Guide to Clinical Evaluation of Suspected COVID patients

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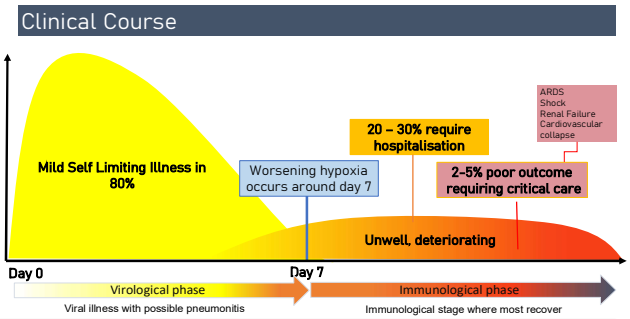
NHS Greater Glasgow and Clyde

Clinical

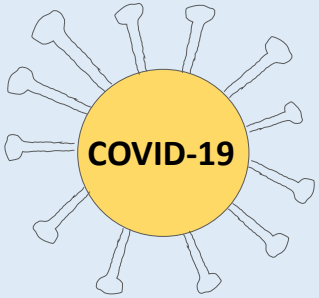
Clinical Symptoms

- Dry cough (occasional sputum)
- Fever
- Dyspnoea
- Fatigue / Myalgia
- Confusion

High rates of atypical presentations in the elderly including delirium



Other symptoms include: Vomiting, Abdominal pain, Headache, Nausea, Chest tightness, Diarrhoea, Dizziness, Anosmia ± Dysgeusia



Oxygen

- **Suspected COVID pneumonia:** Target SpO2 90-94%
- **If COPD or risk of hypercapnia** Target SpO2 88-92%

Consider proning for ward patients with an oxygen requirement

DO NOT USE high flow nasal O2 or NIV out with designated locations and without respiratory consultant review/critical care recommendation

Bloods

- CRP: may be raised or normal and does not reflect presence of bacterial co-infection
- Lymphopenia is common
- Transaminitis may occur
- NT Pro BNP, Troponin and D Dimer may be elevated and need to be interpreted with caution

Imaging

- CXR (typical initial presentation is bilateral peripheral ground glass opacities)
- Chest CT only if will change management

Differential Diagnosis

- Patients are likely to have comorbidities
- Always consider other diagnoses or dual pathology including bacterial infection/sepsis

Treatment Escalation Plan (TEP) required for all suspected COVID patients

Drugs to think about in suspected COVID patients

VTE Prophylaxis

- The risk of VTE is increased
- Ensure VTE prophylaxis prescribed unless contraindicated
- Refer to **Thromboprophylaxis in COVID-19 Patients (NHSGGC Guidelines)**

Dexamethasone /Steroids*

Dexamethasone 6mg daily is indicated if

1. COVID suspected or confirmed

And

2. Supplemental 02 required

And

3. Adult (In pregnancy use 40mg prednisolone or IV hydrocortisone 80mg bd)

- Use PPI for GI protection
- Duration 10 days (stop if alternative diagnosis or discharged before this)

* Refer to NHS GGC Therapeutics Handbook

Remdesivir*

- Antiviral treatment for severe cases only (SpO2 ≤ 94% on room air or requiring supplemental oxygen or ventilatory support)
- Discuss with senior colleague/pharmacy

* Refer to NHS GGC Therapeutics Handbook

ACE inhibitors or ARB AND FLUIDS

(Drugs ending '-pril' or '-sartan')

- Patients may be dehydrated due to insensible losses whilst febrile and may need IV fluids.
- Do not stop these drugs unless
  - haemodynamic upset (e.g. if SBP >20mmHg lower than usual)
  - AKI (serum Creatinine >30% higher than 'baseline')

Antibiotics

- **Most patients do not require antibiotics**
- **Infective Exacerbation COPD with purulent sputum :**
  - Doxycycline 200mg stat then 100mg daily or oral Amoxicillin 500mg 8hrly (5 days total)
- **Suspected Bacterial Pneumonia:**
  - Follow NHS GGC CAP guidelines however **DO NOT ADD clarithromycin unless on Micro/ID/Resp advice**
  - Oral Doxycycline may be used for atypical cover if required
- **Suspected Hospital acquired pneumonia:**
  - **Non-severe:** Doxycycline 100mg 12 hourly or Co-trimoxazole 960mg 12 hourly (5 days).
  - **Severe:** Co-amoxiclav (± Gentamicin) or *Levofloxacin (if penicillin allergy)* and review. (usually 5 days)
- **Remember:**
  - QTc (levofloxacin), Drug interactions (doxycycline, levofloxacin)
  - IVOST when improving