Clinical Evaluation and Management of COVID-19 Adults

S Lip, B White, E Peters v9.0 25022021

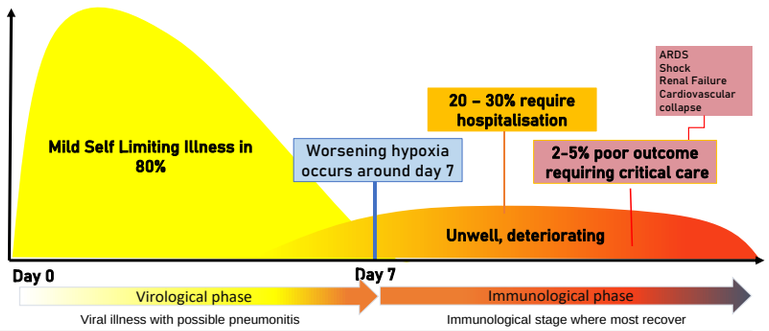
Clinical

Clinical Symptoms

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

High rates of atypical presentations in the elderly including delirium

Clinical Course



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

- Check HbA1c in all patients with COVID-19
- Consider HIV testing especially if COVID negative.

iV Fluids

Patients may be dehydrated due to insensible losses whilst febrile and may need IV fluids.

Imaging

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

Differential Diagnosis

- Co-infection with bacteria is uncommon
- Do not forget Flu!
- Always consider other diagnoses especially if COVID negative (e.g. HIV and PCP or Flu (during flu season)

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

COVID-19

Drugs to consider in all patients with suspected COVID

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)

- Duration 10 days (stop if alternative diagnosis or discharged before this)
- Check blood glucose daily (even in non-diabetics)

*** Refer to NHS GGC Therapeutics Handbook**

IL-6 Inhibitors*

Tocilizumab

- Consider in patients with a CRP of at least 75mg/L

AND

- sats <92% on room air OR requiring O2

AND

- Not already treated during this episode with an IL-6 inhibitor

OR

- Within 24-48 hours of starting respiratory support for COVID pneumonia

Caution in immunosuppressed patients

- **This may suppress CRP for several weeks**
- **It is a potent immunosuppressant, patient is at risk of opportunistic infection**

*** Refer to NHS GGC Therapeutics Handbook and document discussion with consultant before prescribing**

Antibiotics

- **Most patients do not require antibiotics**
- Bacterial co-infection in the unventilated patient is very rare (3-4% of hospitalised patients)
- CRP does not predict need for an antibiotic
- Antibiotic if IECOPD with purulent sputum or clinical/radiological CAP
- Limit antibiotics to 5 days of Amoxicillin or doxycycline and avoid Clarithromycin unless on ID/Resp/Micro advice
- Reserve Co-amoxiclav for severe CAP **(link to GGC guideline)**
- REVIEW and STOP antibiotic before 5 days if SARSCoV-2 result positive unless clear evidence of bacterial co-infection
- Do not escalate antibiotic therapy in the deteriorating COVID-19 patient unless clear evidence of secondary bacterial infection