking in controlled and real world scenarios are smaller than 5 μm , and sometimes they peak at 1 μm . Most recently, US CDC states that surface contact transmission of COVID-19 is minimal (the authors should certainly update the review). Therefore, how do the authors explain the COVID-19 transmission between people? They might attribute the droplet transmission. But, airborne droplet is an aerosol by definition. The review did not provide any data for droplet transmission. Instead, they have provided a lot of studies that have detected SARS-CoV-2 in aerosol particles.

3. This review lacks a significant amount of discussion of aerosol physics (very important) in terms with aerosol transmission of COVID-19. For example, a lot of studies they provided used a filter to sample air, and it is known that filtration itself can cause desiccation which affects the integrity of biological cells/particles over a prolonged time period. Accordingly, it partially attributed to low recovery of viable SARS-CoV-2 virus. For impaction or liquid based studies, the sampling velocity could also damage the integrity of the viruses, e.g., the BioSampler has an impact velocity of up to 300 m/s by calculation, which would somehow damage the virus. Besides, when the viruses are released into the air, they would be rapidly diluted and transported away given any ventilation of either natural or mechanical nature is present. Thus, the airborne viral concentration level is time, ventilation, and space dependent. The aging of the virus in the air also affect its viability. In addition, the in vitro viability tests with cells can not be directly translated back to the infection of human cells inside the body where the overall physiological environment is different, and more favorable for viral replication. So far, no studies have demonstrated that those in vitro tested non-infectious viruses cannot infect humans. Human inhalation takes place at a rate of about 12 L/min, which is relatively gentle in terms of sampling stress on the virus. Therefore, their argument that lack of recovery of viable virus prevents a firm conclusion of airborne transmission of COVID-19 is not supported by their reasoning and existing data. Instead, many outbreaks or infections are difficult to explain without referring to airborne/aerosol transmission.

4. In their review, I do not know how they could define a low quality study. They stated that all 67 primary studies are of low quality. However, these studies are published by peer-reviewed journals including those premier ones. If they are of low quality, how they could pass the rigorous screening of these journals? On the other hand, this review did not state which are high quality studies and they did not provide them either. I think they should at least provide high quality data to support their conclusion. It seems they used "low quality data" to produce "high quality" conclusions.

5. For bioaerosol studies, there are no unified or standardized methods or procedures. Different studies have different purposes, different circumstances, different set of sampling tools (the efficiencies could vary greatly; in terms of sampling biological agents higher physical efficiency usually results in higher damage). So, different sampling tools have very different efficiencies. Because viral level is greatly diluted in the air, higher volume or longer sampling time is required to enrich enough viral particles for detection. Most of the studies they complied used RT-PCR for quantification. Depending on the detection kit used, the efficiencies could also vary greatly. Generally, the detection limits of RT-PCR are higher, and accordingly those samples with low viral level would be tested negative. If a more sensitive method such as digital PCR (1 copy per uL) was used, higher percentage of positive samples would be reported.

6. Clearly the review did not discuss how any ventilation would affect the airborne viral levels. Air is constantly moving in not enclosed environments. Thus, air sampling is very time sensitive. Besides, emission of viral particles by the patients might not be continuous. Airborne detection of SARS-CoV-2 is highly time dependent in ventilated environments.

7. For airborne transmission, increasing physical distance significantly reduces the viral levels depending on the indoor building ceiling height and ventilation status. Human inhalation of the airborne virus is a comparably gentle sampling (causing less damage), and the respiratory tract provides a better incubation environment for SARS-CoV-2. Thus, mechanical air sampling together with in vitro viability tests cannot confirm the true non-infectiveness of airborne SARS-CoV-2 given the results are negative. In addition to shared space, shared time in an indoor space might be also important for airborne transmission to occur. Shared time would allow the virus not to age for too long in the air before inhaled. All of this should be discussed in the review.

8. The tables take up most of the review, however high quality discussion is lacking. It is often observed that the statements in the review lack references.

Minor comments

1. Technical presentation of the data are not good. To me, all the tables prepared are like a laundry list of items without in-depth discussion or elaboration. Often, some important information present in certain studies they cited are not included in the table or in the discussion. For example, Ma *et al.* (2020)¹ found COVID-19 patients emit millions of SARS-CoV-2 during just breathing, implying great potential of aerosol transmission of the diseases. Breathing produces fine aerosol particles. However, they did not elaborate on this. Nonetheless, viable SARS-CoV-2 was indeed recovered from hospital air. But, the review did not provide direct data against the airborne transmission.

2. There are many grammar mistakes throughout the manuscript as pointed out by other reviewers.

3. The debate or discrepancy might primarily arise from different understanding and definition of aerosol, droplet or airborne transmission from different communities. Aerosol concentration is higher in close ranges, while it is substantially diluted with increasing physical distance, like injecting a drop of ink into a sea. The dose and viability of the virus also play important roles in terms of causing an infection. This should be discussed in a more neutral tone in the review.

I strongly encourage the authors to include aerosol scientists to provide a comprehensive and correct guidance/review that the WHO can use to save millions of lives. Time and resources for certain regions are running out & actions need to be taken immediately.

I have provided some references for the authors to further read the details of relevant topics I have discussed in the report:

Greenhalgh, Trisha, Jose L. Jimenez, Kimberly A. Prather, Zeynep Tufekci, David Fisman, and Robert Schooley. [Ten scientific reasons in support of airborne transmission of SARS-CoV-2](#). *The Lancet* 397, no. 10285 (2021): 1603-1605.

Morawska, Lidia, Julian W. Tang, William Bahnfleth, Philomena M. Bluyssen, Atze Boerstra, Giorgio Buonanno, Junji Cao *et al.* [How can airborne transmission of COVID-19 indoors be minimised?](#). *Environment international* 142 (2020): 105832.

Yao, Maosheng, Lu Zhang, Jianxin Ma, and Lian Zhou. [On airborne transmission and control of SARS-Cov-2](#). *Science of The Total Environment* 731 (2020): 139178.

Wilson, Nick, Stephen Corbett, and Euan Tovey. [Airborne transmission of covid-19](#). *BMJ* 370 (2020).

Morawska, Lidia, and Donald K. Milton. [It is time to address airborne transmission of coronavirus disease 2019 \(COVID-19\)](#). *Clinical Infectious Diseases* 71, no. 9 (2020): 2311-2313.

Prather, Kimberly A., Linsey C. Marr, Robert T. Schooley, Melissa A. McDiarmid, Mary E. Wilson, and Donald K. Milton. [Airborne transmission of SARS-CoV-2](#). *Science* 370, no. 6514 (2020): 303-304.

References

1. Ma J, Qi X, Chen H, Li X, et al.: COVID-19 patients in earlier stages exhaled millions of SARS-CoV-2 per hour. *Clin Infect Dis*. 2020. [PubMed Abstract](#) | [Publisher Full Text](#)

Are the rationale for, and objectives of, the Systematic Review clearly stated?

No

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

No

Is the statistical analysis and its interpretation appropriate?

Partly

Are the conclusions drawn adequately supported by the results presented in the review?

No

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: I obtained a PhD in conducting bioaerosol related studies from Rutgers University; and did postdoc training at Yale in the same field. I am currently a Professor from Peking University, and has been working in bioaerosol field for about 20 years. My expertise

ranges from bioaerosol sampling and detection to air pollution health effects and particulate matter toxicity.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

Author Response 25 Aug 2021

Carl Carl, University of Oxford, Oxford, UK

Peer Reviewer #3

First, I have to declare that this review is provided solely based on scientific evidence and reasoning without any discipline preferences or conflicting interests. Despite not being exhaustive, I have to greatly applaud the efforts of all the authors for developing this review, especially the compiling of relevant COVID-19 aerosol related articles. However, to me this review serves as a perfect piece for evidence compiled for probable airborne transmission of COVID-19 if the biased discussion and preferences of content inclusion are eliminated/avoided. Thus, I feel this review, if to be indexed, needs to completely change the tone, and better suited for an article with a title like: Evidences for probable aerosol transmission of COVID-19: a systematic review. For its current form, there are many problematic issues with this review, and the discussion is also biased.

Revised: Thanks. We have made several revisions to the original submission and we believe the quality of the manuscript is much improved. We do not agree with the reviewer that the title must be changed based on our rigorous review of the evidence presented within the papers we assessed.

Major comments are listed below:

1. This review is commissioned and supported by the WHO (World Health Organization) which has clearly stated in March 2020 that COVID-19 is not airborne. An effort supported by the WHO is hardly believed to use to overturn its own statements or harm its authority. Thus, the authors should provide documents that can demonstrate such potential conflicting interests can be sufficiently cleared. Otherwise, I can only say that this review just serves as a proxy of the WHO for its statements with a biased science provided.

Response: The guidance by the WHO on modes of transmission of SARS-COV-2 is constantly evolving and has done so since March 2020. The reviewer has made assumptions which are simply untrue and inaccurate. Such documents do not exist as WHO had no influence in any of our reviews, the process included for the reviews or the interpretation of the results. This standard of proof is not required by editors for submitted manuscripts (CH has been an Editor-in-Chief of a BMJ journal, IJO has been a research editor and JMC has also been an Editor-in-Chief of a Journal). A peer reviewer who has submitted previous research would know the requirements for submission according to the ICMJE criteria. The insinuation of overt bias by this reviewer is unfounded and the statement should be retracted.

2. The aerosol definition was not effectively or properly communicated. For example, in the Introduction, they state that “aerosol particle ranges from 0.001 μm to over 100 μm ”. Are they sure that there are 10 cm (100 mm) aerosol particles in the air? In case they mistyped the unit, e.g., 100 μm should be used. Experimental data in many studies (they did not cite) show that major fraction of exhaled particles during breathing or speaking in controlled and real world scenarios are smaller than 5 μm , and sometimes they peak at 1 μm . Most recently, US CDC states that surface contact transmission of COVID-19 is minimal (the authors should certainly update the review). Therefore, how do the authors explain the COVID-19 transmission between people? They might attribute the droplet transmission. But, airborne droplet is an aerosol by definition. The review did not provide any data for droplet transmission. Instead, they have provided a lot of studies that have detected SARS-CoV-2 in aerosol particles.

Response: We have redefined aerosol (see the response to peer reviewer #1 above).

3. This review lacks a significant amount of discussion of aerosol physics (very important) in terms with aerosol transmission of COVID-19. For example, a lot of studies they provided used a filter to sample air, and it is known that filtration itself can cause desiccation which affects the integrity of biological cells/particles over a prolonged time period. Accordingly, it partially attributed to low recovery of viable SARS-CoV-2 virus. For impaction or liquid based studies, the sampling velocity could also damage the integrity of the viruses, e.g., the BioSampler has an impact velocity of up to 300 m/s by calculation, which would somehow damage the virus. Besides, when the viruses are released into the air, they would be rapidly diluted and transported away given any ventilation of either natural or mechanical nature is present. Thus, the airborne viral concentration level is time, ventilation, and space dependent. The aging of the virus in the air also affect its viability. In addition, the in vitro viability tests with cells can not be directly translated back to the infection of human cells inside the body where the overall physiological environment is different, and more favorable for viral replication. So far, no studies have demonstrated that those in vitro tested non-infectious viruses cannot infect humans. Human inhalation takes place at a rate of about 12 L/min, which is relatively gentle in terms of sampling stress on the virus. Therefore, their argument that lack of recovery of viable virus prevents a firm conclusion of airborne transmission of COVID-19 is not supported by their reasoning and existing data. Instead, many outbreaks or infections are difficult to explain without referring to airborne/aerosol transmission.

Response:

We have shown the bewildering array of samplers used in the studies. The reviewer raises a good point, but it is a subject matter beyond the scope of our systematic review and our protocol. We might suggest the reviewer and others in the field could contribute to establish an international standard for air capture and hope that all primary studies conform to that standard which we will be quite happy to report in future reviews.

The review by Verreault and colleagues (Methods for sampling of airborne viruses. *Microbiol Mol Biol Rev.* 2008;72(3):413-444. doi:[10.1128/MMBR.00002-08](https://doi.org/10.1128/MMBR.00002-08)) sets out some of

the basic principles in improving the methods in this area and has been included as a reference in the revised manuscript.

'Many types of samplers have been used over the years, including liquid impingers, solid impactors, filters, electrostatic precipitators, and many others. The efficiencies of these samplers depend on a variety of environmental and methodological factors that can affect the integrity of the virus structure. The aerodynamic size distribution of the aerosol also has a direct effect on sampler efficiency. Viral aerosols can be studied under controlled laboratory conditions, using biological or nonbiological tracers and surrogate viruses, which are also discussed in this review. Lastly, general recommendations are made regarding future studies on the sampling of airborne viruses.'

4. In their review, I do not know how they could define a low quality study. They stated that all 67 primary studies are of low quality. However, these studies are published by peer-reviewed journals including those premier ones. If they are of low quality, how they could pass the rigorous screening of these journals? On the other hand, this review did not state which are high quality studies and they did not provide them either. I think they should at least provide high quality data to support their conclusion. It seems they used "low quality data" to produce "high quality" conclusions.

Response: We have expanded the methods section describing how we assessed study quality (see the response to peer reviewer #1 above).

5. For bioaerosol studies, there are no unified or standardized methods or procedures. Different studies have different purposes, different circumstances, different set of sampling tools (the efficiencies could vary greatly; in terms of sampling biological agents higher physical efficiency usually results in higher damage). So, different sampling tools have very different efficiencies. Because viral level is greatly diluted in the air, higher volume or longer sampling time is required to enrich enough viral particles for detection. Most of the studies they complied used RT-PCR for quantification. Depending on the detection kit used, the efficiencies could also vary greatly. Generally, the detection limits of RT-PCR are higher, and accordingly those samples with low viral level would be tested negative. If a more sensitive method such as digital PCR (1 copy per uL) was used, higher percentage of positive samples would be reported.

See response to comment 3.

Response: We agree that the methods can be improved and made more sensitive. This should be the focus of future work but is not an area that we are able to address.

6. Clearly the review did not discuss how any ventilation would affect the airborne viral levels. Air is constantly moving in not enclosed environments. Thus, air sampling is very time sensitive. Besides, emission of viral particles by the patients might not be continuous. Airborne detection of SARS-CoV-2 is highly time dependent in ventilated environments.

Response: We agree and ventilation issues were considered to be beyond the scope of work outlined for this systematic review. It would be a very interesting topic for a

future systematic review.

7. For airborne transmission, increasing physical distance significantly reduces the viral levels depending on the indoor building ceiling height and ventilation status. Human inhalation of the airborne virus is a comparably gentle sampling (causing less damage), and the respiratory tract provides a better incubation environment for SARS-CoV-2. Thus, mechanical air sampling together with in vitro viability tests cannot confirm the true non-infectiveness of airborne SARS-CoV-2 given the results are negative. In addition to shared space, shared time in an indoor space might be also important for airborne transmission to occur. Shared time would allow the virus not to age for too long in the air before inhaled. All of this should be discussed in the review.

Response: Thanks for the comments. We appreciate the points raised but these mechanistic hypotheses are beyond the scope and intent of our systematic review. A separate review of mechanistic modes of transmission would be of value in the future.

8. The tables take up most of the review, however high quality discussion is lacking. It is often observed that the statements in the review lack references.

Response: The tables report the evidence, we can comment but it's up to the readers to consider our conclusions.

Minor comments

1. Technical presentation of the data are not good. To me, all the tables prepared are like a laundry list of items without in-depth discussion or elaboration. Often, some important information present in certain studies they cited are not included in the table or in the discussion. For example, Ma *et al.* (2020)¹ found COVID-19 patients emit millions of SARS-CoV-2 during just breathing, implying great potential of aerosol transmission of the diseases. Breathing produces fine aerosol particles. However, they did not elaborate on this. Nonetheless, viable SARS-CoV-2 was indeed recovered from hospital air. But, the review did not provide direct data against the airborne transmission.

Response: We have attempted to lay out the information in the tables in line with previous reviews. We have also revisited the information to ensure the information presented is relevant.

Ma and colleagues suggested COVID-19 patients recruited in Beijing exhaled millions of SARS-CoV-2 **RNA copies** into the air per hour and that exhaled breath emission may play an important role in the COVID-19 transmission. The Ct values of the breath and air samples, respectively (35.54±3.14 and 38.40) are extremely high and not compatible with infectious virus based on other studies that have correlated infectious virus and Ct values (Jefferson T, Spencer EA, Brassey J, Heneghan C. Viral cultures for COVID-19 infectious potential assessment - a systematic review. Clin Infect Dis. 2020 Dec 3:ciaa1764. doi: 10.1093/cid/ciaa1764. Epub ahead of print. PMID: 33270107; PMCID: PMC779932). The mere presence of RNA copies based on PCR sampling does not imply infectiousness and the reviewer comments suggesting millions of SARS-CoV-2 intact viruses are emitted

during breathing and capable of causing infection does not have evidence to support the statement from what we have been able to find.

Response: Meaningful inference can only be drawn from solid evidence.

2. There are many grammar mistakes throughout the manuscript as pointed out by other reviewers.

Response: Thanks. We have checked for grammatical errors and typos.

3. The debate or discrepancy might primarily arise from different understanding and definition of aerosol, droplet or airborne transmission from different communities. Aerosol concentration is higher in close ranges, while it is substantially diluted with increasing physical distance, like injecting a drop of ink into a sea. The dose and viability of the virus also play important roles in terms of causing an infection. This should be discussed in a more neutral tone in the review.

Response: We have already commented on the confusing nature of the definitions of aerosol, droplet and airborne transmission.

I strongly encourage the authors to include aerosol scientists to provide a comprehensive and correct guidance/review that the WHO can use to save millions of lives. Time and resources for certain regions are running out & actions need to be taken immediately.

Response: We have substantial expertise and experience within our team (see the response to peer reviewer #2 above.

Of note, in undertaking peer review the ICMJE states: 'Reviewers should declare their relationships and activities that might bias their evaluation of a manuscript and recuse themselves from the peer-review process if a conflict exists.' Intellectual conflicts would introduce such bias to peer review assessments. And according to COPE's Ethical Guidelines for Peer Reviewers, COPE also highlights that the professional responsibility underpinning the peer review requires the necessary expertise to assess the manuscript and can provide an unbiased assessment.

We do not engage in emotive statements regarding the reviewers' opinions. We ensure our comments are evidence-based, unbiased and reflect the best available evidence. The reviewer should note that we do not speak for WHO and two co-authors of this review are currently collaborating with aerosol scientists to look for high-quality evidence relating to the mechanism(s) of transmission.

Competing Interests: No competing interests were disclosed.

Reviewer Report 22 April 2021

<https://doi.org/10.5256/f1000research.55319.r82064>

© 2021 Leung N. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Nancy H. L. Leung

WHO Collaborating Centre for Infectious Disease Epidemiology and Control, School of Public Health, Li Ka Shing Faculty of Medicine, The University of Hong Kong, Hong Kong, Hong Kong

In this systematic review, Heneghan *et al.* attempted to summarise the literature on the role of airborne transmission for SARS-CoV-2, with a focus of air sampling studies or epidemiologic studies that may evaluate the aerosol mode of transmission. They described that all primary research studies selected were low quality, probably attributing to the lack of standard methods, sampling sizes and reporting items. They concluded that SARS-CoV-2 was intermittently detected in the air, but the lack of recoverable viral culture samples prevents conclusions over airborne transmission.

I applaud the authors' attempt in summarising the current literature. I also agree the results of the selected studies are heterogeneous, and that currently there is very minimal number of studies that demonstrated infectious virus recovered in the air. This review would have been very useful as an evidence base for future discussion on the importance of aerosol transmission; however, the lack of objective and systematic evaluation of the methodology used in the selected studies precludes such usefulness. My major concern is that the review set out with the assumption that "the quality of transmission studies is known to be low" (reference #9 was also irrelevantly cited as described further below), although one of the main purposes of this review would be to evaluate the quality of evidence of each study. The benchmarks used to evaluate whether "Analysis & reporting outcomes (are) appropriate" (Table 3) were not described, but which were critical to evaluate the quality of each study. The assumption of air sampling studies were of poor quality in general can be felt along the manuscript, especially in Table 6 with a very large paragraph of criticism on Santarpia 2020, but personally I think a lot of evaluation on this particular study was misguided due to insufficient understanding of the methodology used (as described further below). In some instances, studies were being described as poorly done without explanation of why the authors think so. I think including authors who have working knowledge in the field of air sampling studies and/or epidemiologic transmission studies would help to improve this review greatly.

There are also quite a number of missing information in the Tables, truncated sentences and typos, which requires a thorough re-read and check.

Please also find my specific comments below:

Introduction

Airborne transmission is defined as the spread of an infectious agent caused by the dissemination of droplet nuclei (aerosols) that remain infectious when suspended in air over long distances and time

- For this definition of airborne (aerosol) transmission, emerging discussion has suggested aerosol transmission occurs in both short- and long-range (see my review¹).

A collection of particles (liquid or solid) ranging in size from 0.001 μ m to over 100 μ m suspended in a gas defines an aerosol.

- This is the classic definition of aerosols from the discipline of occupational hygiene, but other disciplines with a specific focus on bioaerosols with the origin of infectious pathogens may differ based on different aspects of transmission¹.

Method

Studies can be observational including case series, ecological, or prospective; or interventional including randomised trials and clinical reports, outbreak reports, case-control studies, experimental studies, non-predictive modelling. Studies should include sampling for the detection of SARs-CoV-2. Studies on factors influencing transmission are included, such as location settings, meteorological or immunological factors. Studies incorporating models to describe observed data were eligible. Studies reporting solely predictive modelling were excluded.

- These classification of study design are ambiguous; for example, what was the intervention being studied in interventional studies? Shouldn't clinical reports, outbreak reports and case-control studies be classified as observational studies? Were retrospective observational studies included, and on the other hand randomised trials would always be prospective? Overall, if these study designs are merely summaries of studies identified from systematic search based on well-defined search terms and are not being used for inclusion/ exclusion of studies, I would suggest to move these descriptions to the Results section instead, and only keep those that are relevant to study selection in the Method section (e.g. "Studies should include sampling for the detection of SARs-CoV-2.")

Studies should include sampling for the detection of SARs-CoV-2.

- Do you mean "air sampling for the detection of SARS-CoV-2"?

We also extracted data on the type of study, setting, sample source and methods, RT-PCR positive samples for SARS-CoV-2 RNA including cycle threshold (Ct) and copies per m3, viral culture methods and results, size of air particles (when reported) and proportion in the sample.

- For "copies per m3", do you mean "copies per m3 air sampled"? For "proportion in the sample", what is the numerator and the denominator - e.g., NIOSH sampler is commonly used in air sampling study, and for each time of collection the same volume of air are segregated into 3 size-fractions, would this be counted as 1 or 3 air samples? Alternatively, some studies will use multiple samplers in the same collection (e.g. being placed at different locations in the patient room), would this be considered as multiple samples or one sample (run)? A clear definition is needed to allow comparison between studies, and should also be clearly described in Table 1.

We assessed quality using a modified QUADAS 2 risk of bias tool⁸. We simplified the tool as the included studies were not designed as primary diagnostic accuracy studies and the quality of transmission studies is known to be low⁹.

- As listed in Table 3, one of the criteria was "Analysis & reporting outcomes appropriate". What were the benchmarks that were being used to be evaluated against about whether the analysis or the reporting outcomes are appropriate or not?
- The use of reference #9 here is inappropriate as it refers to transmission during the symptomatic or asymptomatic phase, with no mention of any modes of transmission.
- Truncated sentence ("after tool,").

Results

Limitations of the sampling methods and the poor-quality reporting make it difficult to discriminate between airborne or droplet nuclei transmission.

- Is "airborne" a typo here?

We included 67 primary studies, of which 53 (79%) reported binary data on RT-PCR air samples (see Table 1). All were descriptive observational and none were comparative.

- Comparative refers to comparison between what?

Overall the reporting was heterogeneous.

- Do you mean the methods or the results in the reported studies were heterogeneous?

Hospital. There were 50 studies conducted in healthcare settings: 45 studies included binary RT-PCR air samples (42 hospitals, 2 outdoors and 1 student healthcare centre).

- Should "outdoors" be considered as healthcare settings? Similarly in the paragraphs follow about outdoors and community, actually I would think the distinction lies in outdoors vs. indoors, and within indoor higher-risk (e.g. healthcare settings/ households with confirmed cases) vs lower-risk (restaurants/ public transport etc)

(142 positives out of 1,403 samples: average 10.1%).

- Please refer to my above comments on the numerator/ denominator for the proportion of samples - can the proportions from different studies (which may refer to different things) be combined? What does this 10.1% represent/ how to interpret?

Three studies reported on two choir practices and potential air transmission. Charlotte N et al. followed-up a choir practice in France with 27 participants who attended a choir practice on 12 March 2020. Two separate publications [Hamner L 2020 and Miller SL 2020] published on the same Choir Practice Skagit County, Washington, USA. In total, 78 members attended two practices: 87% of choir members subsequently became ill (32 confirmed cases and 20 probable secondary cases).

- I suggest to move this paragraph to a new section, as these evidence refers to whether a transmission event has occurred (i.e. whether someone is infected), which is a different outcome measure from recovering virus in the air.

Discussion

Some of the reasons for this may be methodological weaknesses in the study design, the lack of validated methods and the location and variable distance of the sampling.

- Please elaborate what (1) the weaknesses and (2) the lack of validated methods are referring to

Past attempts to detect infectious particles have proved difficult: aerosols are dilute and culturing fine particles is problematic.

- Why is culturing fine particles (as opposed to coarse particles?) problematic, apart from being diluted?

In a NEJM editorial, Roy et al., report 'the only clear proof that any communicable disease is transmitted by aerosol came from the famous experiment by Wells, Riley, and Mills in the 1950s, which required years of continual exposure of a large colony of guinea pigs to a clinical ward filled with patients who had active tuberculosis¹¹.'

- There was clear evidence in terms of observed transmission event via the aerosol route for measles, chickenpox and rhinovirus¹.

For coronaviruses, previous evidence supporting the airborne route of transmission is weak¹³.

- Please clarify that this review was published before the COVID-19 pandemic.

There is a current lack of well-conducted studies addressing airborne transmission: only nine studies identified during the search period reported air sampling outdoors and, in the environment, outside of hospitals.

- How do air sampling studies conducted outdoors (as opposed to indoors), or the lack thereof, suggest the studies are not well-conducted - should the studies be evaluated based on methodological robustness instead (e.g. sampling duration, attempt to recover infectious virus, etc.)?

Transmission evidence should be context specific to particular settings (i.e., indoor or outdoor), environment- specific (i.e., the presence of UV light. ventilation etc.) and ensure that exposure an

infectious agent has taken place.

- exposure to an infectious agent?

No airborne study to date definitively demonstrates SARS-CoV-2 is of an infectious nature, which offers the most robust evidence of transmissibility²².

- Do you mean "SARS-CoV-2 _recovered in the air_"? Do you mean "evidence of aerosol transmission" instead of "transmissibility" (please note the difference between "transmissibility" and "modes of transmission"¹)? I'm not sure whether identifying infectious virus in the air is the most robust evidence of aerosol route, as whether aerosol transmission can take place also depends on the susceptibility of the infected person to the aerosol route, and I would think a demonstration of transmission event takes place via the aerosol route would be a stronger evidence.

Table 1

- Binder 2020: *which decreases to approximately 40% efficiency for aerosols ~80 µm in diameter* - --> typo.
- Charlotte N 2020: please describe the lack of ventilation as described in Charlotte *et al*.
- Horve PF 2020: *14/56 s* ---> typo.
- Li & Qian 2020: missing notes.
- Lu J 2020: please describe the study scenarios/ findings that were relevant to why the study was selected (e.g. airflow consistent with transmission).
- Mponponsuo 2020: why was this study selected? the type of high-risk behaviour/ procedure has not been described in the study?
- Bahl P 2020: please be aware of plagiarism and rephrase.
- Ji B 2020: Missing main results.
- Singhai S 2020: Missing main results and key conclusions.
- Hussain A 2020: Missing key conclusions.
- Correia G 2020: Missing main results.

Figure 1

- Full-text articles excluded because no transmission outcome studied ---> What does 'transmission outcome' refer to here? From my understanding, 'transmission outcome' refers to whether an infection is initiated in an exposed person; but most of the air sampling studies included in this review did not demonstrate such 'transmission outcome'

Figure 2

- For "Was follow up sufficient", referring to Table 2, shouldn't the 83.6% mostly be "Not Applicable" instead of "No/Unclear"?

Table 4

- please check to see the use of unit symbol is consistent in the Table (uM vs. µm; copies/L vs. /L, copies/m³ vs. copies m³, m² vs. m³, m³ vs. m3).
- Chirizz D 2020: please kindly indicate which size ranges were reported.
- Horve PF 2020: truncated sentence.
- Liu Y & Ning Z 2020: typo ("rang-").
- Zhou J 2020: 101 copies per how much air?

Table 5

- Feng B 2020: truncated sentence.

Figure 4

- Similar to my comments about numerator/ denominator above, were the proportions reported between studies directly comparable?

Table 6

- Binder 2020: a Ct of <20 would be considered as high viral load that may be sufficient to be culturable?
- Hu J: missing publication year.

Lednicky 2020a:

- *it is not clear why plaque assays could not be performed due to a nationwide non-availability of some critical media components in the US.* ---> I think Lednicky *et al.* meant that due to lack of components which make up the culture media (for cultivating the cells to be infected), plaque assay (which involves the use of cells to be infected) cannot be performed.

Santarpia JL 2020a:

- *For Santarpia 2020 (a) we could only find a preprint publication.* ---> it is now published in Scientific Reports.
- *Increased viral RNA presence is a surrogate and subject to many interpretations and should not be considered equal to the cultivation of replication and infection competent virus on cell culture which was not identified.* ---> Please elaborate on this statement - how to explain the increased viral RNA presence if it is not because of viral replication?
- *Western blot assay was not done in cell supernatant samples with non-statistically significant evidence of replication, which would have acted as a control to ensure the findings were not spurious. Western blots are very weak, with no positive control or size markers and the signal doesn't necessarily come from a replicating virus, there's no "before culture" analysis.* ---> In contrast to this statement, referring to Figure 2 in Santarpia JL 2020a, mock (negative control) samples have already been included. Anti-SARS nucleocapsid protein (SARS-CoV N) antibody were used in Western blot which is specific to SARS-CoV-2 virions. A significant test has been done for viral load between day 1 vs. day 5/6, and significant increase in viral load would be suggestive of viral replication between these days.
- *No size-fractionation techniques were used to determine the size range of SARS-CoV-2 droplets and particles, raising major issues with the statement the data suggests that viral aerosol particles are produced by individuals that have the COVID-19.* ---> The NIOSH samplers (commonly used in air sampling studies) were used in this study, which size-fractionated the sampled air.
- *No plaques were reported to have been detected and no serial passage on subculture was reported.* ---> Plaque assay nor serial passage was attempted in the study.
- Statistical inferences are very difficult to interpret in Figure 1 based on the error bars. ---> Student's t test was done to compare viral load between day 1 vs. day 5/6.
- *The broad sweeping conclusions that SARS-CoV-2 RNA exists in respired aerosols less than 5 μ m in diameter; that aerosols containing SARS-CoV-2 RNA exist in particle modes that are produced during respiration is difficult to justify based on the findings presented.* ---> Refers to above comment on the use of NIOSH samplers in this study.
- *It is likely an equation as used to calculate the concentration of the virus, however, it is more*

robust to measure the virus directly than use an equation. ---> Virus in the sample was being measured directly to obtain Ct values, which was then translated to viral load based on standard curve (i. e. a serial dilution of virus of different concentration) from a known quantity of SARS-CoV-2 virus.

- *EM also does not confirm live virus and does not indicate active viral replication as the authors suggest – where are the comparisons control EM photomicrographs. ---> The significant increase in viral RNA from day 1 to day 5/6 would be suggestive of viral replication.*

Table 7

- Santarpia JL 2020b: *Partial evidence of virus replication from one air sample. ---> typo.*

References

1. Leung NHL: Transmissibility and transmission of respiratory viruses. *Nat Rev Microbiol.* 2021. [PubMed Abstract](#) | [Publisher Full Text](#)

Are the rationale for, and objectives of, the Systematic Review clearly stated?

Yes

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

Partly

Is the statistical analysis and its interpretation appropriate?

Not applicable

Are the conclusions drawn adequately supported by the results presented in the review?

Partly

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Infectious disease epidemiology; aerosol transmission; modes of transmission; respiratory viruses; air sampling studies; field studies

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.

Author Response 25 Aug 2021

Carl Carl, University of Oxford, UK

Peer reviewer 2

1. In this systematic review, Heneghan *et al.* attempted to summarise the literature on the role of airborne transmission for SARS-CoV-2, with a focus of air sampling studies or epidemiologic studies that may evaluate the aerosol mode of transmission. They described that all primary research studies selected were low quality, probably attributing to the lack

of standard methods, sampling sizes and reporting items. They concluded that SARS-CoV-2 was intermittently detected in the air, but the lack of recoverable viral culture samples prevents conclusions over airborne transmission.

Response:

Thank you. Our team includes an expert virologist, a vaccinologist and an infectious disease specialist and epidemiologists. We have expanded our methods section to show how we assessed the quality of included studies (see response above).

2. I applaud the authors' attempt in summarising the current literature. I also agree the results of the selected studies are heterogeneous, and that currently there is very minimal number of studies that demonstrated infectious virus recovered in the air. This review would have been very useful as an evidence base for future discussion on the importance of aerosol transmission; however, the lack of objective and systematic evaluation of the methodology used in the selected studies precludes such usefulness. My major concern is that the review set out with the assumption that "the quality of transmission studies is known to be low" (reference #9 was also irrelevantly cited as described further below), although one of the main purposes of this review would be to evaluate the quality of evidence of each study. The benchmarks used to evaluate whether "Analysis & reporting outcomes (are) appropriate" (Table 3) were not described, but which were critical to evaluate the quality of each study. The assumption of air sampling studies were of poor quality in general can be felt along the manuscript, especially in Table 6 with a very large paragraph of criticism on Santarpia 2020, but personally I think a lot of evaluation on this particular study was misguided due to insufficient understanding of the methodology used (as described further below). In some instances, studies were being described as poorly done without explanation of why the authors think so. I think including authors who have working knowledge in the field of air sampling studies and/or epidemiologic transmission studies would help to improve this review greatly.

Response:

Thanks for your observations. We have made some revisions.

We have revised the statement regarding reference #9.

"We simplified the tool because the included studies were not designed as primary diagnostic accuracy studies, and there is a lack of high-quality data in published transmission studies"

We have expanded the process used to assess the reporting quality in the methods section.

Our team includes viral transmission experts, epidemiologists, clinicians and systematic review experts. This review set out to assess whether published studies demonstrated evidence of SARS-CoV-2 transmissibility.

The included studies where the culture of viable virus was attempted were analysed in-depth given their importance and the potential for bias. We have considerable expertise in transmission studies. Across nine reviews we have assessed over 500

studies to date. CH and TJ are contact editors in the Cochrane Acute Respiratory Group and as a group, we have over 3 decades of experience in systematic reviews and infections. We, therefore, dispute this reviewer's assertion. We have clarified the methods as per the previous reviewer's response.

3. There are also quite a number of missing information in the Tables, truncated sentences and typos, which requires a thorough re-read and check.

Response:

We have re-read the manuscript to check for any grammatical errors and typos.

4. Introduction

Airborne transmission is defined as the spread of an infectious agent caused by the dissemination of droplet nuclei (aerosols) that remain infectious when suspended in air over long distances and time

For this definition of airborne (aerosol) transmission, emerging discussion has suggested aerosol transmission occurs in both short- and long-range (see my review).

Response:

Our definition was based on current WHO guidance. However, we have added a statement to reflect this view:

"Airborne transmission is defined as the spread of an infectious agent caused by the dissemination of droplet nuclei (aerosols) that remain infectious when suspended in air over long distances and time.¹ However, some authors have defined aerosol transmission as occurring over both short and long distances (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7982882/>)."

5. *A collection of particles (liquid or solid) ranging in size from 0.001 µm to over 100 µm suspended in a gas defines an aerosol.*

Response:

We have revised our definition of aerosol (see response to peer reviewer 1 above).

6. Method

Studies can be observational including case series, ecological, or prospective; or interventional including randomised trials and clinical reports, outbreak reports, case-control studies, experimental studies, non-predictive modelling. Studies should include sampling for the detection of SARS-CoV-2. Studies on factors influencing transmission are included, such as location settings, meteorological or immunological factors. Studies incorporating models to describe observed data were eligible. Studies reporting solely predictive modelling were excluded.

Response:

We have revised the paragraph.

"We primarily included studies that reported sampling for the detection of SARS-CoV-2. However, we also included observational and randomised studies that investigated

airborne transmission of SARS-CoV-2." Non-predictive and experimental studies were also considered for inclusion."

7. Studies should include sampling for the detection of SARS-CoV-2.

- Do you mean "air sampling for the detection of SARS-CoV-2"?

Response:

Thank you. Revised.

"air sampling for the detection of SARS-CoV-2"

8. We also extracted data on the type of study, setting, sample source and methods, RT-PCR positive samples for SARS-CoV-2 RNA including cycle threshold (Ct) and copies per m³, viral culture methods and results, size of air particles (when reported) and proportion in the sample.

Response:

Revised to "copies per m³ of sampled air".

The included studies reported the total number of air samples as well as proportion of positive samples (if any). We presented the results as reported by the authors.

We have added the following footnote to table 1:

"For positive air sample proportions, the denominator refers to the total number of air samples as reported by the study authors irrespective of the method used for sampling."

9. Results

Limitations of the sampling methods and the poor-quality reporting make it difficult to discriminate between airborne or droplet nuclei transmission.

- Is "airborne" a typo here?

Response:

Thanks. Revised.

"The variation in sample methods coupled with flaws in the reporting make it difficult to distinguish between aerosol and droplet nuclei transmission."

10. We included 67 primary studies, of which 53 (79%) reported binary data on RT-PCR air samples (see Table 1). All were descriptive observational and none were comparative.

Response: Revised. Deleted "and none were comparative".

"All the studies were observational."

11. Overall the reporting was heterogeneous.

- Do you mean the methods or the results in the reported studies were heterogeneous?

Response:

Thanks. We have revised the sentence. "Overall, there was heterogeneity in the methods

used for air sampling across the studies."

12. *Hospital. There were 50 studies conducted in healthcare settings: 45 studies included binary RT-PCR air samples (42 hospitals, 2 outdoors and 1 student healthcare centre).*

Response:

The outdoors here refers to hospital outdoor environments. We have revised the statements.

"Hospital. There were 50 studies conducted in healthcare settings: 45 studies included binary RT-PCR air samples: 42 hospitals, 1 hospital outdoor environment, 1 hospital indoor and outdoor environment and 1 student healthcare centre)." (revise figure 1).

"Of the studies conducted in the community, 15 were conducted in indoor settings: choir practice (2), care home (1), inside a bus (3), quarantine households (1), meat processing plant (1), block of flats (2), restaurant (3), buses and subway trains (1), and home residence (1); three studies were conducted in outdoor settings: public places (1), industrial outdoor (1) and outdoor of a working/residential area (1)."

13. *(142 positives out of 1,403 samples: average 10.1%).*

Response:

We have described the denominator above (total number of air samples irrespective of sampling method).

14. *Three studies reported on two choir practices and potential air transmission. Charlotte N et al. followed-up a choir practice in France with 27 participants who attended a choir practice on 12 March 2020. Two separate publications [Hamner L 2020 and Miller SL 2020] published on the same Choir Practice Skagit County, Washington, USA. In total, 78 members attended two practices: 87% of choir members subsequently became ill (32 confirmed cases and 20 probable secondary cases).*

Response:

Revised. Added a new sub-title.

"Indoors."

15. Discussion

Some of the reasons for this may be methodological weaknesses in the study design, the lack of validated methods and the location and variable distance of the sampling.

Response: We have emphasized the need for a framework to assess studies of transmissibility and included a reference.

16. *Past attempts to detect infectious particles have proved difficult: aerosols are dilute and culturing fine particles is problematic.*

- Why is culturing fine particles (as opposed to coarse particles?) problematic, apart

from being diluted?

Response: Thank you for raising this point. We have several references below which address this point. The reference by Verreault is one of the most comprehensive on this subject.

Verreault D, Moineau S, Duchaine C. Methods for sampling of airborne viruses. *Microbiol Mol Biol Rev.* 2008;72(3):413-444. doi:[10.1128/MMBR.00002-08](https://doi.org/10.1128/MMBR.00002-08)

Aaron J. Prussin, II, Linsey C. Marr, Kyle J. Bibby, **Challenges of studying viral aerosol metagenomics and communities in comparison with bacterial and fungal aerosols**, *FEMS Microbiology Letters*, Volume 357, Issue 1, August 2014, Pages 1–9,

see also Lednicky

Viable SARS-CoV-2 in the air of a hospital room with COVID-19 patients

[https://www.ijidonline.com/article/S1201-9712\(20\)30739-6/fulltext#](https://www.ijidonline.com/article/S1201-9712(20)30739-6/fulltext#).

‘The amount of airborne virus detected per liter of air was small, and future studies should address (a) whether this is typical for COVID-19, (b) if this represented virus production relative to the phase of infection in the patient, (c) if this was a consequence of active air flow related to air exchanges within the room, (d) or if the low number of virus was due to technical difficulties in removing small airborne particles from the air.’

See also Collection, particle sizing and detection of airborne viruses

Pan A, Lednicky JA, Wu C.-Y. *International Journal of Infectious Diseases.* 100 (2020) 476–482

We have referenced Verreault D and Pan M as new references.

17. *In a NEJM editorial, Roy et al., report ‘the only clear proof that any communicable disease is transmitted by aerosol came from the famous experiment by Wells, Riley, and Mills in the 1950s, which required years of continual exposure of a large colony of guinea pigs to a clinical ward filled with patients who had active tuberculosis.’*

Response: We quote what Roy *et al.* reported in the New England Journal of Medicine who also states there is a “need for a better understanding of aerosol-acquired disease.”

18 *For coronaviruses, previous evidence supporting the airborne route of transmission is weak*¹³.
○ Please clarify that this review was published before the COVID-19 pandemic.

Response: Clarified: “*For coronaviruses, previous review evidence supporting the airborne route of transmission is weak*¹³; however, it should be noted that this review was published before the COVID-19 pandemic.”

19. *There is a current lack of well-conducted studies addressing airborne transmission: only nine studies identified during the search period reported air sampling outdoors and, in the environment, outside of hospitals.*

Response: We have deleted this statement within the manuscript.

20. *Transmission evidence should be context specific to particular settings (i.e., indoor or outdoor), environment- specific (i.e., the presence of UV light. ventilation etc.) and ensure that exposure an infectious agent has taken place.*

Response: Revised: "... ensure that there is evidence of exposure to a transmissible agent"

21. *No airborne study to date definitively demonstrates SARS-CoV-2 is of an infectious nature, which offers the most robust evidence of transmissibility²².*

Response: We have revised the statement. "None of the included studies definitively demonstrated that SARS-CoV-2 can be recovered in the air."

22.
Table 1

Response: Thank you for pointing out the typographical errors and missing notes. We have made revisions to Table 1

≥80 µm in diameter
The choir rehearsal room was not ventilated.
14 out of 56 samples
Analysed outbreak using computer models and experiments based on airflow dynamics
Air-conditioned, 5-floor building without windows
It satisfied our inclusion criteria - observational studies of RCT that investigated airborne transmission
Revised; used quotation marks where necessary
Results added
Added
Added
Added

24. Figure 1

Response: For instance, several modelling studies did not 'study' a transmission outcome and were therefore excluded. This is different to whether studies 'demonstrate' an effect or not as both would be included irrespective of the result. Otherwise, we would introduce publication bias.

25. Figure 2

Response:
We have revised what we mean by follow-up. See methods section.

26. Table 4

Response:

Thanks. Revised. We have presented the units as reported by the study authors ($D < 0.056 \mu\text{m}$) up to coarse particles ($D > 18 \mu\text{m}$); as reported by the study authors
No truncation. Sentence extends into next page
Corrected
Corrected

27. Table 5

Response:

No truncation; statement extends into the next page.

28. Figure 4

Response:

We have addressed this comment earlier.

29. Table 6

Response:

"A Ct of <20 would be considered positive..."

Corrected: Hu J 2020

30 Lednicky 2020a:

Response:

Revised: "The authors reported that plaque assays could not be performed due non-availability of the components which make up the culture media in the USA."

31. Santarpia JL 2020a:

Response: As far as we are aware, Santarpia 2020(a) is still only available as a preprint. The Scientific Reports citation is the journal publication for Santarpia 2020(b)

See the following reference. The reported changes in RNA were very small and may not be truly reflective of active replicating virus.

Jefferson T, Spencer EA, Brassey J, Heneghan C. Viral cultures for COVID-19 infectious potential assessment - a systematic review [published online ahead of print, 2020 Dec 3]. Clin Infect Dis. 2020;ciaa1764. doi:[10.1093/cid/ciaa1764](https://doi.org/10.1093/cid/ciaa1764)

'Complete live viruses are necessary for transmission, not the fragments identified by PCR. Prospective routine testing of reference and culture specimens and their relationship to symptoms, signs and patient co-factors should be used to define the reliability of PCR for assessing infectious potential. Those with a high cycle threshold are unlikely to have infectious potential.'

**Thanks. We have deleted the statement
changed text to:**

"Neither plaque assay nor serial passage was attempted in the study."

Competing Interests: No competing interests were disclosed.

Reviewer Report 16 April 2021

<https://doi.org/10.5256/f1000research.55319.r82591>

© 2021 Tomlinson D. This is an open access peer review report distributed under the terms of the [Creative Commons Attribution License](#), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

David R. Tomlinson

University Hospitals Plymouth NHS Trust, Plymouth, UK

Dear Professor Heneghan and team,

I would firstly like to congratulate you for publishing this systematic review on an open access site and for inviting comments. I am grateful for being given the opportunity to respond and to provide peer review. I hope you will consider the points I raise to be in the spirit of the best principles of scientific discourse - i.e., having a focus on methodology and without bias. I also hope that you and your team are open to performing major revisions to your manuscript, after consideration of all comments I provide below, and the other forms of feedback received through open access disclosure of this manuscript. Thank you.

1. Page 4: *'A collection of particles (liquid or solid) ranging in size from 0.001 μm to over 100 mm suspended in a gas defines an aerosol.'*

You have made a typographical error here (easily done!), since aerosols – 'suspensions in air (or a gas) of solid or liquid particles small enough that they will remain airborne for a prolonged period of time because of their low settling velocity' (Tellier R, 2009¹) – are typically stated as being <100 μm diameter, not mm. In addition, the definition of an aerosol typically includes reference to the time over which such particles may remain suspended in the air: would you consider adding this to the definition used in this present manuscript, please? For example, your methods document uses this wording, which is rather more complete in this respect: *'Respiratory droplets <5 μm in diameter are referred to as droplet nuclei or aerosols. Airborne transmission is the spread of an infectious agent caused by the dissemination of aerosols that remain infectious when suspended in air over long distances and time.'* Thank you.

2. Paragraph 2 of your introduction contains two sentences with 55% match to the abstract of Kutter *et al.* (2018) - your reference 4.

This is evidence of presumably accidental plagiarism. The wording should be modified to remedy this please. Thank you.

3. Appendix 7 outlines chosen methodology for excluding studies. Phrases including words such as 'adequately', 'sufficient' and 'clearly defined' are used yet without objective definition provided, introducing the possibility of selection bias.

I would be grateful if you could provide such methodological points in objectively definable terms, please, thereby permitting a more appropriate description as to why each of these studies was ineligible for inclusion. Thank you.

4. Thank you for providing a link to the 'Protocol for a living evidence review (Version 3: 1 December 2020)'. Under 'Study inclusion and exclusion' is stated: *'Eligible studies should include sampling for the detection of SARs-CoV-2 in the population or the environment on any potential mode of transmission, including droplet, airborne, fomite, orofecal, bloodborne, vertical or other. Studies can be observational including case series, ecological, or prospective; or interventional including randomised trials and clinical reports, outbreak reports, case-control studies, experimental studies, non-predictive modelling. Studies should include sampling for the detection of SARs-CoV-2.'*

Given this description of your intended methods, I am surprised that the methods for the present manuscript state: *'We included field studies that included airborne sampling for SARs-CoV-2 in the population or the environment.'* Ironically, table 3 of Kutter *et al.* (your ref 4) is highly relevant to this important methodological point, since these authors describe the pros and cons of various methods to determine respiratory virus transmission. The cons of air sampling are noted: technical difficulty and possibly only circumstantial level evidence. However, these authors provide a list of further methods usefully employed including virus stability, outbreak (household or hospital) reports, aircraft outbreaks, non-pharmaceutical intervention, experimental infection, air tracer studies and computational modelling / simulation. Each method has its pros and cons, but it is my contention that restricting your present analyses to studies which *'included airborne sampling'* excludes a large body of data which has been the foundation of investigations towards establishing routes of transmission of respiratory viruses amongst humans. Indeed, if your present methods were applied to measles, one would have to conclude that measles is not transmitted via the airborne route since live virus has never been successfully cultured from air samples. Therefore, and in line with this accepted and referenced practice within the field of infectious diseases, it is my contention that your present manuscript should include data from all suitably rigorous* experimental resources and outbreak reports listed here and as described by Kutter *et al.* Thank you.

[*Please forgive my use of a subjective term here: wording would be usefully informed by your response to point (3) I raise, above.]

In case this suggestion seems rather 'obtuse', I would like to draw upon two examples of excluding studies purely on the basis of their laboratory setting and the impact this may have on the validity of any such transmission review.

Firstly, the experiments of van Doremalen *et al.* (2020)², in my opinion, represent a particularly valuable contribution towards understanding the possibility of airborne transmission of SARS-CoV-2.

Van Doremalen outline methods:

'Virus stability in aerosols was determined as described previously at 65% relative humidity (RH) and 21-23°C (Fischer et al., 2016). In short, aerosols (<5 µm) containing HCoV-19 (105.25 TCID₅₀/mL) or SARS-CoV-1 (106.75-7 TCID₅₀/mL) were generated using a 3-jet Collison nebulizer and fed into a Goldberg drum to create an aerosolized environment. Aerosols were maintained in the Goldberg drum and samples were collected at 0, 30, 60, 120 and 180 minutes post-aerosolization on a 47mm gelatin filter (Sartorius). Filters were dissolved in 10 mL of DMEM containing 10% FBS. Three replicate experiments were performed.'

'Viable virus in all surface and aerosol samples was quantified by end-point titration on Vero E6 cells as described previously (van Doremalen et al., 2013).'

Results (extract):

'SARS-CoV-2 remained viable in aerosols throughout the duration of our experiment (3 hours), with a reduction in infectious titer from 10^{3.5} to 10^{2.7}TCID₅₀ per liter of air. This reduction was similar to that observed with SARS-CoV-1, from 10^{4.3} to 10^{3.5}TCID₅₀ per milliliter.'

Conclusions (extract):

'Our results indicate that aerosol and fomite transmission of SARS-CoV-2 is plausible, since the virus can remain viable and infectious in aerosols for hours and on surfaces up to days (depending on the inoculum shed). These findings echo those with SARS-CoV-1, in which these forms of transmission were associated with nosocomial spread and super-spreading events, and they provide information for pandemic mitigation efforts.'

That this study was excluded from your review on the basis of its laboratory setting can only imply that you believe different physical laws might be in operation in a Goldberg drum compared to 'normal air'. However, it is clearly inconceivable that the air within a Goldberg drum using the methods described has unique virus lifespan-enhancing properties. Furthermore, it is biologically implausible that SARS-CoV-2 only ever achieves aerosol **viability** when these same aerosols are created using a Collison nebuliser. Indeed, if the converse was true, you must have reason to believe that physiological aerosol creation during breathing, speech, singing, coughing and/or sneezing uniquely results in immediate (presumably mechanical?) viricidal action. No evidence is presented for this hypothesis, and on the basis of universally applicable physical laws, it is impossible.

Extending this thought process, since [WHO IPC Scientific Brief \(July 2020\)](#) authors (including, I note, co-author TJ on this present manuscript) consider SARS-CoV-2 to be transmitted via close-range *respiratory droplets*, following the logic presented above, for aerosols released from COVID-19 patients to be **non-infectious**, the only mechanism by which SARS-CoV-2 released on respiratory droplets (>5-10µm diameter as per WHO criteria) to be **infectious**, is for SARS-CoV-2 viruses to be possessed with the ability to simultaneously measure and move between liberated respiratory particles to ensure that **only those >5-10µm diameter** contain live SARS-CoV-2. Clearly, this is fantasy, since it also [logically] implies that SARS-CoV-2 is sentient and is aware of the current WHO convention for dichotomising respiratory particle size.

Secondly, excluding animal models of transmission not only goes against methods used by Wells and Riley towards the original proof that TB transmission occurs via the airborne route, but suggests that methods employing animal models of infection within strictly controlled

environmental conditions are of no use towards understanding human-to-human transmission. It is my contention that – for example – the experiments of Kutter *et al.* (2021) using ferrets represent a very important contribution to our understanding, providing ‘*experimental evidence of robust transmission of SARS-CoV-2 via the air*’³.

I hope you are able to appreciate the important possible harms in excluding such lines of research towards ‘understanding the objective nature of reality’, and that you are able to provide major revisions to this present manuscript to include all relevant data, as described. Thank you.

5. From this same review article (your ref 4), table 2 states the known transmission routes of SARS-CoV (Coronaviridae) as contact, droplet & aerosol.

As I am sure you are aware, the [WHO Ebola 2014 IPC guideline](#) states ‘*scientists are unaware of any virus that has dramatically changed its mode of transmission*’. So, in light of what is already known about human-to-human Coronaviridae transmission and the potential harms in failing to adequately mitigate every transmission route of SARS-CoV-2, I am curious as to why any infectious disease specialist or team of scientists investigating viral transmission would seek to ‘second-guess’ the inevitability of its [SARS-CoV-2] airborne transmission? This requires explanation please. Thank you.

6. Following the logic of point (3), your table 3 cannot be interpreted since objectively defined descriptions of ‘Quality of included studies’ is not provided.

I would be grateful if this analysis of study ‘quality’ could be updated in line with my suggestion of adopting objective ‘quality definitions’ above, please. Thank you.

Finally, I do not think it would be appropriate – and I don’t want to risk wasting your time in reading yet further comments – for me to undertake any further point-by-point discussion/review of the conclusions which you have drawn from your chosen methods, since it is my contention that your chosen methods are so importantly flawed that the present manuscript should be completely re-written using methods with greater scientific validity, and including the whole range of available data towards SARS-CoV-2 transmission, as described. I hope this seems reasonable.

Many thanks again for providing me with the opportunity to provide peer review. This is a hugely important topic and I sincerely hope you can use comments raised during this process to improve the quality of this manuscript.

References

1. Tellier R: Aerosol transmission of influenza A virus: a review of new studies. *J R Soc Interface*. 2009; **6 Suppl 6**: S783-90 [PubMed Abstract](#) | [Publisher Full Text](#)
2. van Doremalen N, Bushmaker T, Morris D, Holbrook M, et al.: Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1. *New England Journal of Medicine*. 2020; **382** (16): 1564-1567 [Publisher Full Text](#)
3. Kutter J, de Meulder D, Bestebroer T, Lexmond P, et al.: SARS-CoV and SARS-CoV-2 are transmitted through the air between ferrets over more than one meter distance. *Nature Communications*. 2021; **12** (1). [Publisher Full Text](#)

Are the rationale for, and objectives of, the Systematic Review clearly stated?

Yes

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

No

Is the statistical analysis and its interpretation appropriate?

Not applicable

Are the conclusions drawn adequately supported by the results presented in the review?

No

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: My regular daytime job since 2009 has been as Consultant Cardiologist and Electrophysiologist - perhaps an unlikely job title for anyone reviewing this manuscript. However, as MedRxiv Affiliate since June 2019, I have been exposed to and performing 'release review' of a constant stream of early published works on SARS-CoV-2 - something which has catalysed my interest in this field. I am also experienced in assessing the validity of experimental methods chosen (please see my recent peer reviewed publications and/or preprints) and believe my background allows me to approach this topic without risk of anchoring bias towards one or other mode of respiratory viral transmission. My interest in this area can be further affirmed by evidence of my 'peer review' of the WHO SARS-CoV-2 IPC Scientific Briefing July 2020, assessing the validity of the chosen references *against* airborne transmission of SARS-CoV-2 (my pinned tweet @DRTomlinsonEP). I mention this to illustrate the breadth and depth of my reading and background on this subject, which may otherwise be assumed to be insufficient for someone in my professional role. I hope this is acceptable and that you are able to consider my comments constructively - since this is my intention. Thank you.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to state that I do not consider it to be of an acceptable scientific standard, for reasons outlined above.

Author Response 25 Aug 2021

Carl Carl, University of Oxford, UK

Peer reviewers' comments

Authors' responses

Peer Reviewer #1

Dear Professor Heneghan and team,

I would firstly like to congratulate you for publishing this systematic review on an open access site and for inviting comments. I am grateful for being given the opportunity to respond and to provide peer review. I hope you will consider the points I raise to be in the

spirit of the best principles of scientific discourse - i.e., having a focus on methodology and without bias. I also hope that you and your team are open to performing major revisions to your manuscript, after consideration of all comments I provide below, and the other forms of feedback received through open access disclosure of this manuscript. Thank you.

Response: Thank you.

1. Page 4: *'A collection of particles (liquid or solid) ranging in size from 0.001 μm to over 100 mm suspended in a gas defines an aerosol.'*

You have made a typographical error here (easily done!), since aerosols – 'suspensions in air (or a gas) of solid or liquid particles small enough that they will remain airborne for a prolonged period of time because of their low settling velocity' (Tellier R, 2009¹) – are typically stated as being <100 μm diameter, not mm. In addition, the definition of an aerosol typically includes reference to the time over which such particles may remain suspended in the air: would you consider adding this to the definition used in this present manuscript, please? For example, your methods document uses this wording, which is rather more complete in this respect: *'Respiratory droplets <5 μm in diameter are referred to as droplet nuclei or aerosols. Airborne transmission is the spread of an infectious agent caused by the dissemination of aerosols that remain infectious when suspended in air over long distances and time.'* Thank you.

Response: We have revised the definition.

"There are varied definitions of aerosols in the published literature. An aerosol is defined as a collection of particles (liquid or solid) with varying aerodynamic diameters, suspended in the air (gas) for a prolonged period of time. The size of the particles and the distance they may travel is highly variable and depends on many factors,(

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2843947/>;

https://apps.who.int/iris/bitstream/handle/10665/112656/9789241507134_eng.pdf;jsessionid=41AA684FB64

)"Consider to add this reference Xie X, Li Y, Chwang AT, Ho PL, Seto WH. How far droplets can move in indoor environments--revisiting the Wells evaporation-falling curve. *Indoor Air*. 2007 Jun;17(3):211-25. doi: 10.1111/j.1600-0668.2007.00469.x. PMID: 17542834

2. Paragraph 2 of your introduction contains two sentences with 55% match to the abstract of Kutter *et al.* (2018) - your reference 4.

This is evidence of presumably accidental plagiarism. The wording should be modified to remedy this please. Thank you.

Response: We have revised the wording.

"Transmission via droplets and aerosols in specific settings or situations may potentiate the spread of some viruses in humans, resulting in disease outbreaks that are difficult to manage. The results of several studies investigating human-to-human virus transmission have been largely inconclusive, and the evidence to inform such transmission in experimental studies is often not available."

3. Appendix 7 outlines chosen methodology for excluding studies. Phrases including words such as 'adequately', 'sufficient' and 'clearly defined' are used yet without objective definition provided, introducing the possibility of selection bias.

I would be grateful if you could provide such methodological points in objectively definable terms, please, thereby permitting a more appropriate description as to why each of these studies was ineligible for inclusion. Thank you.

Response: There is no Appendix 7 in the submission. However, see the response to comment 6 below where we expand on the methods used to assess reporting quality.

4. Thank you for providing a link to the 'Protocol for a living evidence review (Version 3: 1 December 2020)'. Under 'Study inclusion and exclusion' is stated: *'Eligible studies should include sampling for the detection of SARs-CoV-2 in the population or the environment on any potential mode of transmission, including droplet, airborne, fomite, orofecal, bloodborne, vertical or other. Studies can be observational including case series, ecological, or prospective; or interventional including randomised trials and clinical reports, outbreak reports, case-control studies, experimental studies, non-predictive modelling. Studies should include sampling for the detection of SARs-CoV-2.'*

Given this description of your intended methods, I am surprised that the methods for the present manuscript state: *'We included field studies that included airborne sampling for SARs-CoV-2 in the population or the environment.'* Ironically, table 3 of Kutter *et al.* (your ref 4) is highly relevant to this important methodological point, since these authors describe the pros and cons of various methods to determine respiratory virus transmission. The cons of air sampling are noted: technical difficulty and possibly only circumstantial level evidence. However, these authors provide a list of further methods usefully employed including virus stability, outbreak (household or hospital) reports, aircraft outbreaks, non-pharmaceutical intervention, experimental infection, air tracer studies and computational modelling / simulation. Each method has its pros and cons, but it is my contention that restricting your present analyses to studies which *'included airborne sampling'* excludes a large body of data which has been the foundation of investigations towards establishing routes of transmission of respiratory viruses amongst humans. Indeed, if your present methods were applied to measles, one would have to conclude that measles is not transmitted via the airborne route since live virus has never been successfully cultured from air samples. Therefore, and in line with this accepted and referenced practice within the field of infectious diseases, it is my contention that your present manuscript should include data from all suitably rigorous* experimental resources and outbreak reports listed here and as described by Kutter *et al.* Thank you.

[*Please forgive my use of a subjective term here: wording would be usefully informed by your response to point (3) I raise, above.]

In case this suggestion seems rather 'obtuse', I would like to draw upon two examples of excluding studies purely on the basis of their laboratory setting and the impact this may have on the validity of any such transmission review.

Firstly, the experiments of van Doremalen *et al.* (2020)², in my opinion, represent a particularly valuable contribution towards understanding the possibility of airborne transmission of SARS-CoV-2.

Van Doremalen outline methods:

'Virus stability in aerosols was determined as described previously at 65% relative humidity (RH) and 21-23°C (Fischer et al., 2016). In short, aerosols (<5 µm) containing HCoV-19 (105.25 TCID₅₀/mL) or SARS-CoV-1 (106.75-7 TCID₅₀/mL) were generated using a 3-jet Collison nebulizer and fed into a Goldberg drum to create an aerosolized environment. Aerosols were maintained in the Goldberg drum and samples were collected at 0, 30, 60, 120 and 180 minutes post-aerosolization on a 47mm gelatin filter (Sartorius). Filters were dissolved in 10 mL of DMEM containing 10% FBS. Three replicate experiments were performed.'

"Viable virus in all surface and aerosol samples was quantified by end-point titration on Vero E6 cells as described previously (van Doremalen et al., 2013)."

Results (extract):

'SARS-CoV-2 remained viable in aerosols throughout the duration of our experiment (3 hours), with a reduction in infectious titer from 10^{3.5} to 10^{2.7}TCID₅₀ per liter of air. This reduction was similar to that observed with SARS-CoV-1, from 10^{4.3} to 10^{3.5}TCID₅₀ per milliliter.'

Conclusions (extract):

'Our results indicate that aerosol and fomite transmission of SARS-CoV-2 is plausible, since the virus can remain viable and infectious in aerosols for hours and on surfaces up to days (depending on the inoculum shed). These findings echo those with SARS-CoV-1, in which these forms of transmission were associated with nosocomial spread and super-spreading events, and they provide information for pandemic mitigation efforts.'

That this study was excluded from your review on the basis of its laboratory setting can only imply that you believe different physical laws might be in operation in a Goldberg drum compared to 'normal air'. However, it is clearly inconceivable that the air within a Goldberg drum using the methods described has unique virus lifespan-enhancing properties. Furthermore, it is biologically implausible that SARS-CoV-2 only ever achieves aerosol **viability** when these same aerosols are created using a Collison nebuliser. Indeed, if the converse was true, you must have reason to believe that physiological aerosol creation during breathing, speech, singing, coughing and/or sneezing uniquely results in immediate (presumably mechanical?) viricidal action. No evidence is presented for this hypothesis, and on the basis of universally applicable physical laws, it is impossible.

Extending this thought process, since **WHO IPC Scientific Brief (July 2020)** authors (including, I note, co-author TJ on this present manuscript) consider SARS-CoV-2 to be transmitted via close-range *respiratory droplets*, following the logic presented above, for aerosols released from COVID-19 patients to be **non-infectious**, the only mechanism by which SARS-CoV-2 released on respiratory droplets (>5-10µm diameter as per WHO criteria) to be **infectious**, is for SARS-CoV-2 viruses to be possessed with the ability to simultaneously measure and move between liberated respiratory particles to ensure that **only those >5-10µm diameter** contain live SARS-CoV-2. Clearly, this is fantasy, since it also [logically] implies that SARS-

CoV-2 is sentient and is aware of the current WHO convention for dichotomising respiratory particle size.

Secondly, excluding animal models of transmission not only goes against methods used by Wells and Riley towards the original proof that TB transmission occurs via the airborne route, but suggests that methods employing animal models of infection within strictly controlled environmental conditions are of no use towards understanding human-to-human transmission. It is my contention that – for example – the experiments of Kutter *et al.* (2021) using ferrets represent a very important contribution to our understanding, providing '*experimental evidence of robust transmission of SARS-CoV-2 via the air*'³.

I hope you are able to appreciate the important possible harms in excluding such lines of research towards 'understanding the objective nature of reality', and that you are able to provide major revisions to this present manuscript to include all relevant data, as described. Thank you.

Response:

We understand the reviewer's point involving the use of other methods to determine respiratory virus transmission. However, in our pre-specified "a priori" protocol, we planned to include sampling in the population or the environment. We do not discount the suggestion that SARS-CoV-2 can be sampled via other methods as the reviewer suggests. We have included this as a limitation of the study.

"We excluded study designs/settings that attempted to detect SARS-CoV-2 via other methods apart from air sampling, e.g., virus stability, outbreak reports, aircraft outbreaks, non-pharmaceutical intervention, experimental infection, air tracer studies and computational modelling/simulation"

Laboratory studies such as the one quoted provide insights into the stability of the virus in airborne suspensions but provide no insights into whether there exist ordinary biological mechanisms capable of generating such high-titer aerosols in the first place. The fact that one can put humans into orbit, doesn't mean it is an easily achieved or common task. It simply says humans can survive in orbit.

The inclusion of laboratory studies was not a part of our protocol but could be included as a part of a separate review but is outside the scope of our study.

The suggestion to include animal models or laboratory-based studies, in general, would not be appropriate. An animal review would be a separate review with a specific methodology. The Collaborative Approach to Meta-Analysis and Review of Animal Experimental Studies (CAMARADES) research group aims to address the gap in systematic review and meta-analysis in this area. See: [CAMARADES | The University of Edinburgh](#).

We would like to point the classic 1964 Nature paper [Survival of Measles Virus in Air | Nature](#) (DE JONG, J., WINKLER, K. Survival of Measles Virus in Air. *Nature* 201, 1054–1055 (1964). <https://doi.org/10.1038/2011054a0>).

5. From this same review article (your ref 4), table 2 states the known transmission routes of SARS-CoV (Coronaviridae) as contact, droplet & aerosol.

As I am sure you are aware, the [WHO Ebola 2014 IPC guideline](#) states '*scientists are unaware of any virus that has dramatically changed its mode of transmission*'. So, in light of what is already known about human-to-human Coronaviridae transmission and the potential harms in failing to adequately mitigate every transmission route of SARS-CoV-2, I am curious as to why any infectious disease specialist or team of scientists investigating viral transmission would seek to 'second-guess' the inevitability of its [SARS-CoV-2] airborne transmission? This requires explanation please. Thank you.

Response:

We do consider a peer review seriously and do not seek to second-guess any conclusion but prefer to examine the evidence base in a rigorous manner. We have published over a hundred (100) systematic reviews and synthesize the evidence objectively in both this and a previous pandemic (see as an example: Neuraminidase inhibitors for preventing and treating influenza in adults and children Version published: 10 April 2014 Version history <https://doi.org/10.1002/14651858.CD008965.pub4>).

We analysed as in our previous work the published evidence to the date specified. We set out to determine whether SARS-CoV-2 could be detected in air samples. We have stated in our conclusion that the lack of positive samples does not rule-out airborne transmission and have tried to be as objective and open as possible but maintaining a rigorous evidence based approach.

The citation "[WHO Ebola 2014 IPC guideline](#)" may have been quoted out of context. Coronaviruses exhibit a variety of infection modes (respiratory, enteric, systemic), but if one looks beyond humans the disease is most commonly enteric in nature [see Saif (2004) Rev. sci. tech. Off. int. Epiz., 23 (2), 643-660]. The human respiratory strain OC-43 may have originated as a bovine enteric coronavirus. This is the reason why there has been so much interest in trying to detect and retrieve the SARS-CoV-2 from fecal specimens.

6. Following the logic of point (3), your table 3 cannot be interpreted since objectively defined descriptions of 'Quality of included studies' is not provided.

I would be grateful if this analysis of study 'quality' could be updated in line with my suggestion of adopting objective 'quality definitions' above, please. Thank you.

Response: Thank you. We have expanded the section on the methods used to assess the quality of reporting.

"We assessed quality using a modified QUADAS 2 risk of bias tool,⁸. We simplified the tool as the included studies were not designed as primary diagnostic accuracy studies and the quality of transmission studies is known to be low⁹. We gave particular importance to the description of methods for air sampling and the reporting of sufficient detail to enable

replication of the study. We examined the following domains: (i) Source population – did the study authors adequately describe the source population? E.g. setting, severity of SARS-CoV-2, baseline demographics including concurrent respiratory infections or other comorbidities, distance between study subjects; (ii) Methods – did the study authors sufficiently describe the methods used to enable replication of the study? E.g. methods used for diagnosing SARS-CoV-2 in patients, procedure used for air sampling, time-point for sampling, number of samples per site, cycle thresholds, culture methods, airflow/ventilation settings, humidity; (iii) Sample sources – did the authors clearly describe the sources for the air samples? What was the volume of air in each sample? Was the period of sampling similar across various sites? (iv) Outcome reporting – was the reporting of the results consistent with the study outcomes? Was the analysis of the results appropriate – e.g., interval and time-point for testing study participants for potential transmission; (v) Follow-up – was the pattern and number of air samples sufficient to demonstrate airborne transmission - e.g. repeat sampling, serial sampling?” The risk of bias for each domain was rated “low”, “moderate” or “high” depending on the adequacy of reporting. One reviewer (CJH) assessed the risk of bias while a second author (EAS) independently verified the risk of bias. Any disagreements were resolved through discussion. Where a consensus could not be reached, a third reviewer (IJO) arbitrated.”

Finally, I do not think it would be appropriate – and I don’t want to risk wasting your time in reading yet further comments – for me to undertake any further point-by-point discussion/review of the conclusions which you have drawn from your chosen methods, since it is my contention that your chosen methods are so importantly flawed that the present manuscript should be completely re-written using methods with greater scientific validity, and including the whole range of available data towards SARS-CoV-2 transmission, as described. I hope this seems reasonable.

Response: We already have a published protocol that has been used to conduct our series of systematic reviews of studies investigating transmission dynamics of COVID-19. However, our research is ongoing, the quality of the evidence and methods have changed over time and we make necessary adjustments to improve the robustness of the evidence as more studies (and evidence) become available (and examined). We are in contact with several original authors to clarify and update the methods.

Many thanks again for providing me with the opportunity to provide peer review. This is a hugely important topic and I sincerely hope you can use comments raised during this process to improve the quality of this manuscript.

Response:

Thanks. We have made several revisions to improve the quality of the manuscript.

Competing Interests: No competing interests were disclosed.

Comments on this article

Version 2

Reader Comment 18 Sep 2021

Étienne Booth, Université du Québec à Chicoutimi, Saguenay, Canada

Heneghan et al's submission of *SARS-CoV-2 and the role of airborne transmission: a systematic review* in an Open Research publishing platform is commendable. It is in my opinion an encouraging sign that the authors are seeking transparent evaluation from competent peers from the scientific community.

I want to specify I am not one of those peers.

I do not hold the academic credentials required for such a title. My only claim to having any ability towards contributing something of value here is the fact that I have spent much of the past year working on an ongoing book project named *In Defense of Training*, which is on the subject of what the SARS-CoV-2 pandemic has revealed about the place given to physical activity in society. Part of that project has required to immerse myself in the scientific literature regarding the risks of transmission during physical training.

In short, I am not commenting here as an academic or as an aerosol expert, but as a writer who has been interested in the broad subject of understanding and communicating the risks of SARS-CoV-2 transmission.

As such, I am limiting my comments to my level of competence and, to have a margin of safety, I am aiming to not go beyond college level science principles. By doing so, I by no means imply that Heneghan et al are not already expertly familiar with these. By basing my comments on fundamental principles, my goal is to distance myself from what I am not competent enough to have an opinion on, and try to contribute by pointing out what may simply be too obvious to be recognized.

Scientific thinking

At its core, scientific thinking is taking pertinent objective observations and using reason to draw out logical conclusions. Arguably one of the greatest traps of this process is cognitive dissonance and its bias manifestations, because they masquerade to its originator and unaware bystanders as logically coherent and scientifically valid.

As humans, we are all prone to logical inconsistencies because we harbor contradicting and often unconscious motivations. Given this reality, I am not negatively accusatory when I comment here that there seems to be cognitive dissonance and biases at work in Heneghan *et al*'s publication. It simply means that scientists are human.

Coherent sequence of objectives

At the highest level, the greater objective of the WHO funded series of rapid reviews, of which Heneghan *et al*'s publication is a part of, is stated as: "to undertake a series of living systematic searches and appraisal of evidence on SARS-CoV-2 modes of transmission and its related updates are informing WHO guidance and scientific documents." (Center for Evidence-Based Medicine, 2021)

At the level of this publication, the objective is "to identify, appraise, and summarize the evidence (from studies peer-reviewed or awaiting peer review) relating to the role of airborne transmission of SARS-CoV-2 and the factors influencing transmissibility." To Heneghan *et al*'s credit, the scope of the publication's objective is very well communicated. It is broad and inclusive. It is also coherent with the greater objective of the WHO funded series.

Even more importantly, Heneghan *et al*'s objective is worthy and necessary. It is meaningful. In the midst of this global pandemic, we need science to guide public health measures, which in turn guide individual actions. We need to understand if SARS-CoV-2 is transmitted through the air, and what factors increase or decrease the risk of such transmission.

At the title level, *SARS-CoV-2 and the role of airborne transmission: a systematic review*, is once again coherent with both the greater objective of the WHO funded living rapid review series and the specific objective from Heneghan *et al*'s publication.

Incoherent methodology with stated objectives

Together, all three levels (series, publication, title) form a consistent and logical sequence from the general to the specific. Broad in its scope. Inclusive in its search. Meaningful in its implications. But from that point, there are several logical inconsistencies within and between the methodology, discussion and conclusion.

Foremost, given the broad scope and inclusive search for evidence that is stated at all levels, it is hard to understand why Heneghan *et al* "excluded study designs/settings that attempted to detect SARS-CoV-2 via other methods apart from air sampling, e.g., virus stability, outbreak reports, aircraft outbreaks, non-pharmaceutical intervention, experimental infection, air tracer studies and computational modelling/simulation." As these studies have value towards attaining the publication's objectives, this is as logical as having the goal to "identify, appraise, and summarize all letters of the alphabet", while simultaneously excluding "letters B through Z".

Because of its overarching importance, I am reformulating here what commenter Jose-Luis Jimenez and reviewer Maosheng Yao have already put forward. Respectfully, there seems to be a logical disconnection between the scope of this publication's broad and inclusive objectives (at the series, publication and title level) and its narrow and exclusionary methodology.

To re-establish coherence, the publication could either:

1. Aim to review the evidence relating to the role of airborne transmission (and fulfil its practical mission of informing WHO guidance and scientific documents) and take in account all pertinent evidence.

OR

1. Aim to limit the review to evidence of RNA detection and viral culture of air samples, and change its stated objective, title and content to reflect this limited scope (but will be at odds with the overarching rapid review series mission).

Quite simply, the publication cannot logically be both. One option excludes the other. In its current form, the publication's duality of broad objectives coupled with its narrow methodology almost inevitably leads to a misinterpretation and overreach of Heneghan *et al*'s conclusions.

Rationalization of exclusions

It is especially incoherent to exclude, for example, laboratory and animal studies, then including in the discussion the Wells, Riley and Mills experiments (which are combined laboratory and animal studies) as a reference for the level of proof required to demonstrate airborne transmission:

"the only clear proof that any communicable disease is transmitted by aerosol came from the famous experiment by Wells, Riley, and Mills in the 1950s, which required years of continual exposure of a large colony of guinea pigs to a clinical ward filled with patients who had active tuberculosis" (Roy *et al.* 2004)

Furthermore, when reviewer David R. Tomlinson underlined the incoherence in version 1 of this publication, the authors' response was: "The suggestion to include animal models or laboratory-based studies, in general, would not be appropriate. An animal review would be a separate review with a specific methodology." As this does not address the core incoherence of excluding animal and laboratory studies, then including them as required proof in the discussion, this seems to be rationalization of cognitive dissonance.

Weighing evidence asymmetrically

A similar inconsistency appears at the end of Heneghan *et al*'s discussion, where a paragraph is dedicated to studies for which the authors interpret the results as not supporting airborne transmission. Of the four studies cited, three are retrospective investigations of SARS-CoV-2 exposure that do not include air sampling for the detection of the virus (Bays D 2020, Mponponsuo K 2020, Wong SCY *et al.*, 2020). Inclusion of these studies as evidence against airborne transmission even if they should be excluded by the publication's own methodology standards is incoherent. But excluding all other equivalent studies that could, by the same logic, be exposed as evidence in favor of airborne transmission, is the application of a double standard.

Hence, there is an asymmetry in how Heneghan *et al*'s publication weighs and discusses evidence. In fact, the discussion only mentions studies that "do not support the airborne transmission hypothesis." There is no mention that any study supports airborne transmission. Yet many of the studies reviewed by Heneghan *et al* retrospectively investigated outbreaks in buses (Luo K 2020, Shen Y 2020), choirs (Charlotte N 2020, Hamner L 2020 and Miller SL 2020), a nursing home (De Man P 2020), a meat processing plant (Günther T 2020), an apartment building (Lin G 2020), and restaurants (Li Y & Qian H 2020, Lu J 2020), which conclude in favor of airborne transmission.

The selective inclusion in the discussion of studies concluding against airborne transmission, while excluding any mention of similar studies that conclude the opposite, is not only illogical, it is the text book manifestation of confirmation bias.

Strengths seen as limitations

Heneghan *et al* are clearly correct in stating that “SARS-COV-2 RNA can be detected intermittently by RT-PCR in the air in a variety of settings”. That is an empirical fact. The stated “lack of recoverable viral samples” is beyond my own competence to comment on. But even without taking into account the technical issues commented by Raymond Tellier and Jose-Luis Jimenez regarding SARS-CoV-2 RNA detection and viral culture, there are several purely logical flaws in Heneghan *et al*’s analysis of data.

First of all, absence of proof is not proof of absence. In this case, this is especially true for environments designed to dilute and evacuate airborne containments. Of the 42 indoor hospital studies that included air sampling RT-PCR data, my own review showed that:

- 19 studies took samples in Airborne Infection Isolation Rooms (AIIRs) or in environments with equivalent or higher ventilation rates (12 air changes per hour (ACH) or more), although 3 of them were using methods to prevent dilution and evacuation of contaminants during sampling.
- 11 studies mentioned no ventilation rates, but had airborne infection mitigating measures such as being a negative pressure environment (usually, but not necessarily meaning at least 12 ACH), low CO2 measures (ranging from 341 to 503 ppm), being a “level 2 or 3 protection level”, having UV air disinfection or open windows during sampling.
- 7 studies mentioned no ventilation rates or airborne infection mitigating measure.
- 4 had relatively low stated ventilation rates (ranging from 1.5 to 7 ACH) and no mention of airborne infection mitigating measures.
- 1 Did not take air samples in rooms, but only in HVAC systems.

These numbers are not to be taken as absolute, as there is considerable overlap and grey areas in the methodology of each study (which is exactly Heneghan *et al*’s point). But what should be taken into account is that most studies were done in hospital environments with ventilation and or airborne transmission mitigating measures that do not represent the typical ventilation conditions of indoor environments in society.

Again, these are only estimations (true ventilation is usually based on occupant density and type of activity, as per ASHRAE 62.1, for example), but many homes will have a ventilation rate of around 1 ACH, offices and retail shops around 2-3 ACH, and restaurants around 6-8 ACH. And in most of these environments, the occupant density will be much higher than in an AIIR (were there is usually only one occupant). In consequence, any allusion that intermittent detection in the hospital studies

goes against airborne transmission is tenuous.

Logically, it is to be expected that air samples taken in indoor environments engineered to dilute, evacuate or destroy airborne contaminants will have less chance of being positive than in indoor environments that are not. At a minimum, even intermittent positive detection in an AIIR or similar setting should be concerning, if not taken as a sign of increased risk of airborne transmission in less ventilated environments. Concluding otherwise is the logical equivalent of believing that there are no leaks because water is intermittently found at the bottom of boats with actively functioning bilge pumps.

A similar logical flaw seems to be made in Heneghan *et al*'s conclusion: "A number of studies that looked for viral RNA in air samples found none, even in settings where surfaces were found to be contaminated with SARS-CoV-2 RNA". Although this could be defended as being the statement of a fact, the phrasing implies that this should be considered evidence against airborne transmission. Again, absence of proof is not proof of absence. Finding positive surface samples (sometimes in unreachable ventilation ducts and filters) should logically lead to the question: "How did it get there?".

Yes, variable environmental conditions are stated by Heneghan *et al* as a limitation. But if the objective is not simply to suggest a standardised method of sampling and reporting, but to truly review evidence regarding the "role of airborne transmission of SARS-CoV-2 and the factors influencing transmissibility", intermittent detection in settings designed to be unfavorable to airborne transmission should actually be considered as strength of evidence.

In my opinion, logically reviewing even the limited data considered by Heneghan *et al*'s methodology should not lead to a "eureka" against airborne transmission, but at a number of "that's funny..." in favor of it.

Science is provisional

Up to this point, I have essentially used basic logical reasoning to analyse and comment Heneghan *et al*'s publication, mainly regarding its content. Now, I wish to shift to another basic scientific principle to analyse and comment on what the publication does not contain.

I need to underline that I understand that by setting viral culture of air samples as the "gold standard" of proof and by concluding that there is a need for standardised methods and improved reporting, Heneghan *et al*'s intention is to recognize nothing less than the direct and undeniable observation of infectious SARS-CoV-2 virus contained in expelled respiratory airborne particles by an index patient. There is nothing intrinsically wrong with this. High standards are commendable.

But this intention misses a fundamental principle and, by doing so, distances the publication from its functional objective.

Science is forever provisional on available data.

We formulate hypotheses and construct models to explain reality, and these must be changed

when new data disconfirms them. Although models are inherently imperfect (the map is not the territory), they are still useful. As such, action based on science is using the best available model, the one that best fits our empirical observations of reality, even if direct proof has not been observed.

If the map works, it is better to use it than flying blind.

So, what Heneghan *et al.*'s publication is missing is the mention that airborne transmission is the best model humanity has to explain and combat the SARS-CoV-2 pandemic, even if viral cultures from airborne samples were to be discarded.

It also does not mention the comparative weakness of any alternative model of transmission, all of which do not hold up to any practical comparison to the empirical observations accumulated after nearly two years of this global pandemic.

The streams of evidence supporting this claim have been very well summarized in the peer-reviewed Lancet commentary from Greenhalgh *et al.* Many of these were brought to the attention of Heneghan *et al.* by the comments of Jose-Luis Jimenez on version 1 of their publication, such as:

- Animal studies showing airborne transmission (e.g. Kutter *et al.* 2021).
- Long distance transmission (e.g. Katelaris *et al.* 2021).
- Transmission is twenty times more frequent indoors than outdoors (Bulfone *et al.* 2021). This cannot be explained by large droplet transmission, but is readily explained by airborne transmission, due to much higher dispersion outdoors than indoors.
- Superspreading events appear to occur dominantly in poorly-ventilated indoor spaces. This has led e.g. WHO to recommend ventilation as a way to reduce transmission, including detailed guidelines (World Health Organization 2021). This again is easily explained by airborne transmission, but not by large droplets or fomites which are not substantially impacted by ventilation.
- Presymptomatic and oligosymptomatic transmission is known to occur (Johansson *et al.* 2021), and may be an important reason why we are in such a difficult-to-control pandemic. Measurements show that people without cough produce few droplets but abundant aerosols, (Chen *et al.* 2020), favoring the airborne route of transmission for people without a cough.
- Nosocomial infections have been reported in several studies, including some showing genomic match, despite wearing of surgical masks and eye protection (Klompas, Baker, Griesbach, *et al.* 2021; Klompas, Baker, Rhee, *et al.* 2021; Goldberg *et al.* 2021).
- SARS-CoV-2 virus material has been measured (by PCR) after sampling ducts and filters in a hospital building (Nissen *et al.* 2020). It could only have reached these locations as an aerosol.

Airborne transmission elegantly fits all of the above streams of evidence. All other transmission theories do not.

Science is unconstrained to a specific discipline

In the same line of thought, I am adding a final principle; science is not constrained to a specific discipline. It gains by being open. A theory that holds up against the basic models of physics, engineering, biology and medicine has a better chance of surviving the test of reality than if it is isolated in the theoretical vacuum of a single discipline.

The alternative SARS-CoV-2 transmission theory of combined ballistic droplets and fomites as main drivers of the pandemic can only live in the theoretical vacuum of historically accepted medical norms. It does not hold up to the previously stated streams of evidence. In fact, it is incoherent with even some of the most basic models of science:

- The ballistic droplet theory excluding particles $>5\text{-}10\text{ }\mu\text{m}$ from airborne transmission, as stated in Appendix 1, goes against Newtonian physics. In reality, particles up to around $100\text{ }\mu\text{m}$ can remain suspended long enough to be transported in the air and inhaled, the $5\text{-}10\text{ }\mu\text{m}$ limit being a historical mix up with the particles able to reach the deep lung (Randall *et al.* 2021).
- As David R. Tomlinson pointed out in his version 1 review, to the best of humanity's understanding of biology, viruses are not sentient. They cannot choose to be contained only in to respiratory particles that do not remain suspended in the air.
- As Jose-Luis Jimenez commented on version 1 of this publication, ballistic droplets and fomites cannot explain superspreading events that occur exclusively in poorly-ventilated indoor environments, but the basic engineering models of fluid dynamics can (e.g. Lewis 2021 and references therein, Hamner L 2020).

So, for the alternative theory of ballistic droplets and fomite transmission to be true, it requires us not to compare it to numerous streams of evidence and basic models coming from multiple scientific disciplines. Fundamentally, it requires us not to observe or think. That is a bad sign.

What is missing in Heneghan *et al.*'s publication is the consideration that airborne transmission becomes more robust as you compare it to the basic models of different scientific disciplines.

Belief Perseverance

The other telltale signs of a dysfunctional theory or model is the necessity of adding exceptions, ignoring contradicting observations, or explaining them in an increasingly improbable way in order to fit reality. Individually or combined, the direct contact, fomite and ballistic droplet theories require all of these.

Confirmation bias is the often-unconscious search and inclusion of evidence in favor of an initial hypothesis, while also unconsciously missing or misinterpreting evidence against it. But, once disconfirming evidence is clearly presented, refusing to take these into account becomes a

conscious, intentional affair.

There comes a point where consciously refusing credible evidence becomes belief perseverance, a bias so great that no contradicting proof can change the believer's perspective.

Ignaz Semmelweis proved with a simple hand washing protocol that unclean hands were the source of many post partum infections, even before the bacteria responsible could be observed. John Snow did the same regarding the propagation mode of cholera through his famous pump handle removal of a fecal contaminated water source. William Wells proved airborne transmission of tuberculosis with an experiment using logic and reason, not by bacterial culture from air samples.

In all of these historic cases, the evidence was for many years deemed unconvincing, of low quality. But what truly prevented acceptance (and has led to unnecessary death) was not the lack or the quality of evidence, but the perseverance of strongly held beliefs.

Contrary to these examples, where only a few individuals were toiling away to produce a single piece of proof against a dominant belief, the SARS-CoV-2 pandemic has brought the whole world's scientists together in producing enormous amounts and diversity of evidence.

Viral culture from airborne samples could be completely discarded as an evidence stream, it would not change the overwhelmingly coherent sum of all other empirical evidence in favor of airborne transmission and the comparative weakness of alternative theories.

If this fact is being ignored, even after being brought forward numerous times by commenters and reviewers, it would be an indicator that belief perseverance is at work as a bias in Heneghan *et al's* publication.

Conclusion

Given some of the fundamental principles that science is:

1. Using reason to draw out logical conclusions.
2. Provisional, yet we should still use the best available model.
3. Not constrained to a specific discipline.

I respectfully encourage Heneghan *et al's* to wonder what the great scientific minds that they themselves respect and admire would do with the relevant empirical data that has been accumulated after nearly two years of this worldwide pandemic. What would these people of reason do with what has been commented here (by other more competent minds than me) as credible arguments in favor of airborne transmission, especially considering the comparative weakness of any evidence for an alternative mode of transmission?

Although the process of eliminating biases in the pursuit of truth is central to the role of a scientist,

it still takes great effort, strength and courage to recognize and untangle them. In fact, it is sometimes so difficult that, as Max Planck has said, only the passage of time leads to acceptance :

"A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die and a new generation grows up that is familiar with it."

I truly hope, for humanity's sake, that we will all prove him wrong.

Étienne Booth

References:

Bays, D., Nguyen, M., Cohen, S., Waldman, S., Martin, C., Thompson, G., . . . Penn, B. (2020). "Investigation of nosocomial SARS-CoV-2 transmission from two patients to healthcare workers identifies close contact but not airborne transmission events." *Infection Control & Hospital Epidemiology*, 1-7. doi:10.1017/ice.2020.321

Bulfone, Tommaso Celeste, Mohsen Malekinejad, George W. Rutherford, and Nooshin Razani. 2021. "Outdoor Transmission of SARS-CoV-2 and Other Respiratory Viruses: A Systematic Review." *The Journal of Infectious Diseases* 223 (4): 550–61.

Center for Evidence Based Medicine. (September 18th, 2021).
<https://www.cebm.ox.ac.uk/research/transmission-of-sars-cov-2>

Charlotte N. "High Rate of SARS-CoV-2 Transmission due to choir practice in France at the beginning of the COVID-19 pandemic." medRxiv 2020.07.19.20145326

Chen, Wenzhao, Nan Zhang, Jianjian Wei, Hui-Ling Yen, and Yuguo Li. 2020. "Short-Range Airborne Route Dominates Exposure of Respiratory Infection during Close Contact." *Building and Environment* 176 (June): 106859.

De Man P *et al.* "Outbreak of COVID-19 in a nursing home associated with aerosol transmission as a result of inadequate ventilation." *Clinical Infectious Diseases*, ciaa1270

Goldberg, Lotem, Yoel Levinsky, Nufar Marcus, Vered Hoffer, Michal Gafner, Shai Hadas, Sraya Kraus, Meirav Mor, and Oded Scheuerman. 2021. "SARS-CoV-2 Infection among Healthcare Workers despite the Use of Surgical Masks and Physical Distancing - the Role of Airborne Transmission." *Open Forum Infectious Diseases*, January.

Greenhalgh, Trisha, Jose L. Jimenez, Kimberly A. Prather, Zeynep Tufekci, David Fisman, and Robert Schooley. 2021. "Ten Scientific Reasons in Support of Airborne Transmission of SARS-CoV-2." *The Lancet*, April.

Günther T, Czech-Sioli M, Indenbirken *et al.* "SARS-CoV-2 outbreak investigation in a German meat processing plant." *EMBO Mol Med* (2020) 12: e13296

Hamner L, Dubbel P, Capron *et al.* "High SARS-CoV-2 attack rate following exposure at a choir practice—Skagit County, Washington", March 2020. *Morb Mortal Wkly.* 2020; 69(19): 606– 610.

Also published as: Miller, SL, Nazaroff, WW, Jimenez, JL, *et al.* "Transmission of SARS-CoV-2 by inhalation of respiratory aerosol in the Skagit Valley Chorale superspreading event." *Indoor Air.* 2020;00: 1– 10.

Heneghan CJ, Spencer EA, Brassey J *et al.* "SARS-CoV-2 and the role of airborne transmission: a systematic review" [version 1; peer review: 1 approved with reservations, 2 not approved]. F1000Research 2021, 10:232

Johansson, Michael A., Talia M. Quandelacy, Sarah Kada, Pragati Venkata Prasad, Molly Steele, John T. Brooks, Rachel B. Slayton, Matthew Biggerstaff, and Jay C. Butler. 2021. "SARS-CoV-2 Transmission From People Without COVID-19 Symptoms." *JAMA Network Open* 4 (1): e2035057

Katellaris, Anthea L., Jessica Wells, Penelope Clark, Sophie Norton, Rebecca Rockett, Alicia Arnott, Vitali Sintchenko, Stephen Corbett, and Shopna K. Bag. 2021. "Epidemiologic Evidence for Airborne Transmission of SARS-CoV-2 during Church Singing, Australia, 2020." *Emerging Infectious Diseases* 27 (6).

Klompas, Michael, Meghan A. Baker, Diane Griesbach, Robert Tucker, Glen R. Gallagher, Andrew S. Lang, Timelia Fink, *et al.* 2021. "Transmission of SARS-CoV-2 from Asymptomatic and Presymptomatic Individuals in Healthcare Settings despite Medical Masks and Eye Protection." *Clinical Infectious Diseases*, March.

Klompas, Michael, Meghan A. Baker, Chanu Rhee, Robert Tucker, Karen Fiumara, Diane Griesbach, Carin Bennett-Rizzo, *et al.* 2021. "A SARS-CoV-2 Cluster in an Acute Care Hospital." *Annals of Internal Medicine*, February.

Kutter, Jasmin S., Dennis de Meulder, Theo M. Bestebroer, Pascal Lexmond, Ard Mulders, Mathilde Richard, Ron A. M. Fouchier, and Sander Herfst. 2021. "SARS-CoV and SARS-CoV-2 Are Transmitted through the Air between Ferrets over More than One Meter Distance." *Nature Communications* 12 (1): 1653.

Lin G, Zhang S, Zhong Y *et al.* "Community evidence of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission through air." *Atmospheric Environment*, 2020, 118083

Li Y, Qian H, Hang J, *et al.* "Evidence for probable aerosol transmission of SARS-CoV-2 in a poorly ventilated restaurant." *medRxiv*; 2020.

Lu J, Gu J, Li K, Xu C, Su W, Lai Z, *et al.* "COVID-19 outbreak associated with air conditioning in restaurant, Guangzhou, China, 2020". *Emerg Infect Dis.* 2020;26(7):1628-1631.

Luo K, Lei Z, Hai Z, Shanliang Xiao, *et al.* "Transmission of SARS-CoV-2 in public transportation

vehicles: a case study in Hunan Province, China", Open Forum Infectious Diseases, Volume 7, Issue10, October 2020, ofaa430

Lewis, Dyani. 2021. "Superspreading Drives the COVID Pandemic - and Could Help to Tame It." Nature 590 (7847): 544–46.

Mponponsuo, K., Kerkerian, G., Somayaji, R., Missaghi, B., Vayalumkal, J. V., Larios, O. E., Berenger, B. M., Lauzon, M., McDonnell, N., & Conly, J. (2021). "Lack of nosocomial transmission to exposed inpatients and coworkers in an investigation of five SARS-CoV-2-infected healthcare workers." Infection control and hospital epidemiology, 42(8), 1025–1026.

Nissen, Karolina, Janina Krambrich, Dario Akaberi, Tove Hoffman, Jiaxin Ling, Åke Lundkvist, Lennart Svensson, and Erik Salaneck. 2020. "Long-Distance Airborne Dispersal of SARS-CoV-2 in COVID-19 Wards." Scientific Reports 10 (1): 19589.

Randall, Katherine and Ewing, E. Thomas and Marr, Linsey and Jimenez, Jose and Bourouiba, Lydia, "How Did We Get Here: What Are Droplets and Aerosols and How Far Do They Go? A Historical Perspective on the Transmission of Respiratory Infectious Diseases" (April 15, 2021).

Roy CJ, Milton DK. "Airborne transmission of communicable infection--the elusive pathway." N Engl J Med. 2004; 350(17): 1710–1712.

Shen Y, Li C, Dong H, *et al.* "Community outbreak investigation of SARS-CoV-2 transmission among bus riders in Eastern China." JAMA Intern Med. 2020

Wong, S., Kwong, R. T., Wu, T. C., Chan, J., Chu, M. Y., Lee, S. Y., Wong, H. Y., & Lung, D. C. (2020). "Risk of nosocomial transmission of coronavirus disease 2019: an experience in a general ward setting in Hong Kong." The Journal of hospital infection, 105(2), 119–127.

World Health Organization (WHO). 2021. "Roadmap to Improve and Ensure Good Indoor Ventilation in the Context of COVID-19." World Health Organization. March 1, 2021.

Competing Interests: No competing interests

Version 1

Reader Comment 18 May 2021

Raymond Tellier, McGill University, Montreal, Canada

Regarding the review in Heneghan *et al.* of Lednicky 2020a [1], which reported successful isolation in cell culture of SARS-CoV-2 from aerosol samples: Heneghan *et al.* take issues with the following:

1) No plaque assays was performed to estimate the concentration of viable viruses in the air due to shortage of some reagents, and a TCID₅₀ based assay was performed instead.

- 2) The cytopathic effect (CPE) was observed 6 to 11 days post inoculation.
- 3) No serial subcultures were done.
- 4) Infection of susceptible animals with cultured isolates was not performed.
- 5) There was no attempt to demonstrate a gradient effect by collecting aerosol samples at different distances from the source patient.

These criticisms appear very unconvincing.

1) Infectious titration by plaque assay typically requires a soft agar overlay; I would speculate that soft agar was the reagent unavailable as there is a shortage of several agarose products. At any rate there is nothing wrong with an infectious titration done by the TCID method, which is a standard and well established method in virology and indeed essentially equivalent to the plaque assay for viruses that produce plaques (one TCID₅₀ is approximately 0.69 plaque forming unit [PFU]). We note that many other authors have used TCID-based titration for SARS-CoV-2 (e.g., [2]).

2) *"With the exception of a few slower-growing viruses such as CMV, or when viruses are present at very low titers, the time to detection by traditional tube culture method is generally between 1 and 7 days of inoculation"* [3].

As such, observing CPE 6 to 11 days following inoculation of a low viral load sample is therefore not unexpected. Other authors have used an observation period of 14 days for CPE when attempting to culture SARS-CoV-2 from samples with a very low viral load [4]. We would also note that although the complete CPE with rounding and detachment of cells took 6 to 11 days, early CPE foci with vacuolisation were already noted by 4 to 6 days [1].

3) The implied requirement for serial passage looks very much like an attempt to move the goalpost for acceptance of the existence of infectious SARS-CoV-2 viruses in aerosols. If the isolate would have been passage N times, would there have been a request to passage it (N+1) times?

Primary isolates from clinical samples are not laboratory adapted strains; they typically require specific mutations to adapt to the cell lines and when dealing with a low viral load sample the adaptation and the serial passage may or may not be successful; this does not negate the reality of infectious viruses being present in the sample. It has been reported that SARS-CoV-2 undergo adaptation in Vero E6 cells for at least 5-6 passages, with an increasing viral titer, acquisition of a large plaque phenotype and deletions in the furin cleavage site [5, 6].

4) Likewise, the implied requirement for successful animal infection with isolates recovered from air samples looks like another attempt to move the goalpost, and is especially surprising given that, as noted by the Reviewer #1, Heneghan *et al.* did not include in their review animal transmission studies.

5) Why would the demonstration of a spatial gradient be considered essential? To be sure a greater

concentration of aerosols near the source is to be expected but the steepness of the gradient would be modulated by the specific ventilation characteristics of the room. There would be also stochastic effects since an essential property of aerosol is that they will disperse randomly, not uniformly [7]. But in the end the important result is the demonstration of infectious viruses in aerosol particles.

We find all of the above disquieting in a review that aspires to be seen as authoritative, as it strongly suggests a lack of familiarity with the methods of Clinical Virology and the problems involved in culturing viruses present in very low viral load in clinical samples.

One may ask, of what benefit can it be to have a review of a very large number of published studies if one cannot trust that the studies have been summarized accurately and knowledgeably evaluated?

Raymond Tellier McGill University
Julian W. Tang University of Leicester

References:

- [1] Lednicky JA *et al.*, [Viable SARS-CoV-2 in the air of a hospital room with COVID-19 patients](#). Int J Infect Dis. 2020 Nov;100:476-482.
- [2] Harcourt J, *et al.*, [Severe Acute Respiratory Syndrome Coronavirus 2 from Patient with Coronavirus Disease, United States](#). Emerg Infect Dis. 2020;26(6):1266-1273.
- [3] Capraro GA, Ginocchio CC; Reagents, Stains, Media and Cell Cultures: Virology. Chapter 82 in Manual of Clinical Microbiology 12th ed. Carroll KC, Pfaller ME eds., ASM Press 2019 Washington DC.
- [4] Singanayagam A *et al.*, [Duration of infectiousness and correlation with RT-PCR cycle threshold values in cases of COVID-19, England, January to May 2020](#). Euro Surveill. 2020;25(32):pii=2001483.
- [5] Ogando NS *et al.* [SARS-Coronavirus-2 replication in Vero E6 cells: replication kinetics, rapid adaptation and cytopathology](#). J Gen Virol 2020; 101: 925-940
- [6] Klimstra WB *et al.* [SARS-CoV-2 growth, furin-cleavage-site adaptation and neutralization using serum from acutely infected hospitalized Covid-19 patients](#). J Gen Virol 2020; 101: 1156-1169
- [7] Riley RL, O'Grady F. Airborne Infection, Transmission and Control. MacMillan New York 1961

Competing Interests: No competing interests were disclosed.

Reader Comment 14 May 2021

Jose-Luis Jimenez, University of Colorado-Boulder, USA

Heneghan *et al.*'s paper is not, as it claims, a systematic review on the role of airborne transmission for SARS-CoV-2 (Heneghan *et al.* 2021). The mismatch between the paper's title, scope, methodology and conclusions could potentially misinform global policy and cost many lives.

The authors, who do not appear to have extensive (or perhaps any?) empirical experience in sampling viruses from the air, judge all the studies they reviewed to be of "low quality." Aerosol scientists would not reach the same conclusions. Indeed, a study of viable influenza virus released in aerosol particles during coughing and breathing (Lindsley *et al.* 2016) illustrates a number of quality criteria which a reviewer with expertise in aerosol science would expect of an empirical study in the field, namely the use of a well-characterized sampling system, detailed description of the sampling medium, careful accounting of collection efficiency as a function of particle size, sample replication, and purging to prevent cross-contamination. Heneghan *et al.*'s technocratic application of a 'risk of bias tool', QUADAS2, that was developed in a completely different discipline (clinical epidemiology) for assessing studies of an entirely different kind (diagnostic accuracy studies) has led these authors to misclassify many excellent studies. This is a troubling example of what has been termed "epistemological trespassing," and could have been avoided had the review team included an expert from the relevant academic field. Indeed, we are surprised that the World Health Organisation did not require some minimum level of topic expertise when commissioning the review.

A comprehensive review on the question of airborne transmission would need to include a much wider range of types of evidence. Importantly, airborne transmission of other diseases was accepted mainly on the basis of types of evidence not included in the Heneghan review, such as:

- Tuberculosis: animal studies (Riley *et al.* 1962)
- Measles: efficacy of UV disinfection (Wells 1943) and superspreading events with long-distance transmission (e.g. Bloch *et al.* 1985)
- Chickenpox: superspreading events (Leclair *et al.* 1980)

The type of evidence reviewed by Heneghan *et al.*, namely demonstrating the infectivity of pathogens captured from the air, has never been achieved, to our knowledge, for tuberculosis, measles, or chickenpox (Morawska and Milton 2020; Fennelly 2020). Therefore if a review of only this narrow type of evidence allows one to reach the conclusion that "The lack of recoverable viral culture samples of SARS-CoV-2 prevents firm conclusions over airborne transmission," as done in this paper, we must reach the same conclusion for tuberculosis, measles, and chickenpox. This would clearly be nonsensical. Heneghan *et al.* have thus applied a much higher standard of proof to SARS-CoV-2 than to other pathogens that are widely agreed to be airborne. There is no discussion in the Heneghan paper about why such a higher standard of evidence is needed only for SARS-CoV-2, and of why the other types of evidence that led to the acceptance of other diseases as airborne have not even been considered.

Indeed, the types of evidence that led to the acceptance of tuberculosis, smallpox, and measles as airborne are available for SARS-CoV-2:

- Animal studies showing airborne transmission (e.g. Kutter *et al.* 2021)

- Superspreading events that occur exclusively in poorly-ventilated indoor environments, and can be generally explained by airborne transmission but not large droplet or fomite transmission, (e.g. Lewis 2021 and references therein; Miller *et al.* 2021)
- Long distance transmission (e.g. Katelaris *et al.* 2021)

In addition, as recently summarized in a peer-reviewed commentary in *The Lancet* (Greenhalgh *et al.* 2021), there are multiple additional streams of evidence that are also not considered at all by Heneghan *et al.*, and that also support airborne transmission of SARS-CoV-2. These include:

- Transmission is twenty times more frequent indoors than outdoors (Bulfone *et al.* 2021). This cannot be explained by large droplet transmission, but is readily explained by airborne transmission, due to much higher dispersion outdoors than indoors.
- Superspreading events appear to occur dominantly in poorly-ventilated indoor spaces. This has led e.g. WHO to recommend ventilation as a way to reduce transmission, including detailed guidelines (World Health Organization 2021). This again is easily explained by airborne transmission, but not by large droplets or fomites which are not substantially impacted by ventilation.
- Presymptomatic and oligosymptomatic transmission is known to occur (Johansson *et al.* 2021), and may be an important reason why we are in such a difficult-to-control pandemic. Measurements show that people without cough produce few droplets but abundant aerosols, (Chen *et al.* 2020), favoring the airborne route of transmission for people without a cough.
- Nosocomial infections have been reported in several studies, including some showing genomic match, despite wearing of surgical masks and eye protection (Klompas, Baker, Griesbach, *et al.* 2021; Klompas, Baker, Rhee, *et al.* 2021; Goldberg *et al.* 2021).
- SARS-CoV-2 virus material has been measured (by PCR) after sampling ducts and filters in a hospital building (Nissen *et al.* 2020). It could only have reached these locations as an aerosol.

Therefore, it is clear that there are many more lines of evidence to consider in order to ascertain the importance of airborne transmission of SARS-CoV-2. It is well-known that viruses are fragile and they are easily damaged when sampling them from the air (Pan *et al.* 2017), leading to difficulties in detecting viable virus. Amounts of pathogens in air that scientists have so far failed to cultivate can still drive disease transmission, as exemplified by measles and tuberculosis. Studying only the narrow topic of cultivation of viruses from air samples is therefore likely to give a highly misleading picture of the relevant evidence base.

The authors also appear to expect that live virus should be detectable in all locations where COVID-19 patients are present. However, it is clear that viral load is extremely variable both in time (He *et al.* 2020) and between people (Yang *et al.* 2021). Aerosol generation is also highly variable among different people (Asadi *et al.* 2019; Edwards *et al.* 2021). Measurements of viral load by PCR in exhaled breath showed 73% of COVID-19 patients did not produce detectable virus in their breath,

but 27% exhaled, on average, millions of virus copies an hour (Ma *et al.* 2020). The very high variability in the amount of exhaled virus may apply to other diseases, and perhaps explain cases of lack of infection with shared air, that were used to deny the airborne character of measles for 7 decades (Bloch *et al.* 1985). This variability in virus emission may be a key reason why some people transmit SARS-CoV-2 to lots of others, while others do not transmit to anyone (Sun *et al.* 2021; Endo *et al.* 2020). In addition, ventilation of indoor spaces varies substantially across different environments and will lead to very variable amounts of dilution of any exhaled virus across the studies. Given all of these considerations, a high variability in the amount of virus captured from the air is not just not surprising but expected, and it is not an argument against airborne transmission of SARS-CoV-2.

In summary, no conclusions can be made about the importance of airborne transmission from only this review, while excluding all the other lines of evidence. We caution against using the findings of this review to inform policy.

Prof. Jose L. Jimenez, Univ. of Colorado-Boulder
Prof. Trisha Greenhalgh, Univ. of Oxford
Prof. David Fisman, Univ. of Toronto
Prof. Linsey C. Marr, Virginia Tech

References:

- Asadi, Sima, Anthony S. Wexler, Christopher D. Cappa, Santiago Barreda, Nicole M. Bouvier, and William D. Ristenpart. 2019. "Aerosol Emission and Superemission during Human Speech Increase with Voice Loudness." *Scientific Reports* 9 (1): 2348.
- Bloch, A. B., W. A. Orenstein, W. M. Ewing, W. H. Spain, G. F. Mallison, K. L. Herrmann, and A. R. Hinman. 1985. "Measles Outbreak in a Pediatric Practice: Airborne Transmission in an Office Setting ." *Pediatrics* 75 (4): 676–83.
- Bulfone, Tommaso Celeste, Mohsen Malekinejad, George W. Rutherford, and Nooshin Razani. 2021. "Outdoor Transmission of SARS-CoV-2 and Other Respiratory Viruses: A Systematic Review." *The Journal of Infectious Diseases* 223 (4): 550–61.
- Chen, Wenzhao, Nan Zhang, Jianjian Wei, Hui-Ling Yen, and Yuguo Li. 2020. "Short-Range Airborne Route Dominates Exposure of Respiratory Infection during Close Contact." *Building and Environment* 176 (June): 106859.
- Edwards, David A., Dennis Ausiello, Jonathan Salzman, Tom Devlin, Robert Langer, Brandon J. Beddingfield, Alyssa C. Fears, *et al.* 2021. "Exhaled Aerosol Increases with COVID-19 Infection, Age, and Obesity." *Proceedings of the National Academy of Sciences of the United States of America* 118 (8).
- Endo A, Centre for the Mathematical Modelling of Infectious Diseases COVID-19 Working Group, Abbott S *et al.* *Estimating the overdispersion in COVID-19 transmission using outbreak sizes outside China* [version 3; peer review: 2 approved]. *Wellcome Open Res* 2020, **5**:67

Fennelly, Kevin P. 2020. "Particle Sizes of Infectious Aerosols: Implications for Infection Control." *The Lancet. Respiratory Medicine* 8 (9): 914–24.

Goldberg, Lotem, Yoel Levinsky, Nufar Marcus, Vered Hoffer, Michal Gafner, Shai Hadas, Sraya Kraus, Meirav Mor, and Oded Scheuerman. 2021. "SARS-CoV-2 Infection among Healthcare Workers despite the Use of Surgical Masks and Physical Distancing - the Role of Airborne Transmission." *Open Forum Infectious Diseases*, January.

Greenhalgh, Trisha, Jose L. Jimenez, Kimberly A. Prather, Zeynep Tufekci, David Fisman, and Robert Schooley. 2021. "Ten Scientific Reasons in Support of Airborne Transmission of SARS-CoV-2." *The Lancet*, April.

Heneghan CJ, Spencer EA, Brassey J *et al.* SARS-CoV-2 and the role of airborne transmission: a systematic review [version 1; peer review: 1 approved with reservations, 2 not approved]. *F1000Research* 2021, **10**:232

He, Xi, Eric H. Y. Lau, Peng Wu, Xilong Deng, Jian Wang, Xinxin Hao, Yiu Chung Lau, *et al.* 2020. "Temporal Dynamics in Viral Shedding and Transmissibility of COVID-19." *Nature Medicine* 26 (5): 672–75.

Johansson, Michael A., Talia M. Quandelacy, Sarah Kada, Pragati Venkata Prasad, Molly Steele, John T. Brooks, Rachel B. Slayton, Matthew Biggerstaff, and Jay C. Butler. 2021. "SARS-CoV-2 Transmission From People Without COVID-19 Symptoms." *JAMA Network Open* 4 (1): e2035057.

Katellaris, Anthea L., Jessica Wells, Penelope Clark, Sophie Norton, Rebecca Rockett, Alicia Arnott, Vitali Sintchenko, Stephen Corbett, and Shopna K. Bag. 2021. "Epidemiologic Evidence for Airborne Transmission of SARS-CoV-2 during Church Singing, Australia, 2020." *Emerging Infectious Diseases* 27 (6).

Klompas, Michael, Meghan A. Baker, Diane Griesbach, Robert Tucker, Glen R. Gallagher, Andrew S. Lang, Timelia Fink, *et al.* 2021. "Transmission of SARS-CoV-2 from Asymptomatic and Presymptomatic Individuals in Healthcare Settings despite Medical Masks and Eye Protection." *Clinical Infectious Diseases*, March.

Klompas, Michael, Meghan A. Baker, Chanu Rhee, Robert Tucker, Karen Fiumara, Diane Griesbach, Carin Bennett-Rizzo, *et al.* 2021. "A SARS-CoV-2 Cluster in an Acute Care Hospital." *Annals of Internal Medicine*, February.

Kutter, Jasmin S., Dennis de Meulder, Theo M. Bestebroer, Pascal Lexmond, Ard Mulders, Mathilde Richard, Ron A. M. Fouchier, and Sander Herfst. 2021. "SARS-CoV and SARS-CoV-2 Are Transmitted through the Air between Ferrets over More than One Meter Distance." *Nature Communications* 12 (1): 1653.

Leclair, J. M., J. A. Zaia, M. J. Levin, R. G. Congdon, and D. A. Goldmann. 1980. "Airborne Transmission of Chickenpox in a Hospital." *The New England Journal of Medicine* 302 (8): 450–53.

Lewis, Dyani. 2021. "Superspreading Drives the COVID Pandemic - and Could Help to Tame It." *Nature* 590 (7847): 544–46.

Lindsley, William G., Francoise M. Blachere, Donald H. Beezhold, Robert E. Thewlis, Bahar Noorbakhsh, Sreekumar Othumpangat, William T. Goldsmith, *et al.* 2016. "Viable Influenza A Virus in Airborne Particles Expelled during Coughs versus Exhalations." *Influenza and Other Respiratory Viruses* 10 (5): 404–13.

Ma, Jianxin, Xiao Qi, Haoxuan Chen, Xinyue Li, Zheng Zhang, Haibin Wang, Lingli Sun, *et al.* 2020. "COVID-19 Patients in Earlier Stages Exhaled Millions of SARS-CoV-2 per Hour." *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*, August.

Miller, Shelly L., William W. Nazaroff, Jose L. Jimenez, Atze Boerstra, Giorgio Buonanno, Stephanie J. Dancer, Jarek Kurnitski, Linsey C. Marr, Lidia Morawska, and Catherine Noakes. 2021. "Transmission of SARS-CoV-2 by Inhalation of Respiratory Aerosol in the Skagit Valley Chorale Superspreading Event." *Indoor Air* 31 (2): 314–23.

Morawska, Lidia, and Donald K. Milton. 2020. "Reply to Chagla *et al.*, and Thomas." *Clinical Infectious Diseases: An Official Publication of the Infectious Diseases Society of America*, August.

Nissen, Karolina, Janina Krambrich, Dario Akaberi, Tove Hoffman, Jiaxin Ling, Åke Lundkvist, Lennart Svensson, and Erik Salaneck. 2020. "Long-Distance Airborne Dispersal of SARS-CoV-2 in COVID-19 Wards." *Scientific Reports* 10 (1): 19589.

Pan, Maohua, Tania S. Bonny, Julia Loeb, Xiao Jiang, John A. Lednicky, Arantzazu Eiguren-Fernandez, Susanne Hering, Z. Hugh Fan, and Chang-Yu Wu. 2017. "Collection of Viable Aerosolized Influenza Virus and Other Respiratory Viruses in a Student Health Care Center through Water-Based Condensation Growth." *mSphere* 2 (5).

Riley, R. L., C. C. Mills, F. O'grady, L. U. Sultan, F. Wittstadt, and D. N. Shivpuri. 1962. "Infectiousness of Air from a Tuberculosis Ward. Ultraviolet Irradiation of Infected Air: Comparative Infectiousness of Different Patients." *The American Review of Respiratory Disease* 85 (April): 511–25.

Sun, Kaiyuan, Wei Wang, Lidong Gao, Yan Wang, Kaiwei Luo, Lingshuang Ren, Zhifei Zhan, *et al.* 2021. "Transmission Heterogeneities, Kinetics, and Controllability of SARS-CoV-2." *Science* 371 (6526).

Wells, W. F. 1943. "Air Disinfection in Day Schools." *American Journal of Public Health and the Nation's Health* 33 (12): 1436–43.

World Health Organization (WHO). 2021. "Roadmap to Improve and Ensure Good Indoor Ventilation in the Context of COVID-19." World Health Organization. March 1, 2021.

Yang, Qing, Tassa K. Saldi, Patrick K. Gonzales, Erika Lasda, Carolyn J. Decker, Kimngan L. Tat, Morgan R. Fink, *et al.* 2021. "Just 2% of SARS-CoV-2-Positive Individuals Carry 90% of the Virus

Circulating in Communities." Proceedings of the National Academy of Sciences of the United States of America 118 (21).

Competing Interests: No competing interests

The benefits of publishing with F1000Research:

- Your article is published within days, with no editorial bias
- You can publish traditional articles, null/negative results, case reports, data notes and more
- The peer review process is transparent and collaborative
- Your article is indexed in PubMed after passing peer review
- Dedicated customer support at every stage

For pre-submission enquiries, contact research@f1000.com

F1000Research