

BMJ Best Practice

Coronavirus disease 2019 (COVID-19)

The right clinical information, right where it's needed



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Summary

- ◇ The World Health Organization declared the COVID-19 outbreak a pandemic on 11 March 2020. The situation is evolving rapidly. Clinical trials and investigations to learn more about the virus, its origin, and how it affects humans are ongoing.
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Definition

Coronavirus disease 2019 (COVID-19) is a potentially severe acute respiratory infection caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).[1] The virus was identified as the cause of an outbreak of pneumonia of unknown cause in Wuhan City, Hubei Province, China, in December 2019.[2] The clinical presentation is that of a respiratory infection with a symptom severity ranging from a mild common cold-like illness, to a severe viral pneumonia leading to acute respiratory distress syndrome that is potentially fatal.

Epidemiology

The World Health Organization (WHO) was informed of 44 cases of pneumonia of unknown microbial etiology associated with Wuhan City, Hubei Province, China on 31 December 2019. Most of the patients in the outbreak reported a link to a large seafood and live animal market (Huanan South China Seafood Market).[4] The WHO announced that a novel coronavirus had been detected in samples taken from these patients. Laboratory tests ruled out severe acute respiratory syndrome coronavirus (SARS-CoV), Middle East respiratory syndrome (MERS)-CoV, influenza, avian influenza, and other common respiratory pathogens.[5] Since then, the outbreak has escalated rapidly, with the WHO first declaring a public health emergency of international concern on 30 January 2020 and then formally declaring it a pandemic on 11 March 2020.

Consult the resources below for updated information on daily case counts:

- [\[Johns Hopkins University: coronavirus COVID-19 global cases\]](#)
- [\[WHO: coronavirus disease \(COVID-19\) emergency dashboard\]](#)
- [\[WHO: coronavirus disease \(COVID-2019\) situation reports\]](#)
- [\[CDC: coronavirus disease 2019 \(COVID-19\) – cases in US\]](#)
- [\[CDC: COVIDView\]](#)

Data from the largest case series in China found that 87% of confirmed cases were ages 30 to 79 years, 1% were ages 9 years or younger, 1% were ages 10 to 19 years, and 3% were ages 80 years or older. Approximately 51% of patients were male and 49% were female.[7] Approximately 4% of cases were in healthcare workers, with 23 deaths reported.[8]

In the US, older patients (ages ≥ 65 years) accounted for 31% of all cases, 45% of hospitalizations, 53% of intensive care unit admissions, and 80% of deaths, with the highest incidence of severe outcomes in patients ages ≥ 85 years.[9]

Infection in children is reported much less commonly than among adults. A systematic review found that children account for only 1% to 5% of confirmed cases (depending on the country).[10] In the US, children accounted for only 1.7% of all cases.[11] All cases have been in family clusters or in children who have a history of close contact with an infected patient.[12] [13] [14] In a case series of 2143 pediatric patients in China, the median age of children was 7 years.[15]

Emerging evidence suggests that ambient temperature has no significant impact on the transmission of COVID-19; however, further research is required on how weather conditions influence transmission.[16]

Etiology

Virology

- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is a previously unknown betacoronavirus that was discovered in bronchoalveolar lavage samples taken from clusters of patients who presented with pneumonia of unknown cause in Wuhan City, Hubei Province, China, in December 2019.[2] Coronaviruses are a large family of enveloped RNA viruses, some of which cause illness in people (e.g., common cold, severe acute respiratory syndrome [SARS], Middle East respiratory syndrome [MERS]), and others that circulate among mammals and birds. Rarely, animal coronaviruses can spread to humans and subsequently spread between people, as was the case with SARS and MERS.
- SARS-CoV-2 belongs to the *Sarbecovirus* subgenus of the *Coronaviridae* family, and is the seventh coronavirus known to infect humans. The virus has been found to be similar to SARS-like coronaviruses from bats, but it is distinct from SARS-CoV and MERS-CoV.[17] [18] The full genome has been determined and published in GenBank. [GenBank]
- A preliminary study suggests that there are two major types (or strains) of the SARS-CoV-2 virus in China, designated L and S. The L type was found to be more prevalent during the early stages of the outbreak in Wuhan City and may be more aggressive (although this is speculative), but its frequency decreased after early January. The relevance of this finding is unknown at this stage and further research is required.[19]

[Fig-1]

Origin of virus

- A majority of patients in the initial stages of this outbreak reported a link to the Huanan South China Seafood Market, a live animal or "wet" market, suggesting a zoonotic origin of the virus.[20] [21] [22]
- While the potential animal reservoir and intermediary host(s) are unknown at this point, studies suggest they may derive from a recombinant virus between the bat coronavirus and an origin-unknown coronavirus; however, this is yet to be confirmed.[17] [18] [23] [24] Pangolins have been suggested as an intermediate host as they have been found to be a natural reservoir of SARS-CoV-2-like coronaviruses.[25] [26]

Transmission dynamics

- Person-to-person spread has been confirmed in community and healthcare settings, with local transmission occurring in many countries around the world.
- An initial assessment of the transmission dynamics in the first 425 confirmed cases found that 55% of cases before 1 January 2020 were linked to the Huanan South China Seafood Market, whereas only 8.6% of cases after this date were linked to the market. This confirms that person-to-person spread occurred among close contacts since the middle of December 2019, including infections in healthcare workers.[22]
- It is uncertain how easily the virus spreads between people, but transmission in chains involving several links has been recognized. Available evidence indicates that human transmission occurs via close contact with respiratory droplets produced when a person exhales, sneezes, or coughs; via direct contact with infected people; or via contact with fomites. Airborne transmission has not been reported; however, it may be possible during aerosol-generating procedures performed in clinical care.[20] [22] [27] [28]

- The virus has been found to be more stable on plastic and stainless steel (up to 72 hours) compared with copper (up to 4 hours) and cardboard (up to 24 hours).[29] This study also found that the virus was viable in aerosol particles for up to 3 hours; however, aerosols were generated using high-powered apparatus that do not reflect normal human cough conditions or a clinical setting where aerosol-generating procedures are performed. The World Health Organization has confirmed that there have been no reports of airborne transmission.[30] In healthcare settings, the virus is widely distributed in the air and on object surfaces (e.g., floors, trash cans, sickbed handrails, and computer mice) in both general wards and intensive care units, with a greater risk of contamination in the intensive care unit.[31]
- The contribution to transmission by the presence of the virus in other body fluids is unknown; however, the virus has been detected in blood, cerebrospinal fluid, urine, saliva, tears, and conjunctival secretions. Fecal-oral transmission may be possible (virus has been detected in the stool samples of almost half of the patients in one meta-analysis), although it has not been reported yet.[32] [33] [34] [35] [36] [37] [38] The presence of virus in these fluids or viral RNA shedding does not necessarily equate with infectivity.
- Nosocomial transmission in healthcare workers and patients has been reported in 41% of patients in one case series.[39] The majority of healthcare workers with COVID-19 reported contact in the healthcare setting. In a study of over 9000 cases reported in healthcare workers in the US, 55% had contact only in a healthcare setting, 27% only in a household, 13% only in the community, and 5% in more than one setting.[40]
- Widespread transmission has been reported in long-term care facilities and on cruise ships (19% of 3700 passengers and crew were infected aboard the Diamond Princess).[41] [42]
- Clusters of cases originating from family gatherings have been reported, emphasizing the importance of social distancing even within families.[43]
- The secondary attack rate among all close contacts is approximately 0.45%.[28] The secondary attack rate among household members is 10% to 30%.[28] [44] [45] The secondary attack rate in children is lower compared with adults, and is higher for spouse contacts of the index case. The rate lowered to 0% in one study where index patients were quarantined by themselves from the onset of symptoms.[45]

Presymptomatic transmission

- A small number of studies suggest that some people can be contagious during the incubation period, the time between exposure to the virus and the onset of symptoms. The incubation period is estimated to be between 1 and 14 days, with a median of 5 to 7 days (possibly longer in children). Approximately 97.5% of patients develop symptoms within 11.5 days of infection.[46] [47] [48] [49] [50]
- Presymptomatic transmission has been reported in 12.6% of cases in China.[51] A study in Singapore identified 6.4% of patients among seven clusters of cases in which presymptomatic transmission was likely to have occurred 1 to 3 days before symptom onset.[52]
- Presymptomatic transmission still requires the virus to be spread by infectious droplets or contact with fomites.

Asymptomatic transmission

- An asymptomatic case is a laboratory-confirmed case who does not develop symptoms. There is some evidence that spread from asymptomatic carriers is possible, although it is thought that transmission is greatest when people are symptomatic (especially around the time of symptom onset).[53] [54] [55] [56] [57] [58] [59]

- Estimating the prevalence of asymptomatic cases in the population is difficult. The best evidence so far comes from the Diamond Princess cruise ship, which was quarantined with all passengers and crew members repeatedly tested and closely monitored. A modeling study found that approximately 700 people with confirmed infection (18%) were asymptomatic.[60] However, a Japanese study of citizens evacuated from Wuhan City estimates the rate to be closer to 31%.[61] Data from a long-term care facility in the US found that 30% of patients with positive test results were asymptomatic (or presymptomatic) on the day of testing.[62] Early data from an isolated village of 3000 people in Italy estimates the figure to be higher at 50% to 75%.[63] Other studies ranged from 4% to 80%.[64]
- A study in a New York obstetric population found that 88% of women who tested positive for SARS-CoV-2 at admission were asymptomatic at presentation.[65]
- The proportion of asymptomatic cases in children is thought to be significant, and children may play a role in community spread.[66]

Superspreading events

- Multiple superspreading events have been reported with COVID-19. These events are associated with explosive growth early in an outbreak and sustained transmission in later stages.[67]
- Superspreaders can pass the infection on to large numbers of contacts, including healthcare workers. This phenomenon is well documented for infections such as severe acute respiratory syndrome (SARS), Ebola virus infection, and MERS.[68] [69]
- Some of these individuals are also supershedders of virus, but the reasons underlying superspreader events are often more complex than just excess virus shedding and can include a variety of behavioral and environmental factors.[68]

Perinatal transmission

- It is unknown whether perinatal transmission (including transmission via breastfeeding) is possible. Retrospective reviews of pregnant women with COVID-19 found that there is no evidence for intrauterine infection in women with COVID-19.[70] [71] [72] However, vertical transmission cannot be ruled out, and has been suspected in one case in New York.[73] There have been case reports of infection in neonates born to mothers with COVID-19, and virus-specific antibodies have also been detected in neonatal serum samples.[74] [75] [76] [77] [78]

Pathophysiology

Reproductive number

- Preliminary reports suggested that the reproductive number (R_0), the number of people who acquire the infection from an infected person, was estimated to be 2.2 to 3.3.[22] [79] However, the R_0 may actually be lower in light of social distancing measures that have been instituted.

Angiotensin-converting enzyme-2 receptor

- While the pathophysiology is currently unknown, it has been confirmed that the virus binds to the angiotensin-converting enzyme-2 (ACE2) receptor in humans, which suggests a similar pathogenesis to SARS.[18] [80] However, a unique structural feature of the spike glycoprotein receptor binding domain of SARS-CoV-2 (which is responsible for the entry of the virus into host cells) confers potentially higher binding affinity for ACE2 on host cells compared with SARS-CoV.[81] A furin-like cleavage site has been identified in the spike protein of the virus; this does not exist in other SARS-like coronaviruses.[82]

- Based on an analysis of single-cell RNA sequencing datasets derived from major human physiologic systems, the organs considered more vulnerable to SARS-CoV-2 infection due to their ACE2 expression levels include the lungs, heart, esophagus, kidneys, bladder, and ileum.[83]
- Mechanistic evidence from other coronaviruses suggests that SARS-CoV-2 may downregulate ACE2, leading to a toxic overaccumulation of angiotensin-II, which may induce acute respiratory distress syndrome and fulminant myocarditis.[84]

Viral load and shedding

- High viral loads have been detected in nasal and throat swabs soon after symptom onset, and it is thought that the viral shedding pattern may be similar to that of patients with influenza. An asymptomatic patient was found to have a similar viral load compared with symptomatic patients.[85] [86]
- Pharyngeal viral shedding is high during the first week of symptoms when symptoms are mild or prodromal, peaking on day 4. This suggests active virus replication in upper respiratory tract tissues.[87]
- The median duration of viral shedding has been estimated to be between 8 and 20 days after symptoms resolve. Also, the virus has been detected in sputum and feces for up to 39 days after pharyngeal swabs became negative. However, it is unclear whether the virus is capable of transmission later in the course of the disease or after negative pharyngeal swabs.[88] [89] [90] [91] Viral shedding continued until death in nonsurvivors.[88]
- Factors associated with prolonged viral shedding include male sex, older age, comorbid hypertension, delayed admission to hospital after symptom onset or severe illness on admission, and use of invasive mechanical ventilation or corticosteroids.[92]

Classification

World Health Organization: clinical classification of COVID-19[3]

Mild illness

- Patients with uncomplicated upper respiratory tract viral infection may have nonspecific symptoms such as fever, fatigue, cough (with or without sputum production), anorexia, malaise, muscle pain, sore throat, dyspnea, nasal congestion, or headache. Rarely, patients may also present with diarrhea, nausea, and vomiting.
- Older and/or immunosuppressed patients may present with atypical symptoms.
- Symptoms due to physiologic adaptations of pregnancy or adverse pregnancy events (e.g., dyspnea, fever, gastrointestinal symptoms, fatigue) may overlap with COVID-19 symptoms.

Pneumonia

- Adults: pneumonia with no signs of severe pneumonia (see below) and no need for supplemental oxygen.
- Children: pneumonia with cough or difficulty breathing plus fast breathing (i.e., <2 months of age: ≥ 60 breaths/minute; 2-11 months of age: ≥ 50 breaths/minute; 1-5 years years of age: ≥ 40 breaths/minute) and no signs of severe pneumonia (see below).

Severe pneumonia in adults and adolescents

- Fever or suspected respiratory infection plus one of the following:

- Respiratory rate >30 breaths/minute
- Severe respiratory distress
- SpO₂ ≤93% on room air.

Severe pneumonia in children

- Cough or difficulty breathing plus at least one of the following:
 - Central cyanosis or SpO₂ <90%
 - Severe respiratory distress (e.g., grunting, very severe chest indrawing)
 - Signs of pneumonia with a general danger sign (i.e., inability to breastfeed or drink, lethargy or unconsciousness, or convulsions).
- Other signs of pneumonia may be present in children including chest indrawing or fast breathing (i.e., <2 months of age: ≥60 breaths/minute; 2-11 months of age: ≥50 breaths/minute; 1-5 years years of age: ≥40 breaths/minute).
- While the diagnosis is made on clinical grounds, chest imaging may identify or exclude some pulmonary complications.

Primary prevention

General prevention measures

- The only way to prevent infection is to avoid exposure to the virus and people should be advised to:[\[109\]](#) [\[110\]](#)
 - Wash hands often with soap and water for at least 20 seconds or an alcohol-based hand sanitizer (that contains at least 60% alcohol), especially after being in a public place, blowing their nose, or coughing/sneezing. Avoid touching the eyes, nose, and mouth with unwashed hands
 - Avoid close contact with people (i.e., maintain a distance of at least 3 feet [1 meter]) including shaking hands, particularly those who are sick, have a fever, or are coughing or sneezing. It is important to note that recommended distances differ between countries (for example, 6 feet [2 meters] is recommended in the US and UK) and you should consult local guidance
 - Practice respiratory hygiene (i.e., cover mouth and nose when coughing or sneezing, discard tissue immediately in a closed bin, and wash hands)
 - Seek medical care early if they have a fever, cough, and difficulty breathing, and share their previous travel and contact history (travelers or suspected/confirmed cases) with their healthcare provider
 - Stay at home if they are sick, even with mild symptoms, until they recover (except to get medical care)
 - Clean and disinfect frequently touched surfaces daily (e.g., light switches, door knobs, countertops, handles, phones).
- [\[BMJ Learning: Covid-19 - handwashing technique and PPE videos\]](#)
- [\[WHO: coronavirus disease \(COVID-19\) advice for the public\]](#)

Face masks

- Recommendations on the use of face masks in community settings vary between countries.[\[111\]](#) It is mandatory to wear a mask in public in certain countries, and masks may be worn in some countries according to local cultural habits. Consult local guidance for more information.
- The World Health Organization recommends that medical masks should be reserved for healthcare workers. People with symptoms should also wear a medical mask, self-isolate, and seek medical advice as soon as possible. Masks are also recommended for those caring for a sick person at home when in the same room. There is currently no evidence that wearing a mask (medical or other types) in the community setting can prevent infection with respiratory viruses, including COVID-19, in a healthy person.[\[112\]](#)
- The Centers for Disease Control and Prevention recommends that homemade cloth face coverings can be worn in public settings where social distancing measures are difficult to maintain (e.g., pharmacies, grocery stores), especially in areas where there is significant community transmission.[\[113\]](#) However, there is no evidence to support this.[\[114\]](#)
- Use of a mask alone is insufficient to provide adequate protection, and they should be used in conjunction with other infection prevention and control measures such as frequent hand hygiene and social distancing. It is important to wash your hands with soap and water (or an alcohol-based sanitizer) prior to putting on a face mask, and to remove it correctly. Used masks should be disposed of properly.[\[112\]](#) [\[115\]](#)
- Standard surgical masks are as effective as respirator masks for preventing infection of healthcare workers in outbreaks of viral respiratory illnesses such as influenza, but it is unknown whether this

applies to COVID-19.[116] A small study found that surgical and cotton masks are ineffective at preventing viral spread to the environment from the cough of patients with COVID-19.[117]

- [\[BMJ: facemasks for the prevention of infection in healthcare and community settings\]](#)
- [\[BMJ: analysis - face masks for the public during the covid-19 crisis\]](#)
- [\[WHO: coronavirus disease \(COVID-19\) advice for the public - when and how to use masks\]](#)

Screening and quarantine

- People traveling from areas with a high risk of infection may be screened using questionnaires about their travel, contact with ill persons, symptoms of infection, and/or measurement of their temperature. Combined screening of airline passengers on exit from an affected area and on arrival elsewhere has been relatively ineffective when used for other infections such as Ebola virus infection, and has been modeled to miss up to 50% of cases of COVID-19, particularly those with no symptoms during the incubation period.[118] Symptom-based screening processes have been reported to be ineffective in detecting SARS-CoV-2 infection in a small number of patients who were later found to have evidence of SARS-CoV-2 in a throat swab.[119]
- Enforced quarantine is being used to isolate easily identifiable cohorts of people at potential risk of recent exposure (e.g., groups evacuated by aeroplane from affected areas, people returning to their home countries before border closures, or groups on cruise ships with infected people on board).[120] The psychosocial effects of enforced quarantine may have long-lasting repercussions.[121] [122] Despite limited evidence, a Cochrane review found quarantine to be important in reducing the number of people infected and deaths, especially when started earlier and when used in combination with other prevention and control measures.[123]

Social distancing

- Many countries have implemented mandatory social distancing measures in order to reduce and delay transmission (e.g., city lockdowns, stay-at-home orders, curfews, nonessential business closures, bans on gatherings, school and university closures, travel restrictions and bans, remote working, quarantine of exposed people/travelers).
- Although the evidence for social distancing for COVID-19 is limited, it is emerging, and the best available evidence appears to support social distancing measures to reduce the transmission and delay spread. The timing and duration of these measures appears to be critical.[124] [125]
- Researchers in Singapore found that social distancing measures (isolation of infected individuals and family quarantine, school closures, and workplace distancing) significantly decreased the number of infections in simulation models.[126]
- [\[Public Health England: guidance on social distancing for everyone in the UK\]](#)

Shielding extremely vulnerable people

- Shielding is a measure used to protect vulnerable people (including children) who are at very high risk of severe illness from COVID-19 because they have an underlying health condition. Shielding involves minimizing all interactions between those who are extremely vulnerable and other people to protect them from coming into contact with the virus.
- Extremely vulnerable groups include:[127]
 - Solid organ transplant recipients
 - People with specific cancers
 - People with severe respiratory conditions (e.g., cystic fibrosis, severe asthma, or COPD)
 - People with rare diseases or inborn errors of metabolism that increase the risk of infections (e.g., sickle cell anemia, severe combined immunodeficiency)
 - People on immunosuppression therapies sufficient to significantly increase the risk of infection
 - Women who are pregnant with significant heart disease (congenital or acquired).

- These groups are advised to stay at home at all times, and avoid any face-to-face contact for a period of at least 12 weeks (this time period is subject to change). Visits from people who provide essential support should continue provided these people do not have symptoms and follow hand hygiene measures.
- Consult local health authorities for more guidance as recommendations, procedures, and resources differ between countries.
- [\[Public Health England: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19\]](#)

Vaccine

- There is currently no vaccine available. Vaccines are in development, but it may take at least 12 months before one is available. An mRNA vaccine (mRNA-1273) has been shipped to the National Institute of Allergy and Infectious Diseases for phase 1 clinical trials in the US.[\[128\]](#) The vaccine includes a short segment of genetic code copied from the virus. The trial started in humans on 16 March 2020. The vaccine is being fast-tracked and has skipped the animal testing stage. Clinical trials in humans have also started on an experimental adenoviral vector vaccine in China.[\[129\]](#) Other vaccines are currently in development or clinical trials around the world.[\[130\]](#)

Smoking cessation

- Past or current smokers have double the risk for severe disease, and smoking cessation should be encouraged.[\[105\]](#)

Screening

Management of contacts

People who may have been exposed to individuals with suspected COVID-19 (including healthcare workers) should be advised to monitor their health for 14 days from the last day of possible contact. A contact is a person who is involved in any of the following from 2 days before, and up to 14 days after, the onset of symptoms in the patient:[\[219\]](#)

- Face-to-face contact with a COVID-19 patient within 3 feet (1 meter) for more than 15 minutes
- Providing direct care for patients with COVID-19 without using proper personal protective equipment
- Staying in the same close environment (e.g., workplace, classroom, household, gathering) as a COVID-19 patient for any amount of time
- Traveling in close proximity within 3 feet (1 meter) with a COVID-19 patient in any kind of conveyance
- Other situations as indicated by local risk assessments.

If a contact develops symptoms, they should notify the receiving facility, wear a medical mask while traveling to seek care, avoid taking public transport (e.g., call an ambulance or use a private vehicle), perform respiratory and hand hygiene, sit as far away from others as possible in transit, and clean any contaminated surfaces.

Screening of travelers

Exit and entry screening may be recommended in countries where borders are still open, particularly when repatriating nationals from affected areas. Travelers returning from affected areas should self-monitor for symptoms for 14 days and follow local protocols of the receiving country. Some countries may require travelers to enter mandatory quarantine in a designated location (e.g., a hotel). Travelers who develop symptoms are advised to contact their local healthcare provider, preferably by phone.[\[220\]](#) One study of 566 repatriated Japanese nationals from Wuhan City found that symptom-based screening performed poorly and missed presymptomatic and asymptomatic cases. This highlights the need for testing and follow-up.[\[221\]](#)

Drive-through screening centers

Drive-through screening centers have been set up in some countries for safer and more efficient screening. The testee does not leave their car throughout the entire process, which includes registration and questionnaire, exam, specimen collection, and instructions on what to do after. This method has the advantage of increased testing capacity and prevention of cross-infection between testees in the waiting space.^[222]

Secondary prevention

Early recognition of new cases is the cornerstone of prevention of transmission. Immediately isolate all suspected and confirmed cases and implement recommended infection prevention and control procedures according to local protocols, including standard precautions at all times, and contact, droplet, and airborne precautions while the patient is symptomatic.^[133] COVID-19 is a notifiable disease; report all suspected and confirmed cases to your local health authorities.

Detailed guidance on infection prevention and control measures are available from the World Health Organization and the Centers for Disease Control and Prevention:

- [\[WHO: infection prevention and control during health care when COVID-19 is suspected\]](#)
- [\[CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 \(COVID-19\) in healthcare settings\]](#)

Case history

Case history #1

A 61-year-old man presents to the hospital with fever, dry cough, and difficulty breathing. He also reports feeling very tired and unwell. He has a history of hypertension, which is controlled with enalapril. On exam, his pulse is 120 bpm and his temperature is 101.6°F (38.7°C). He is admitted to hospital in an isolation room and is started on oxygen, intravenous fluids, empiric antibiotics, and acetaminophen. Chest x-ray shows bilateral lung infiltrates, and computed tomography of the chest reveals multiple bilateral lobular and subsegmental areas of ground-glass opacity. A nasopharyngeal swab is sent for real-time reverse transcriptase polymerase chain reaction testing, and the result comes back positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) the next day. The patient develops respiratory distress 7 days after admission and is transferred to the intensive care unit and started on mechanical ventilation.

Case history #2

A 26-year-old woman calls her doctor complaining of a sore throat and a persistent dry cough. She denies having a fever, and has not traveled in the last 14 days or knowingly been in contact with a confirmed case of COVID-19. She is advised to stay at home and self-isolate and to call her doctor if her symptoms get worse.

Step-by-step diagnostic approach

Early recognition and rapid diagnosis are essential to prevent transmission and provide supportive care in a timely manner. Have a high index of clinical suspicion for COVID-19 in all patients who present with fever and/or acute respiratory illness and who live in or report a travel history to an area with local transmission or close contact with a suspected or confirmed case in the 14 days prior to symptom onset. Evaluation should be performed according to pneumonia severity indexes and sepsis guidelines (if sepsis is suspected) in all patients with severe illness.

It is important that primary care physicians avoid in-person assessment of patients with suspected COVID-19 in primary care when possible.^[131] Most patients can be managed remotely by telephone or video consultations.^[132] Algorithms for dealing with these patients are available:

- [\[BMJ: covid-19 in primary care \(UK\)\]](#)
- [\[BMJ: covid-19 - a remote assessment in primary care\]](#)

Infection prevention and control

Triage all patients on admission and immediately isolate all suspected and confirmed cases in an area separate from other patients. Suspected patients should be given a mask and kept at least 3 feet (1 meter) from other suspected patients. It is important to note that recommended distances differ between countries and you should consult local guidance. Implement appropriate infection prevention and control procedures. Screening questionnaires may be helpful. COVID-19 is a notifiable disease; report all suspected and confirmed cases to your local health authorities.

[[BMJ: covid-19 - PPE guidance](#)]

The World Health Organization (WHO) recommends the following basic principles:[133]

- Immediately isolate all suspected cases in an area that is separate from other patients
- Implement standard precautions at all times:
 - Practice hand and respiratory hygiene
 - Offer a medical mask to patients who can tolerate one
 - Wear personal protective equipment
 - Practice safe waste management, environmental cleaning, and sterilization of patient care equipment and linen
- Implement additional contact and droplet precautions until the patient is asymptomatic:
 - Place patients in adequately ventilated single rooms; when single rooms are not available, place all suspected cases together in the same ward
 - Wear a medical mask, gloves, an appropriate gown, and eye/facial protection (e.g., goggles or a face shield)
 - Use single-use or disposable equipment
 - Consider limiting the number of healthcare workers, family members, and visitors in contact with the patient, ensuring optimal patient care and psychosocial support for the patient
 - Consider placing patients in negative pressure rooms, if available
- Implement airborne precautions when performing aerosol-generating procedures
- All specimens collected for laboratory investigations should be regarded as potentially infectious.

Some countries and organizations recommend airborne precautions for any situation involving the care of a COVID-19 patient.

It is important to disinfect inanimate surfaces in the surgery or hospital as patients may touch and contaminate surfaces such as door handles and desktops.[134]

Detailed guidance on infection prevention and control procedures are available from the WHO and the Centers for Disease Control and Prevention (CDC):

- [[WHO: infection prevention and control during health care when COVID-19 is suspected](#)]
- [[CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 \(COVID-19\) in healthcare settings](#)]
- [[CDC: strategies to optimize the supply of PPE and equipment](#)]

History

Take a detailed history to ascertain the level of risk for COVID-19 and assess the possibility of other causes, including a travel history, smoking history, and presence of any underlying health conditions.

Diagnosis should be suspected in:[93]

- Patients with acute respiratory illness (i.e., fever and at least one sign/symptom of respiratory disease such as cough or shortness of breath) and a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.
- Patients with any acute respiratory illness if they have been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to symptom onset.

See our Diagnostic criteria section for full case definitions.

Clinical presentation

The clinical presentation resembles viral pneumonia, and the severity of illness ranges from mild to severe. Approximately 80% of patients present with mild illness, 14% present with severe illness, and 5% present with critical illness.[7] Severe illness is associated with older age and the presence of underlying health conditions.[7] [94] Older patients and/or those with comorbidities may present with mild symptoms, but have a high risk of deterioration.[3] Atypical presentations may occur, especially in older patients or patients who are immunocompromised.

Approximately 5% of patients with a mild influenza-like illness (and no risk factors for COVID-19) who presented to a Los Angeles emergency department tested positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), although this study was limited by the brief sampling period at one medical center.[135]

The most common symptoms are:[20] [21] [39] [136] [137] [138]

- Fever
- Cough
- Dyspnoea
- Myalgia
- Fatigue
- Anosmia/dysgeusia.

Less common symptoms include:

- Anorexia
- Sputum production
- Conjunctivitis
- Gastrointestinal symptoms
- Sore throat
- Confusion
- Dizziness
- Headache
- Rhinorrhoea or nasal congestion
- Chest pain
- Hemoptysis
- Cutaneous manifestations.

Approximately 90% of patients present with more than one symptom, and 15% of patients present with fever, cough, and dyspnea.[21] Some patients may be minimally symptomatic or asymptomatic. Mild illness is defined as patients with an uncomplicated upper respiratory tract infection with nonspecific

symptoms such as fever, cough (with or without sputum production), fatigue, anorexia, malaise, myalgia, sore throat, dyspnea, nasal congestion, or headache. Patients may have gastrointestinal symptoms. The most common diagnosis in patients with severe COVID-19 is severe pneumonia.[3]

Initial impressions from cases in the US note that the clinical presentation may be broader than that observed in China and Italy, with chest pain, headaches, altered mental status, and gastrointestinal symptoms all observed on initial presentation. Severe hepatic and renal dysfunction that spares the lungs has also been observed.[139] Data from the first 393 hospitalized patients in New York found that while the most common presenting symptoms were fever, cough, dyspnea, and myalgia, gastrointestinal symptoms appeared to be more common than in China.[101]

A retrospective case series of 62 patients in Zhejiang province found that the clinical features were less severe than those of the primary infected patients from Wuhan City, indicating that second-generation infection may result in milder infection. This phenomenon was also reported with Middle East respiratory syndrome.[140]

Coinfections have been reported. In a sample of approximately 1200 patients with respiratory symptoms, 21% of nasopharyngeal swab specimens that tested positive for SARS-CoV-2 also tested positive for other respiratory pathogens, most commonly rhinovirus/enterovirus, respiratory syncytial virus, and non-SARS-CoV-2 *Coronaviridae* .[141] Patients with influenza coinfection showed similar characteristics to those patients with COVID-19 only.[88] [142] [143]

Perform a physical exam. Avoid use of a stethoscope if possible due to risk of viral contamination. Patients may be febrile (with or without chills/rigors) and have obvious cough and/or difficulty breathing. Auscultation of the chest may reveal inspiratory crackles, rales, and/or bronchial breathing in patients with pneumonia or respiratory distress. Patients with respiratory distress may have tachycardia, tachypnea, or cyanosis accompanying hypoxia.

Children

Signs and symptoms may be similar to other common viral respiratory infections and other childhood illnesses, so a high index of suspicion for COVID-19 is required in children.

Children are typically asymptomatic or present with mild symptoms (e.g., brief and rapidly resolving fever, mild cough, sore throat, congestion, rhinorrhea).[11] [12] [13] [144] [145] [146] Infants may present with fever and no respiratory symptoms.[147] However, moderate to severe illness has also been reported in children.[148] Polypnea has been reported in children with severe illness.[149] There are case reports of neonates and infants presenting with predominantly gastrointestinal symptoms.[150] [151]

In a case series of 2143 pediatric patients in China, over 90% of children were asymptomatic or had a mild or moderate illness; 16% were asymptomatic and had no radiologic evidence of pneumonia.[15] However, it is important to note that children may have signs of pneumonia on chest imaging despite having minimal or no symptoms.[152]

Coinfections may be more common in children.[152] It is unknown whether children with underlying health conditions are more at risk of severe illness. Complications in children appear to be milder and more rare.

Pregnant women

Retrospective reviews of pregnant women with COVID-19 found that the clinical characteristics in pregnant women were similar to those reported for nonpregnant adults.[70] [75] It is important to note that

symptoms such as fever, dyspnea, and fatigue may overlap with symptoms due to physiologic adaptations of pregnancy or adverse pregnancy events.[3]

Initial investigations

Order the following investigations in all patients with severe illness:

- Pulse oximetry
- ABG (as indicated to detect hypercarbia or acidosis)
- CBC
- Comprehensive metabolic panel
- Coagulation screen
- Inflammatory markers (e.g., serum procalcitonin, C-reactive protein, and ferritin)
- Serum troponin
- Serum lactate dehydrogenase
- Serum creatine kinase.

The most common laboratory abnormalities in patients hospitalized with pneumonia include leukopenia, lymphopenia, leukocytosis, thrombocytopenia, elevated liver transaminases, elevated lactate dehydrogenase, and elevated C-reactive protein and other inflammatory markers. Other abnormalities include neutrophilia, decreased hemoglobin, decreased albumin, and renal impairment.[20] [21] [39] [101] [138] [153]

[VIDEO: Radial artery puncture animated demonstration]

Pulse oximetry

Pulse oximetry may reveal low oxygen saturation ($SpO_2 < 90\%$).

Clinicians should be aware that patients with COVID-19 can develop "silent hypoxia": their oxygen saturations can drop to low levels and precipitate acute respiratory failure without the presence of obvious symptoms of respiratory distress. Only a small proportion of patients have other organ dysfunction, meaning that after the initial phase of acute deterioration, traditional methods of recognizing further deterioration (e.g., National Early Warning Score 2 [NEWS2] scores) may not help predict those patients who go on to develop respiratory failure.[154]

While NEWS2 is still recommended for use in patients with COVID-19, the UK Royal College of Physicians now advises that any increase in oxygen requirements in these patients should trigger an escalation call to a competent clinical decision maker, and prompt an initial increase in observations to at least hourly until a clinical review happens.[155]

Blood and sputum cultures

Collect blood and sputum specimens for culture in all patients to rule out other causes of lower respiratory tract infection and sepsis, especially patients with an atypical epidemiologic history. Specimens should be collected prior to starting empiric antimicrobials if possible.[3]

Molecular testing

Molecular testing is required to confirm the diagnosis. Diagnostic tests should be performed according to guidance issued by local health authorities and should adhere to appropriate biosafety practices. If

testing is not available nationally, specimens should be shipped to an appropriate reference laboratory. Specimens for testing should be collected under appropriate infection prevention and control procedures.

Decisions about who to test should be based on clinical and epidemiologic factors. The WHO recommends prioritizing people with a likelihood of infection. Consider testing asymptomatic or mildly symptomatic contacts of confirmed COVID-19 cases. Symptomatic pregnant women should also be prioritized in order to enable access to specialized care.^[3] Consult local health authorities for guidance as testing priorities will depend on local guidelines and available resources. See our Criteria section for CDC and Infectious Diseases Society of America recommendations on testing priorities.

Perform a nucleic acid amplification test, such as real-time reverse-transcription polymerase chain reaction (RT-PCR), for SARS-CoV-2 in appropriate patients with suspected infection, with confirmation by nucleic acid sequencing when necessary.^[156]

- Collect upper respiratory specimens (nasopharyngeal and oropharyngeal swab or wash) in ambulatory patients and/or lower respiratory specimens (sputum and/or endotracheal aspirate or bronchoalveolar lavage) in patients with more severe respiratory disease. Consider the high risk of aerolization when collecting lower respiratory specimens.
- Also consider collecting additional clinical specimens (e.g., blood, stool, urine).

One or more negative results do not rule out the possibility of infection. If a negative result is obtained from a patient with a high index of suspicion for COVID-19, additional specimens should be collected and tested, especially if only upper respiratory tract specimens were collected initially.^[156] Guidelines recommend that two consecutive negative tests (at least one day apart) are required to exclude COVID-19; however, there is a case report of a patient who returned two consecutive negative results and didn't test positive until 11 days after symptom onset and confirmation of typical chest computed tomography (CT) findings.^[157]

Collect nasopharyngeal swabs for testing to rule out infection with other respiratory pathogens (e.g., influenza, atypical pathogens) according to local guidance. It is important to note that coinfections can occur, and a positive test for a non-COVID-19 pathogen does not rule out COVID-19.^[3] ^[158]

Serologic testing is becoming increasingly available for use; however, while rapid antibody detection kits have been approved in Europe and the US for the qualitative detection of SARS-CoV-2 immunoglobulin G (IgG)/IgM antibodies in serum, plasma, or whole blood, the World Health Organization does not recommend the use of these tests outside of research settings as they have not been validated as yet.^[159] It typically takes 1 to 2 weeks after symptom onset for antibodies to develop to SARS-CoV-2.^[160] Serum samples can be stored to retrospectively define cases when validated serology tests become available.

Chest x-ray

All imaging procedures should be performed according to local infection prevention and control procedures to prevent transmission. Chest imaging is considered safe in pregnant women.^[161]

Order a chest x-ray in all patients with suspected pneumonia. Unilateral lung infiltrates are found in 25% of patients, and bilateral lung infiltrates are found in 75% of patients.^[20] ^[21] ^[162]

Computed tomography

Consider ordering a computed tomography (CT) scan of the chest. CT imaging is the primary imaging modality in some countries, such as China. It may be helpful in making the diagnosis, guiding individual patient management decisions, aiding the diagnosis of complications, or giving clues to an alternative diagnosis. However, it is not diagnostic for COVID-19 and local guidance should be consulted on whether to perform a CT scan.

The British Society of Thoracic Imaging (BSTI) recommends CT imaging in patients with clinically suspected COVID-19 who are seriously ill if chest x-ray is uncertain or normal. Without the suspicion of COVID-19, the radiology is nonspecific and could represent many other disease processes. The BSTI in collaboration with NHS England have produced a radiology decision support tool to help clinicians decide whether or not chest imaging should be ordered.[163]

[BSTI: radiology decision support tool for suspected COVID-19]

The American College of Radiology recommends reserving CT for hospitalized, symptomatic patients with specific clinical indications for CT, and emphasizes that a normal chest CT does not mean that a patient does not have COVID-19 and that an abnormal chest CT is not specific for COVID-19 diagnosis.[164]

Abnormal chest CT findings have been reported in up to 97% of COVID-19 patients in one meta-analysis of 50,466 hospitalized patients.[137] Evidence of pneumonia on CT may precede a positive RT-PCR result for SARS-CoV-2 in some patients.[165] CT imaging abnormalities may be present in minimally symptomatic or asymptomatic patients.[56] [166] Some patients may present with a normal chest finding despite a positive RT-PCR.[167] Also, results of RT-PCR testing may be false-negative, so patients with typical CT findings should have repeat RT-PCR testing to confirm the diagnosis.[168]

Typical features

- Multiple bilateral lobular and subsegmental areas of ground-glass opacity or consolidation are seen in most patients, usually with a peripheral or posterior distribution, mainly in the lower lobes and less frequently in the right lower lobe. Consolidative opacities superimposed on ground-glass opacity may be found in a smaller number of cases, usually older patients.[20] [140] [169]
- Other classic findings include crazy-paving pattern, air bronchograms, and a reverse halo/perilobular pattern (i.e., organizing pneumonia patterns).[163]
- A small comparative study found that patients with COVID-19 are more likely to have bilateral involvement with multiple mottling and ground-glass opacity compared with other types of pneumonia.[170]
- Older people are more likely to have extensive lung lobe involvement, interstitial changes, and pleural thickening compared with younger patients.[171]
- Small nodular ground-glass opacities and consolidation with surrounding halo signs are typical in children.[152] [172] Children tend to have more localized ground-glass opacity, lower ground-glass opacity attenuation, and relatively rare interlobular septal thickening.[173]

Atypical features

- Interlobular or septal thickening (smooth or irregular), thickening of the adjacent pleura, and subpleural involvement are atypical features. Some patients may rarely present with pleural effusion, pericardial effusion, bronchiectasis, cavitation, pneumothorax, lymphadenopathy, and

round cystic changes. Atypical features appear to be more common in the later stages of disease, or on disease progression.[20] [140] [169]

Disease progression

- Abnormalities can rapidly evolve from focal unilateral to diffuse bilateral ground-glass opacities that progress to, or coexist with, consolidations within 1 to 3 weeks.[166]
- The greatest severity of CT findings is usually visible around day 10 after symptom onset, and imaging signs associated with clinical improvement (e.g., resolution of consolidative opacities, reduction in number of lesions and involved lobes) usually occur after week 2 of the disease.[169]

Sensitivity of CT

- In a cohort of over 1000 patients in a hyperendemic area in China, chest CT had a higher sensitivity for diagnosis of COVID-19 compared with initial RT-PCR from swab samples (88% versus 59%). Improvement of abnormal CT findings also preceded change from RT-PCR positivity to negativity in this cohort during recovery. The sensitivity of chest CT was 97% in patients who ultimately had positive RT-PCR results. However, in this setting, 75% of patients with negative RT-PCR results also had positive chest CT findings. Of these patients, 48% were considered highly likely cases, while 33% were considered probable cases.[174]

Lung ultrasound

There is emerging evidence that lung ultrasound may be a useful aid in the diagnosis of COVID-19 as it has high sensitivity for detecting pleural thickening, subpleural consolidation, and ground-glass opacity. It has the advantages of portability, bedside evaluation, reduced healthcare worker exposure, and repeatability during follow-up. However, it also has limitations (e.g., it is unable to discern chronicity of a lesion) and other imaging modalities may be required. Characteristic ultrasound patterns have been reported in patients with COVID-19 and include B-lines, white lung, pleural line thickening, and consolidations with air bronchograms.[175] [176] [177] [178] [179] [180]

Risk factors

Strong

residence in/travel to location reporting community transmission during the 14 days prior to symptom onset

- Diagnosis should be suspected in patients with acute respiratory illness (i.e., fever and at least one sign/symptom of respiratory disease such as cough or shortness of breath) and a history of travel to or residence in a location reporting community transmission of COVID-19 disease during the 14 days prior to symptom onset.[93]

close contact with a confirmed case

- Diagnosis should be suspected in patients with any acute respiratory illness if they have been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to symptom onset.[93]

older age and/or underlying health conditions

- People ages 65 years and older, those who live in a nursing home or long-term care facility, and those with a high-risk condition (e.g., chronic respiratory disease, cardiovascular disease, immunocompromised, severe obesity, diabetes, hypertension, renal or liver disease) are at higher risk for severe illness.[\[94\]](#) [\[95\]](#)
- The most prevalent comorbidities in patients with COVID-19 are hypertension, cardiovascular disease, diabetes, smoking, respiratory disease such as COPD, malignancy, and chronic kidney disease.[\[96\]](#)
- Initial data suggest that immunosuppressed patients are not at increased risk of severe illness from coronaviruses; however, further research is required in this patient group.[\[97\]](#)

obesity

- Obesity is a common risk factor in both younger and older people. These patients are at higher risk of severe disease and intensive care admission.[\[98\]](#) [\[99\]](#) [\[100\]](#) Data from the first 393 hospitalized patients in New York found that 36% of patients had obesity, and this may be a risk factor for respiratory failure leading to invasive mechanical ventilation.[\[101\]](#)

smoking

- Smoking has been associated with more severe disease, adverse outcomes, and a poorer prognosis.[\[102\]](#) [\[103\]](#) [\[104\]](#) Past or current smokers with COVID-19 have double the risk for severe disease outcomes (18%) compared with people who have never smoked (9%) according to a preprint (not peer reviewed) meta-analysis of 9000 patients.[\[105\]](#) This may be due to increased airway expression of the angiotensin-converting enzyme-2 receptor in smokers.[\[106\]](#)

malignancy

- Patients with cancer are thought to be at a higher risk of contracting COVID-19 because treatments such as radiation therapy and chemotherapy are immunosuppressive, and patients with cancer are often in hospital for treatment and monitoring and so may be at risk of nosocomial infection. A retrospective study of 1524 patients at a single institution in Wuhan City, China, found that the infection rate in patients with cancer was higher than the cumulative incidence of all diagnosed cases reported in the city over the same period of time (i.e., 0.79% versus 0.37%). However, fewer than half of these infected patients were undergoing active treatment, suggesting that recurrent hospital visits and admissions were a potential risk factor.[\[107\]](#)

surgery

- Surgery may accelerate and exacerbate disease progression. A retrospective study of 34 patients in China who underwent elective surgeries during the incubation period of COVID-19 found that all patients developed pneumonia after surgery. Approximately 44% of these patients required admission to the intensive care unit, and 20% died. Further study is required.[\[108\]](#)

History & examination factors

Key diagnostic factors

fever (common)

- Reported in 77% to 98% of patients in case series.[\[20\]](#) [\[21\]](#) [\[39\]](#) [\[101\]](#) [\[137\]](#) [\[138\]](#) [\[181\]](#) In one case series, 44% of patients had a fever on presentation, but it developed in 89% of patients after hospitalization.[\[136\]](#)

- Children may not present with fever, or may have a brief and rapidly resolving fever.[12] [145] [146]
- Patients may present with chills/rigors.
- The course of fever is not fully understood yet, but it may be prolonged and intermittent.

cough (common)

- Reported in 57% to 82% of patients in case series.[20] [21] [39] [101] [136] [137] [138] [181]
- Less common in children.[145]
- Cough is usually dry.

dyspnea (common)

- Reported in 18% to 57% of patients in case series.[20] [21] [39] [101] [136] [138] [181]
- Median time from onset of symptoms to development of dyspnea is 5 to 8 days.[20] [21] [39]
- Polypnea has been reported in children with severe illness.[149]

anosmia/dysgeusia (common)

- There is evidence that patients with mild to moderate illness may develop anosmia/hyposmia or ageusia/dysgeusia as an early symptom and in the absence of other symptoms.[182] In one small cross-sectional survey in Italy, approximately 53% of hospitalized patients reported at least one taste or olfactory disorder (or both).[183] In a multicenter European study of 417 patients with mild to moderate illness, 86% of patents reported olfactory dysfunction (most patients reported anosmia without nasal obstruction or rhinorrhea), and 88% of patients reported gustatory dysfunction. Symptoms may appear before, during, or after other COVID-19 symptoms. Prevalence of these symptoms in European patients is substantially higher than that reported in China.[184]
- King's College London has reported that loss of smell/taste has been flagged as a key symptom for COVID-19 in the UK through its symptom tracker app.[185]
- It is possible that these patients may be hidden carriers, but further research is required.[186]
- The American Academy of Otolaryngology - Head and Neck Surgery has proposed adding anosmia and dysgeusia to the list of screening items for potential infection and recommends that clinicians consider testing and self-isolation of these patients (in the absence of other respiratory diseases such as rhinosinusitis or allergic rhinitis).[187]

Other diagnostic factors

fatigue (common)

- Reported in 29% to 69% of patients in case series.[20] [39] [136] [138] [181]
- Patients may also report malaise.

myalgia (common)

- Reported in 11% to 44% of patients in case series.[20] [21] [39] [136] [137] [181]
- Arthralgia has also been reported.

anorexia (common)

- Reported in 40% of patients in case series.[39]

sputum production/expectoration (common)

- Reported in 26% to 33% of patients in case series.[20] [39] [136] [181]

sore throat (common)

- Reported in 5% to 17% of patients in case series, and usually presents early in the clinical course.[21] [39] [136] [181]
- Children may have pharyngeal erythema.[145]

conjunctivitis (uncommon)

- Ocular manifestations consistent with conjunctivitis (i.e., conjunctival hyperemia, chemosis, epiphora, and increased secretions) have been reported in 32% of patients in one case series. Manifestations are more frequent in patients with severe illness.[188]

gastrointestinal symptoms (uncommon)

- Gastrointestinal symptoms (e.g., nausea, vomiting, diarrhea, abdominal pain) have been reported commonly. Early case series in China found up to 11% of patients had gastrointestinal symptoms.[20] [21] [39] [136] [138] [181] [189] However, more recent studies report gastrointestinal symptoms in up to 50% of patients.[37] [190] [191] [192]
- Data from the first 393 hospitalized patients in New York found that 24% of patients presented with diarrhea, and 19% presented with nausea and vomiting.[101] A case-control study in New York found that 35% of patients had gastrointestinal symptoms, and patients with these symptoms were more likely to have an illness duration of more than 1 week. Gastrointestinal symptoms were associated with a 70% relative increased risk of testing positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in this study.[193]
- Some patients may present with predominantly gastrointestinal symptoms, especially children.[150] [151] [194]
- Patients may present with nausea or diarrhea 1 to 2 days prior to onset of fever and breathing difficulties.[39]
- Hematochezia has been reported.[195]

confusion (uncommon)

- Reported in 9% of patients in case series.[21]

dizziness (uncommon)

- Reported in 9% to 12% of patients in case series.[39] [138]

headache (uncommon)

- Reported in 6% to 14% of patients in case series.[20] [21] [39] [136] [138] [181]

hemoptysis (uncommon)

- Reported in 1% to 5% of patients in case series.[20] [136]

rhinorrhea or nasal congestion (uncommon)

- Reported in 4% to 5% of patients in case series.[21] [136]
- Nasal congestion has been reported in nearly 4% of patients in one case series.[196]

chest pain (uncommon)

- Reported in 2% to 5% of patients in case series.[20] [21]
- May indicate pneumonia.

cutaneous manifestations (uncommon)

- Cutaneous manifestations (e.g., erythematous or maculopapular or morbilliform rash, petechiae, urticaria, vesicles) have been reported in some patients; however, further data is required to better understand skin involvement.[\[197\]](#) [\[198\]](#) [\[199\]](#)

bronchial breath sounds (uncommon)

- May indicate pneumonia.

tachypnea (uncommon)

- May be present in patients with acute respiratory distress.

tachycardia (uncommon)

- May be present in patients with acute respiratory distress.

cyanosis (uncommon)

- May be present in patients with acute respiratory distress.

crackles/rales on auscultation (uncommon)

- May be present in patients with acute respiratory distress.

Diagnostic tests

1st test to order

| Test | Result |
|---|---|
| <p>pulse oximetry</p> <ul style="list-style-type: none"> Order in patients with severe illness. Recommended in patients with respiratory distress and cyanosis. Clinicians should be aware that patients with COVID-19 can develop "silent hypoxia": their oxygen saturations can drop to low levels and precipitate acute respiratory failure without the presence of obvious symptoms of respiratory distress. Only a small proportion of patients have other organ dysfunction, meaning that after the initial phase of acute deterioration, traditional methods of recognizing further deterioration (e.g., National Early Warning Score 2 [NEWS2] scores) may not help predict those patients who go on to develop respiratory failure.[154] | <p>may show low oxygen saturation (SpO₂ <90%)</p> |
| <p>ABG</p> <ul style="list-style-type: none"> Order in patients with severe illness as indicated to detect hypercarbia or acidosis. Recommended in patients with respiratory distress and cyanosis who have low oxygen saturation (SpO₂ <90%). | <p>may show low partial oxygen pressure</p> |
| <p>CBC</p> <ul style="list-style-type: none"> Order in patients with severe illness. The most common laboratory abnormalities in patients hospitalized with pneumonia include leukopenia, lymphopenia, and leukocytosis. Other abnormalities include neutrophilia, thrombocytopenia, and decreased hemoglobin.[20] [21] [39] [153] Lymphopenia and thrombocytopenia have been associated with increased risk of severe disease and may be useful as clinical indicators for monitoring disease progression.[200] [201] High neutrophil-to-lymphocyte ratio is a useful marker for indicating risk for severe illness and poor prognosis.[202] [203] | <p>leukopenia; lymphopenia; leukocytosis#</p> |
| <p>coagulation screen</p> <ul style="list-style-type: none"> Order in patients with severe illness. The most common abnormalities are elevated D-dimer and prolonged prothrombin time.[20] [21] [39] Nonsurvivors had significantly higher D-dimer levels and longer prothrombin time and activated partial thromboplastin time compared with survivors in one study.[204] | <p>elevated D-dimer; prolonged prothrombin time</p> |
| <p>comprehensive metabolic panel</p> <ul style="list-style-type: none"> Order in patients with severe illness. The most common laboratory abnormalities in patients hospitalized with pneumonia include elevated liver transaminases. Other abnormalities include decreased albumin and renal impairment.[20] [21] Liver function abnormalities may be more common in patients with COVID-19 compared with other types of pneumonia.[170] | <p>elevated liver transaminases; decreased albumin; renal impairment</p> |
| <p>serum procalcitonin</p> <ul style="list-style-type: none"> Order in patients with severe illness. | <p>may be elevated</p> |

| Test | Result |
|--|---|
| <ul style="list-style-type: none"> • May be elevated in patients with secondary bacterial infection.[20] [21] May be more common in children.[152] | |
| <p>serum C-reactive protein</p> <ul style="list-style-type: none"> • Order in patients with severe illness. • May be elevated in patients with secondary bacterial infection, or may indicate hyperinflammation.[20] [21] • Increases at the initial stage of disease in patients with severe illness; therefore, it may be useful in identifying patients who might become severely ill.[205] | may be elevated |
| <p>serum ferritin level</p> <ul style="list-style-type: none"> • Order in patients with severe illness. • May indicate development of cytokine release syndrome.[206] | may be elevated |
| <p>serum lactate dehydrogenase</p> <ul style="list-style-type: none"> • Order in patients with severe illness. • Elevated lactate dehydrogenase has been reported in 73% to 76% of patients.[20] [21] May be more common in patients with COVID-19 compared with other types of pneumonia.[170] • May indicate hyperinflammation. | may be elevated |
| <p>serum creatine kinase</p> <ul style="list-style-type: none"> • Order in patients with severe illness. • Elevated creatine kinase has been reported in 13% to 33% of patients.[20] [21] • Indicates muscle or myocardium injury. | may be elevated |
| <p>serum troponin level</p> <ul style="list-style-type: none"> • Order in patients with severe illness. • Elevated in patients with cardiac injury.[20] • Other cardiac markers may also be elevated and are associated with severe disease.[207] | may be elevated |
| <p>blood and sputum cultures</p> <ul style="list-style-type: none"> • Collect blood and sputum specimens for culture in all patients to rule out other causes of lower respiratory tract infection and sepsis, especially patients with an atypical epidemiologic history.[3] • Specimens should be collected prior to starting empiric antimicrobials if possible. | negative for bacterial infection |
| <p>real-time reverse transcription polymerase chain reaction (RT-PCR)</p> <ul style="list-style-type: none"> • Molecular testing is required to confirm the diagnosis. Nucleic acid sequencing may be required to confirm the diagnosis.[156] Priorities for testing depend on local guidelines and available resources. • The positive predictive value ranged from 47.3% to 96.4%, and the negative predictive value ranged from 96.8% to 99.9% in one meta-analysis. Pooled sensitivity was 89%.[208] • Collect upper respiratory specimens (nasopharyngeal and oropharyngeal swab or wash) in ambulatory patients and/or lower respiratory specimens (sputum and/or endotracheal aspirate or bronchoalveolar lavage) in patients with more severe respiratory disease. Also consider collecting additional clinical specimens (e.g., blood, stool, urine). Specimens should be collected under appropriate infection prevention and control procedures. Consider the high risk of aerolization when collecting lower respiratory specimens.[156] | positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral RNA; may be positive for influenza A and B viruses and other respiratory pathogens |

| Test | Result |
|--|--|
| <ul style="list-style-type: none"> • There are little data available on the rates of false-positive and false-negative results for the various RT-PCR tests available; however, both have been reported. If a negative result is obtained from a patient with a high index of suspicion for COVID-19, additional specimens should be collected and tested, especially if only upper respiratory tract specimens were collected initially.[156] • Many tests are available under the Food and Drug Administration’s emergency-use authorization scheme. A test that uses saliva has just been approved.[209] • A point-of-care test that provides results within hours is available in some countries.[210] While rapid point-of-care tests are available, the World Health Organization does not recommend the use of these tests outside of research settings as they have not been validated as yet.[159] • Tests are available in many laboratories worldwide and testing should be done according to instructions from local health authorities and adhere to appropriate biosafety practices. If testing is not available nationally, specimens should be shipped to an appropriate reference laboratory. • Sensitivity and specificity of RT-PCR for diagnostic testing are unknown.[211] • Collect nasopharyngeal swabs to rule out influenza and other respiratory infections according to local guidance. It is important to note that coinfections can occur, and a positive test for a non-COVID-19 pathogen does not rule out COVID-19.[3] [158] • There is emerging evidence that saliva may be a reliable specimen for detecting SARS-CoV-2 by RT-PCR.[212] | |
| <p>chest x-ray</p> <ul style="list-style-type: none"> • Order in all patients with suspected pneumonia. • Unilateral lung infiltrates are found in 25% of patients, and bilateral lung infiltrates are found in 75% of patients.[20] [21] [162] | <p>unilateral or bilateral lung infiltrates</p> |
| <p>computed tomography (CT) chest</p> <ul style="list-style-type: none"> • Consider a CT scan of the chest. Consult local guidance on whether to perform a CT scan. • The positive predictive value was low (1.5% to 30.7%) in low-prevalence regions, and the negative predictive value ranged from 95.4% to 99.8% in one meta-analysis. Pooled sensitivity and specificity were 94% and 37%, respectively.[208] • The British Society of Thoracic Imaging (BSTI) recommends CT imaging in patients with clinically suspected COVID-19 who are seriously ill if chest x-ray is uncertain or normal. [BSTI: radiology decision support tool for suspected COVID-19] The American College of Radiology recommends reserving CT for hospitalized, symptomatic patients with specific clinical indications for CT, and emphasizes that a normal chest CT does not mean that a patient does not have COVID-19 and that an abnormal chest CT is not specific for COVID-19 diagnosis.[164] • Abnormal chest CT findings have been reported in up to 97% of hospitalized patients.[137] Evidence of pneumonia on CT may precede a positive RT-PCR result for SARS-CoV-2 in some patients.[165] CT imaging abnormalities may be present in minimally symptomatic or asymptomatic patients.[56] [166] Some patients may present with a normal chest finding despite a positive RT-PCR.[167] Also, results of RT-PCR testing may be false-negative, so | <p>typical features: multiple bilateral lobular and subsegmental areas of ground-glass opacity or consolidation (usually peripheral or posterior, mainly in the lower lobes, less frequently in right lower lobe), crazy-paving pattern, air bronchograms, reverse halo/perilobular pattern; atypical features: interlobular or septal thickening (smooth or irregular), thickening of the adjacent pleura, subpleural involvement, pleural effusion, pericardial effusion, bronchiectasis, cavitation, pneumothorax,</p> |

| Test | Result |
|--|---|
| <p>patients with typical CT findings should have repeat RT-PCR testing to confirm the diagnosis.[168]</p> <ul style="list-style-type: none"> • Atypical features appear to be more common in the later stages of disease, or on disease progression.[20] [140] [169] • Older people are more likely to have extensive lung lobe involvement, interstitial changes, and pleural thickening compared with younger patients.[171] • Small nodular ground-glass opacities and consolidation with surrounding halo signs are typical in children.[152] [172] Children tend to have more localized ground-glass opacity, lower ground-glass opacity attenuation, and relatively rare interlobular septal thickening.[173] • Abnormalities can rapidly evolve from focal unilateral to diffuse bilateral ground-glass opacities that progress to, or coexist with, consolidations within 1 to 3 weeks.[166] The greatest severity of CT findings is usually visible around day 10 after symptom onset, and imaging signs associated with clinical improvement (e.g., resolution of consolidative opacities, reduction in number of lesions and involved lobes) usually occur after week 2 of the disease.[169] • In a cohort of over 1000 patients in a hyperendemic area in China, chest CT had a higher sensitivity for diagnosis of COVID-19 compared with initial RT-PCR from swab samples (88% versus 59%). Improvement of abnormal CT findings also preceded change from RT-PCR positivity to negativity in this cohort during recovery. The sensitivity of chest CT was 97% in patients who ultimately had positive RT-PCR results. However, in this setting, 75% of patients with negative RT-PCR results also had positive chest CT findings. Of these patients, 48% were considered highly likely cases, while 33% were considered probable cases.[174] <p>[Fig-2]</p> | <p>lymphadenopathy, round cystic changes</p> |

Emerging tests

| Test | Result |
|--|--|
| <p>serology</p> <ul style="list-style-type: none"> Serologic testing is becoming increasingly available for use; however, while rapid antibody detection kits have been approved in Europe and the US for the qualitative detection of SARS-CoV-2 IgG/IgM antibodies in serum, plasma, or whole blood, the World Health Organization does not recommend the use of these tests outside of research settings as they have not been validated as yet.^[159] It typically takes 1 to 2 weeks after symptom onset for antibodies to develop to SARS-CoV-2.^[160] Serum samples can be stored to retrospectively define cases when validated serology tests become available. | <p>positive for SARS-CoV-2 virus antibodies</p> |
| <p>lung ultrasound</p> <ul style="list-style-type: none"> There is emerging evidence that lung ultrasound may be a useful aid in the diagnosis of COVID-19 as it has high sensitivity for detecting pleural thickening, subpleural consolidation, and ground-glass opacity. It has the advantages of portability, bedside evaluation, reduced healthcare worker exposure, and repeatability during follow-up. However, it also has limitations (e.g., it is unable to discern chronicity of a lesion) and other imaging modalities may be required.^{[175] [176] [177] [178] [179]} | <p>B-lines; white lung; pleural line thickening; consolidations with air bronchograms</p> |

Differential diagnosis

| Condition | Differentiating signs / symptoms | Differentiating tests |
|---|---|--|
| Middle East respiratory syndrome (MERS) | <ul style="list-style-type: none"> • Travel history to the Middle East or contact with a confirmed case of MERS. • Differentiating COVID-19 from MERS is not possible from signs and symptoms. • Initial data suggest that the clinical course of COVID-19 is less severe and the case fatality rate is lower compared with MERS. | <ul style="list-style-type: none"> • Reverse-transcriptase polymerase chain reaction (RT-PCR): positive for MERS-CoV viral RNA. |
| Severe acute respiratory syndrome (SARS) | <ul style="list-style-type: none"> • There have been no cases of SARS reported since 2004. | <ul style="list-style-type: none"> • RT-PCR: positive for severe acute respiratory syndrome coronavirus (SARS-CoV) viral RNA. |
| Community-acquired pneumonia | <ul style="list-style-type: none"> • Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset. • Differentiating COVID-19 from community-acquired bacterial pneumonia is not usually possible from signs and symptoms. However, patients with bacterial pneumonia are more likely to have rapid development of symptoms and purulent sputum. They are less likely to have myalgia, anosmia, or pleuritic pain.[213] [214] | <ul style="list-style-type: none"> • Blood or sputum culture or molecular testing: positive for causative organism. • RT-PCR: negative for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral RNA (coinfections are possible). • CT chest: centrilobular nodules, mucoid impactions.[215] |
| Pneumocystis jirovecii pneumonia | <ul style="list-style-type: none"> • Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset. • Differentiating COVID-19 from pneumocystis jirovecii pneumonia is not usually possible from signs and symptoms. • Patients are usually immunocompromised (e.g., | <ul style="list-style-type: none"> • Sputum culture: positive for <i>Pneumocystis</i>. • RT-PCR: negative for SARS-CoV-2 viral RNA (coinfections are possible). • CT chest: ground-glass opacity is usually more diffusely distributed with a tendency to spare the subpleural regions.[215] |

| Condition | Differentiating signs / symptoms | Differentiating tests |
|---|---|---|
| | HIV positive) and duration of symptoms may be longer. | |
| Influenza infection | <ul style="list-style-type: none"> Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset. Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms. | <ul style="list-style-type: none"> RT-PCR: positive for influenza A or B viral RNA; negative for SARS-CoV-2 viral RNA (coinfections are possible). |
| Common cold | <ul style="list-style-type: none"> Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset. Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms. | <ul style="list-style-type: none"> RT-PCR: positive for causative organism; negative for SARS-CoV-2 viral RNA (coinfections are possible). |
| Avian influenza A (H7N9) virus infection | <ul style="list-style-type: none"> May be difficult to differentiate based on epidemiologic history as avian influenza H7N9 is endemic in China. Close contact with infected birds (e.g., farmer or visitor to a live market in endemic areas), or living in an area when avian influenza is endemic. | <ul style="list-style-type: none"> RT-PCR: positive for H7-specific viral RNA. |
| Avian influenza A (H5N1) virus infection | <ul style="list-style-type: none"> Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset. Close contact with infected birds (e.g., farmer or visitor to a live market in endemic areas), or living in an area when avian influenza is endemic. | <ul style="list-style-type: none"> RT-PCR: positive for H5N1 viral RNA. |

| Condition | Differentiating signs / symptoms | Differentiating tests |
|---|---|---|
| <p>Other viral or bacterial respiratory infections</p> | <ul style="list-style-type: none"> • Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset. • Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms. • Adenovirus and <i>Mycoplasma</i> should be considered in clusters of pneumonia patients, especially in closed settings such as military camps and schools. | <ul style="list-style-type: none"> • Blood or sputum culture of molecular testing: positive for causative organism. • RT-PCR: negative for SARS-CoV-2 viral RNA (coinfections are possible). |
| <p>Pulmonary tuberculosis</p> | <ul style="list-style-type: none"> • Consider diagnosis in endemic areas, especially in patients who are immunocompromised. • History of symptoms is usually longer. • Presence of night sweats and weight loss may help to differentiate. | <ul style="list-style-type: none"> • Chest x-ray: fibronodular opacities in upper lobes with or without cavitation; atypical pattern includes opacities in middle or lower lobes, or hilar or paratracheal lymphadenopathy, and/or pleural effusion. • Sputum acid-fast bacilli smear and sputum culture: positive. • Molecular testing: positive for <i>Mycobacterium tuberculosis</i>. |
| <p>Febrile neutropenia</p> | <ul style="list-style-type: none"> • Suspect neutropenic sepsis in patients with a history of recent systemic anticancer treatment who present with fever (with or without respiratory symptoms) as this can be rapid and life-threatening.^[216] • Symptoms of COVID-19 and neutropenic sepsis may be difficult to differentiate at initial presentation. | <ul style="list-style-type: none"> • CBC: neutropenia. • RT-PCR: negative for SARS-CoV-2 viral RNA. |

DIAGNOSIS

Diagnostic criteria

World Health Organization: case definitions^[93]

Suspect case

- A. Patients with acute respiratory illness (i.e., fever and at least one sign/symptom of respiratory disease such as cough or shortness of breath) AND a history of travel to or residence in a location reporting community transmission of COVID-19 during the 14 days prior to symptom onset; OR
- B. Patients with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to symptom onset; OR
- C. Patients with severe acute respiratory illness (i.e., fever and at least one sign/symptom of respiratory disease such as cough or shortness of breath) AND requiring hospitalization AND in the absence of an alternative diagnosis that fully explains the clinical presentation.

Probable case

- A. Suspect case for whom testing for the COVID-19 virus is inconclusive (inconclusive being the result of the test reported by the laboratory); OR
- B. Suspect case for whom testing could not be performed for any reason.

Confirmed case

- Patients with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Definition of contact

- A contact is a person who experienced any one of the following exposures during the 2 days before and the 14 days after the onset of symptoms of a probable or confirmed case:
 - Face-to-face contact with a probable or confirmed case within 3 feet (1 meter) and for more than 15 minutes
 - Direct physical contact with a probable or confirmed case
 - Direct care for a patient with probable or confirmed COVID-19 disease without using proper personal protective equipment
 - Other situations as indicated by local risk assessments.
- Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after the date on which the sample was taken that led to confirmation.

[WHO: [global surveillance for COVID-19 caused by human infection with COVID-19 virus](#)]

Centers for Disease Control and Prevention: criteria to guide evaluation and laboratory testing for COVID-19^[217]

Clinicians should use their judgment to determine whether a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing).

Priorities for testing

- Priority 1
 - Hospitalized patients
 - Symptomatic healthcare workers
- Priority 2

- Patients in long-term care facilities with symptoms
- Patients 65 years of age and older with symptoms
- Patients with underlying conditions with symptoms
- First responders with symptoms
- Priority 3
 - Critical infrastructure workers with symptoms
 - Individuals who do not meet any of the above categories with symptoms
 - Healthcare workers and first responders
 - Individuals with mild symptoms in communities experiencing high COVID-19 hospitalizations
- Nonpriority
 - Individuals without symptoms

Other considerations that may guide testing are epidemiologic factors such as the occurrence of local community transmission of COVID-19 infections in a jurisdiction. Clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.

[CDC: [evaluating and testing persons for coronavirus disease 2019 \(COVID-19\)](#)]

[CDC: [priorities for testing patients with suspected COVID-19 infection](#)]

Infectious Diseases Society of America (IDSA): COVID-19 prioritization of diagnostic testing^[218]

IDSA recommends a tiering system for prioritizing patients given the current limited availability of near-patient or point-of-care testing. These recommendations will likely change as testing becomes more widely available.

Tier 1

- Critically ill patients in the intensive care unit with unexplained viral pneumonia or respiratory failure, regardless of travel history or close contact with a suspected or confirmed COVID-19 patient.
- Any person, including healthcare workers, with fever or signs/symptoms of a lower respiratory tract illness and close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset (including all residents of a long-term care facility that has a laboratory-confirmed COVID-19 case).
- Any person, including healthcare workers, with fever or signs/symptoms of a lower respiratory tract illness and a history of travel within 14 days of symptom onset to geographic regions where sustained community transmission has been identified.
- Individuals with fever or signs/symptoms of a lower respiratory tract illness who also are immunosuppressed (including patients with HIV), are older, or have underlying chronic health conditions.
- Individuals with fever or signs/symptoms of a lower respiratory tract illness who are critical to pandemic response including healthcare workers, public health officials, and other essential leaders.

Tier 2

- Hospitalized (non-intensive care unit) patients and long-term care facility residents with unexplained fever and signs/symptoms of a lower respiratory tract illness. The number of confirmed COVID-19 cases in the community should be considered.
- As testing becomes more widely available, routine testing of hospitalized patients may be important for infection prevention and management at discharge.

Tier 3

- Patients in outpatient settings who meet the criteria for influenza testing (e.g., older people and/or those with underlying health conditions). Testing in pregnant women and symptomatic children with similar risk factors for complications is encouraged. The number of confirmed COVID-19 cases in the community should be considered.

Tier 4

- Community surveillance as directed by public health and/or infectious diseases authorities.

[\[IDSA: COVID-19 prioritization of diagnostic testing\]](#)

Step-by-step treatment approach

No specific treatments are known to be effective for COVID-19 yet; therefore, the mainstay of management is early recognition and optimized supportive care to relieve symptoms and to support organ function in more severe illness. Patients should be managed in a hospital setting where possible; however, home care may be suitable for selected patients with mild illness unless there is concern about rapid deterioration or an inability to promptly return to hospital if necessary. Children are less likely to require hospitalization.[11]

[BMJ talk medicine podcast: coping with Covid-19 - advice from a New York City intensivist]

Rationing of medical resources may be required during the pandemic if healthcare infrastructures are overwhelmed. This raises many ethical questions on how to best triage patients to save the most lives. Recommendations have been suggested, but there is no clear international guidance on this issue as yet.[232] [233] [234] [235] [236]

Infection prevention and control

Immediately isolate all suspected or confirmed cases in an area separate from other patients. Suspected cases should be given a mask and kept at least 3 feet (1 meter) from other suspected cases. It is important to note that recommended distances differ between countries and you should consult local guidance. Implement appropriate infection prevention and control procedures. COVID-19 is a notifiable disease; report all suspected and confirmed cases to your local health authorities.

[BMJ: covid-19 - PPE guidance]

Detailed guidance on infection prevention and control procedures are available from the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC):

- [WHO: infection prevention and control during health care when COVID-19 is suspected]
- [CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings]
- [CDC: strategies to optimize the supply of PPE and equipment]

The WHO recommends that patients should remain in isolation for 2 weeks after symptoms disappear, and visitors should not be allowed until the end of this period.[237] Guidance on when to stop isolation depends on local circumstances and may differ between countries; consult local guidelines.

Severe COVID-19: location of care and admission

Promptly admit patients with pneumonia or acute respiratory distress to an appropriate healthcare facility and start supportive care depending on the clinical presentation. Patients with impending or established respiratory failure should be admitted to an intensive care unit. Approximately 14% of patients present with severe illness requiring oxygen therapy, and 5% present with critical illness requiring intensive care unit treatment.[7] The most common reasons for intensive care unit admission are hypoxemic respiratory failure leading to mechanical ventilation and hypotension.[238] The median time from onset of symptoms to hospital admission is reported to be approximately 7 days.[20] [39] Hospitalization rates increase with age, and are highest among older adults or patients with underlying conditions.[239]

Treatment and care planning

- Discuss the risks, benefits, and potential outcomes of treatment options with patients and their families, and allow them to express preferences about their management. Take their wishes and expectations into account when considering the ceiling of treatment. Use decision support tools if available. Put treatment escalation plans in place, and discuss any existing advance care plans or advance decisions to refuse treatment with patients who have preexisting advanced comorbidities.[240]

Admission to critical care

- Assess all adults for frailty on admission to hospital, irrespective of age and COVID-19 status, using the Clinical Frailty Scale (CFS). [Clinical frailty scale]
- Involve critical care teams in discussions about admission to critical care for patients where:
 - The CFS score suggests the person is less frail (e.g., CFS <5), they are likely to benefit from critical care organ support, and the patient wants critical care treatment; or
 - The CFS score suggests the person is more frail (e.g., CFS ≥5), there is uncertainty regarding the benefit of critical care organ support, and critical care advice is needed to help the decision about treatment.
- Take into account the impact of underlying pathologies, comorbidities, and severity of acute illness.[241]

Severe COVID-19: supportive care

Oxygen

- Give supplemental oxygen at a rate of 5 L/minute to patients with severe acute respiratory infection and respiratory distress, hypoxemia, shock, or SpO₂ <90%. [3] [242] Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation. [3] Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition.
- Once the patient is stable, the target SpO₂ is >90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children. [3] Some guidelines recommend that SpO₂ should be maintained no higher than 96%. [242]
- Some locations may recommend different targets in order to support prioritization of oxygen flow for the most severely ill patients in hospital. For example, NHS England recommends a target of 92% to 95% (or 90% to 94% if clinically appropriate). [243]

Intravenous fluids

- Manage fluids conservatively in adults and children with severe acute respiratory infection when there is no evidence of shock as aggressive fluid resuscitation may worsen oxygenation. [3]

Antimicrobials

- Start empiric antimicrobials to cover other potential bacterial pathogens that may cause respiratory infection, according to local protocols. Give within 1 hour of initial patient assessment for patients with suspected sepsis. Choice of empiric antimicrobials should be based on the clinical diagnosis, and local epidemiology and susceptibility data. Consider treatment with a neuraminidase inhibitor until influenza is ruled out. De-escalate empiric therapy based on microbiology results and clinical judgment. [3]

- Some patients with severe illness may require continued antimicrobial therapy once COVID-19 has been confirmed depending on the clinical circumstances.

Monitoring

- Monitor patients closely for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis, and immediately start general supportive care interventions as indicated (e.g., hemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[3]

Prevention of complications

- Implement standard interventions to prevent complications associated with critical illness.[3] Complications such as acute respiratory distress syndrome (ARDS), sepsis, and septic shock should be managed according to usual protocols. See our Complications section for more information.

Palliative care

- Follow local palliative care guidelines for patients in the last days and hours of life.

Severe COVID-19: symptom management

Managing fever

- Guidelines recommend an antipyretic for the relief of fever.[3] [242] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[244] If used, these drugs should only be taken when necessary while symptoms are present.
- Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[245] There is currently no strong evidence to support this. The European Medicines Agency, the Food and Drug Administration, the Commission of Human Medicines, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated.[246] [247] [248] [249] However, the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.[240] [250]

Managing cough

- Advise patients to avoid lying on their back as this makes coughing ineffective. Use simple measures first (e.g., a teaspoon of honey in patients ages 1 year and older). Consider short-term use of an oral opioid in adults if the cough is distressing to the patient.[240]

Managing breathlessness

- Keep the room cool, and encourage relaxation, breathing techniques, and changing body positions. Identify and treat any reversible causes of breathlessness (e.g., pulmonary edema). Consider a trial of oxygen, if available. Consider an opioid and benzodiazepine combination in patients with moderate to severe breathlessness or patients who are distressed.[240]

Managing anxiety, delirium, and agitation

- Identify and treat any reversible causes (e.g., offer reassurance, treat hypoxia). Consider a benzodiazepine for the management of anxiety or agitation. Consider haloperidol or a phenothiazine for the management of delirium.[240]

Severe COVID-19: high flow nasal oxygen/noninvasive ventilation

Provide advanced oxygen or noninvasive ventilation in patients who are deteriorating and failing to respond to standard oxygen therapy.[3] Follow local infection prevention and control procedures to prevent transmission to healthcare workers, especially when performing aerosol-generating procedures. Novel methods to protect clinicians without access to standard personal protective equipment during aerosol-generating procedures have been suggested (e.g., aerosol box, plastic drapes, helmet devices).[251] [252] [253]

Consider a trial of high-flow nasal oxygen or noninvasive ventilation (e.g., continuous positive airway pressure [CPAP] or bilevel positive airway pressure [BiPAP]) in patients with hypoxemic respiratory failure.[3] [242] These procedures may avoid the need for intubation and mechanical ventilation; however, they have a higher risk of aerosol generation.[254]

There is ongoing debate about the optimal mode of respiratory support before mechanical ventilation, and you should check local guidelines for preferred options.[255] NHS England recommends CPAP as the preferred form of noninvasive ventilation, and doesn't advocate the use of high-flow nasal oxygen based on a lack of efficacy, oxygen use, and infection spread. High-flow oxygen delivery can place a strain on oxygen supplies with the risk of site supply failure. Early CPAP may provide a bridge to invasive mechanical ventilation. Use of BiPAP should be reserved for patients with hypercapnic acute or chronic ventilatory failure.[256] Despite the trend to avoid high-flow nasal oxygen, it has been shown to have a similar risk of aerosol generation to standard oxygen masks.[257]

Monitor patients closely for clinical deterioration that could result in the need for urgent intubation.[3] Patients with lower PaO₂/fraction of inspired oxygen (FiO₂) were more likely to experience failure with high-flow nasal oxygen and require ventilation in one study.[258]

Severe COVID-19: mechanical ventilation

Consider intubation and mechanical ventilation in patients who are acutely deteriorating despite advanced oxygen/noninvasive ventilatory support measures. Two-thirds of patients who required critical care in the UK had mechanical ventilation within 24 hours of admission.[259] In New York, 33% of hospitalized patients developed respiratory failure leading to mechanical ventilation. These patients were more likely to be male, have obesity, and have elevated inflammatory markers and liver function tests.[101]

Endotracheal intubation should be performed by an experienced provider using airborne precautions. Young children, or adults who are obese or pregnant, may desaturate quickly during intubation and therefore require preoxygenation with 100% FiO₂ for 5 minutes.[3]

Although some patients with COVID-19 pneumonia can meet the criteria for ARDS, it appears that COVID-19 pneumonia may be its own specific disease with atypical phenotypes. There is emerging evidence from Italy and the US that the main characteristic of the atypical presentation is the dissociation between well-preserved lung mechanics and the severity of hypoxemia.[260] [261] Italian clinicians have defined the two disease phenotypes for COVID-19 pneumonia as follows:

- Type L (or non-ARDS, type 1) – severe hypoxemia associated with: low elastance; low ventilation-to-perfusion ratio; low lung weight; low lung recruitability (the near normal compliance may explain why some patients present without dyspnea)
- Type H (or ARDS, type 2) – severe hypoxemia associated with: high elastance; high right-to-left shunt; high lung weight; high lung recruitability.

These patients are clearly distinguishable by CT scan. Patients may initially present with the type L phenotype, which may remain unchanged for a period of time and then either improve or worsen, or it may transition to type H. Type H pattern fits the severe acute respiratory distress syndrome criteria, and only 20% to 30% of patients in the case series of 150 patients displayed this phenotype. Type L appeared to be more common (more than 50% of patients) in this series.[261] [262]

Italian clinicians have warned that protocol-driven ventilator use may be causing lung injury in some patients, and that ventilator settings should be based on physiologic findings rather than using standard protocols.[260] Patients who fit standard ARDS criteria (type H/type 2) should receive a lung-protective, low tidal volume/low inspiratory pressure ventilation strategy (lower targets are recommended in children). A higher positive end-expiratory pressure (PEEP) strategy is preferred over a lower PEEP strategy.[3] [242] High PEEP may have a detrimental effect on patients with normal compliance, and a lower PEEP strategy should be considered in patients with the type L/type 1 phenotype. NHS England recommends a low PEEP strategy in patients with normal compliance where recruitment may not be required.[263] You should consult an intensivist with experience in treating COVID-19 patients for more detailed guidance.

Consider prone ventilation in patients with persistent severe hypoxic failure.[3] [242] [264] Prone position may be less useful in patients with the type L/type 1 phenotype.[261] Pregnant women may benefit from being placed in the lateral decubitus position.[3] A small cohort study of 12 patients in Wuhan City, China, with COVID-19-related acute respiratory distress syndrome suggests that spending periods of time in the prone position may improve lung recruitability.[265]

A trial of an inhaled pulmonary vasodilator may be considered in adults who have severe acute respiratory distress syndrome and hypoxemia despite optimizing ventilation. Lung recruitment maneuvers are suggested, but staircase recruitment maneuvers are not recommended.[242]

Severe COVID-19: extracorporeal membrane oxygenation

Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise if the above methods fail.[3] [242] [264] [266] However, ECMO is not suitable for all patients, and only those who meet certain inclusion criteria may be considered for ECMO.[267] Preliminary data on the use of ECMO in patients with COVID-19 is not promising.[268]

Severe COVID-19: experimental therapies

Corticosteroids

- Corticosteroids are being used in some patients with COVID-19; however, they have been found to be ineffective and are not recommended.[20] [269] [270]
- The WHO (as well as other international pneumonia guidelines) does not routinely recommend systemic corticosteroids for the treatment of viral pneumonia or acute respiratory distress syndrome unless they are indicated for another reason.[3]
- Surviving Sepsis Campaign guidelines on the treatment of critically ill patients with COVID-19 suggest that adults with acute respiratory distress syndrome who are receiving mechanical

ventilation should receive corticosteroids, although this recommendation is based on weak evidence.[242]

- The Infectious Diseases Society of America recommends against the use of corticosteroids in patients with COVID-19, except in the context of a clinical trial.[271]
- A meta-analysis of over 5000 patients found that corticosteroid treatment in patients with COVID-19 was associated with longer hospital stays and a higher rate of mortality.[272]
- A randomized controlled trial investigating the use of corticosteroids in patients with COVID-19 is in progress.[273]

Other experimental therapies

- Drug therapies (e.g., antivirals) are being used in patients with COVID-19; however, unlicensed or experimental treatments should only be administered in the context of ethically-approved clinical trials.[3] See our Emerging section for more information about these treatments.

Mild COVID-19 with risk factors

Patients with mild illness who have risk factors for poor outcomes (i.e., age >60 years, presence of comorbidities) should also be prioritized for hospital admission.[219] These patients should be managed in the same way as severe COVID-19 (above) depending on the clinical presentation.

Mild COVID-19 without risk factors

All laboratory-confirmed cases, regardless of severity, should be managed in a healthcare facility where possible. In situations where this is not possible, patients with mild illness and no risk factors (i.e., age >60 years, presence of comorbidities) can be isolated in nontraditional facilities (e.g., repurposed hotels or stadiums) or at home. This will depend on guidance from local health authorities and available resources. Forced quarantine orders are being used in some countries.[219]

Home care can be considered when the patient can be cared for by family members and follow-up with a healthcare provider or public health personnel is possible. The decision requires careful clinical judgment and should be informed by an assessment of the patient's home environment.[219]

Patients and household members should follow appropriate infection prevention and control measures while the patient is in home care. Detailed guidance is available from the WHO and CDC:

- [\[WHO: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts\]](#)
- [\[CDC: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 \(COVID-19\)\]](#)

Recommend symptomatic therapies (as per the recommendations above) and advise patients to keep hydrated but not to take too much fluid as this can worsen oxygenation. Advise patients to improve air circulation by opening a window or door (fans can spread infection and should not be used).[240]

Monitor patients closely and advise them to seek medical care if symptoms worsen as mild illness can rapidly progress to lower respiratory tract disease. Two negative test results (on samples collected at least 24 hours apart) are required before the patient can be released from home isolation. If testing is not possible, the patient should remain in isolation for an additional 2 weeks after symptoms resolve.[219] Guidance on when to stop isolation depends on local circumstances and may differ between countries; consult local guidelines.

Pregnancy and breastfeeding

Pregnant women should be managed by a multidisciplinary team, including obstetric, perinatal, neonatal, and intensive care specialists, as well as mental health and psychosocial support. There is no evidence to suggest that pregnant women are more likely to contract COVID-19, or present with increased risk of severe illness or fetal compromise. Data on pregnant women with COVID-19 are limited; however, pregnant women can generally be treated with the same supportive therapies detailed above, taking into account the physiologic changes that occur with pregnancy.[3] [274]

Prenatal care

- Pregnant women have been placed in the vulnerable category in the UK and are advised to engage with strict social distancing measures, particularly if they are above 28 weeks' gestation.[275]
- Remote consultations and self-monitoring of blood pressure may be recommended in healthy women whenever possible to reduce the number of hospital visits.[275] [276]
- Routine prenatal care appointments should be delayed in patients with suspected or confirmed COVID-19 until after the recommended period of self-isolation. More urgent appointments require a senior decision on urgency and potential risks and benefits.[275]

Location of care

- Manage suspected and confirmed cases in a hospital setting with appropriate maternal and fetal monitoring whenever possible. Women with severe illness or complications may require admission to an intensive care unit. Consider home care in women with asymptomatic or mild illness, provided the patient has no signs of potentially severe illness (e.g., breathlessness, hemoptysis, new chest pain/pressure, anorexia, dehydration, confusion), no comorbidities, and no obstetric issues; the patient is able to care for herself; and monitoring and follow-up is possible.[161] [276] [277]
- The American College of Obstetricians and Gynecologists has published an algorithm to help decide whether hospital admission or home care is more appropriate. [ACOG: outpatient assessment and management for pregnant women with suspected or confirmed novel coronavirus (COVID-19)]

Delivery

- Choice of delivery and timing should be individualized based on gestational age, as well as maternal, fetal, and delivery conditions. Induction of labor and vaginal delivery is preferred in pregnant women with confirmed COVID-19 infection to avoid unnecessary surgical complications; however, an emergency cesarean delivery may be required if medically justified (e.g., in patients with complications such as sepsis or if there is fetal distress). A negative pressure isolation room is recommended in confirmed cases for labor, delivery, and neonatal care, if possible.[3] [161] [277]
- Corticosteroid therapy may be considered in women who are at risk of preterm birth from 24 to 37 weeks' gestation for fetal lung maturation, but caution is advised as this could potentially worsen the maternal clinical condition, and the decision should be made in conjunction with the multidisciplinary team.[3] [161] [277] [278]

Newborns and breastfeeding

- Babies born to mothers with suspected or confirmed infection should be considered a person under investigation and tested at 24 hours and 48 hours after birth.[279]
- The WHO recommends that mothers and infants should remain together when possible, and breastfeeding should be encouraged while applying appropriate infection prevention and control

measures (e.g., performing hand hygiene before and after contact with the baby, wearing a mask while breastfeeding).[3] However, the CDC recommends that temporary separation of the mother and baby should be considered on a case-by-case basis using shared-decision making between the mother and the clinical team, at least until the mother’s transmission-based precautions are discontinued. It recommends that mothers who intend to breastfeed should be encouraged to express their breast milk using a dedicated breast pump and using appropriate infection prevention and control measures in order to maintain milk supply. Expressed milk should be fed to the newborn by a healthy caregiver.[280] Separation appears to be the best option for mothers who are severely or critically ill.[161] Consult local guidelines for specific recommendations.

- After discharge, advise mothers with COVID-19 to practice prevention measures (e.g., distance, hand hygiene, respiratory hygiene/mask) for newborn care until they are afebrile for 72 hours without use of antipyretics and at least 7 days have passed since symptoms first appeared. A newborn with documented infection requires close outpatient follow-up after discharge.[279]

Treatment details overview

Please note that formulations/routes and doses may differ between drug names and brands, drug formularies, or locations. Treatment recommendations are specific to patient groups: [see disclaimer](#)

| Initial | | (summary) |
|---------------------------|----------------|--|
| suspected COVID-19 | | |
| | 1st | isolation and infection prevention and control procedures |
| | plus | empiric antimicrobials |
| | plus | monitoring |
| | adjunct | supportive care |
| | adjunct | antipyretic |
| | adjunct | antitussive |

| Acute | | (summary) | |
|---|----------------|--|--|
| confirmed COVID-19 | | | |
| <ul style="list-style-type: none"> ■ severe illness; mild illness with risk factors | 1st | hospital admission | |
| | plus | infection prevention and control procedures | |
| | plus | treatment and care planning | |
| | plus | monitoring | |
| | adjunct | supportive care | |
| | adjunct | empiric antimicrobials | |
| | adjunct | antipyretic | |
| | adjunct | antitussive | |
| | adjunct | advanced oxygen/ventilatory support | |
| | adjunct | experimental therapies | |
| <ul style="list-style-type: none"> ■ mild illness with no risk factors | 1st | isolation in nontraditional facility or at home | |
| | plus | monitoring | |
| | plus | supportive care | |
| | adjunct | antipyretic | |
| | adjunct | antitussive | |

Treatment options

Please note that formulations/routes and doses may differ between drug names and brands, drug formularies, or locations. Treatment recommendations are specific to patient groups: [see disclaimer](#)

Initial

suspected COVID-19

- 1st isolation and infection prevention and control procedures**
- » Immediately isolate all suspected cases in an area separate from other patients, and implement appropriate infection prevention and control procedures. Suspected cases should be given a mask and kept at least 3 feet (1 meter) from other suspected cases. It is important to note that recommended distances differ between countries and you should consult local guidance.
 - » [\[BMJ: covid-19 - PPE guidance\]](#)
 - » Detailed guidance is available from the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC):
 - » [\[WHO: infection prevention and control during health care when COVID-19 is suspected\]](#)
 - » [\[CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 \(COVID-19\) in healthcare settings\]](#)
 - » COVID-19 is a notifiable disease; report all suspected cases to your local health authorities.
 - » Pregnant women should be managed by a multidisciplinary team, including obstetric, perinatal, neonatal, and intensive care specialists, as well as mental health and psychosocial support.[\[3\]](#) [\[277\]](#)
- plus empiric antimicrobials**
- Treatment recommended for ALL patients in selected patient group
- » Start empiric antimicrobials to cover other potential bacterial pathogens that may cause respiratory infection according to local protocols. Give within 1 hour of initial patient assessment for patients with suspected sepsis. Choice of empiric antimicrobials should be based on the clinical diagnosis, and local epidemiology and susceptibility data.[\[3\]](#)
 - » Consider treatment with a neuraminidase inhibitor until influenza is ruled out.[\[3\]](#)
 - » De-escalate empiric therapy based on microbiology results and clinical judgment.
- plus monitoring**

Initial

Treatment recommended for ALL patients in selected patient group

» Monitor patients closely for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis, and immediately start general supportive care interventions as indicated (e.g., hemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[3]

adjunct supportive care

Treatment recommended for SOME patients in selected patient group

» Immediately start supportive care based on the clinical presentation if necessary.

» Oxygen: give supplemental oxygen at a rate of 5 L/minute to patients with severe acute respiratory infection and respiratory distress, hypoxemia, shock, or SpO₂ <90%. [3] [242] Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation. Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition. Once the patient is stable, the target SpO₂ is >90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[3] Some guidelines recommend that SpO₂ should be maintained no higher than 96%. [242] Some locations may recommend different targets in order to support prioritization of oxygen flow for the most severely ill patients in hospital. For example, NHS England recommends a target of 92% to 95% in adults in the first instance (or 90% to 94% if clinically appropriate). [243]

» Intravenous fluids: manage fluids conservatively in adults and children with severe acute respiratory infection when there is no evidence of shock as aggressive fluid resuscitation may worsen oxygenation.[3]

adjunct antipyretic

Treatment recommended for SOME patients in selected patient group

Primary options

» **acetaminophen**: children: 10-15 mg/kg orally every 4-6 hours when required, maximum 75 mg/kg/day; adults: 325-1000 mg orally (immediate-release) every 4-6 hours when required, maximum 4000 mg/day

OR

Initial

» **ibuprofen**: children 6 months to 11 years of age: 5-10 mg/kg orally every 6-8 hours when required, maximum 40 mg/kg/day; children ≥12 years of age and adults: 200-400 mg orally every 4-6 hours when required, maximum 2400 mg/day

» Guidelines recommend an antipyretic for the relief of fever.[3] [242] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[244] If used, these drugs should only be taken when necessary while symptoms are present.

» Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[245] There is currently no strong evidence to support this. The European Medicines Agency, the Food and Drug Administration, the Commission of Human Medicines, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated.[246] [247] [248] [249] However, the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.[240] [250]

» Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <6 months of age (age cut-offs vary by country).

adjunct antitussive

Treatment recommended for SOME patients in selected patient group

Primary options

» **codeine sulfate**: 10-20 mg orally every 4-6 hours when required, maximum 120 mg/day

Secondary options

» **morphine sulfate**: adults: 2.5 to 5 mg orally every 4 hours when required initially, increase to 5-10 mg every 4 hours when required if necessary

» Advise patients to avoid lying on their back as this makes coughing ineffective.

» Use simple measures first (e.g., a teaspoon of honey in patients ages 1 year and older).

Initial

» Consider short-term use of an oral opioid in adults if the cough is distressing to the patient. Codeine (linctus or tablet) is the preferred first-line option, with oral morphine solution reserved as a second-line option.^[240]

Acute

confirmed COVID-19

- severe illness; mild illness with risk factors

1st hospital admission

- » Promptly admit patients with pneumonia or acute respiratory distress to an appropriate healthcare facility. Patients with impending or established respiratory failure should be admitted to an intensive care unit.[3]
- » Patients with mild illness who have risk factors for poor outcomes (i.e., age >60 years, presence of comorbidities) should also be prioritized for hospital admission when possible.[219]
- » Manage suspected and confirmed cases in pregnant women in a hospital setting with appropriate maternal and fetal monitoring whenever possible. Women with severe illness or complications may require admission to an intensive care unit.[161] [276] [277] Pregnant women should be managed by a multidisciplinary team, including obstetric, perinatal, neonatal, and intensive care specialists, as well as mental health and psychosocial support.[3] [277]

plus infection prevention and control procedures

Treatment recommended for ALL patients in selected patient group

- » Immediately isolate all confirmed cases in an area separate from other patients, and implement appropriate infection prevention and control procedures.
- » [BMJ: covid-19 - PPE guidance]
- » Detailed guidance is available from the WHO and the CDC:
- » [WHO: infection prevention and control during health care when COVID-19 is suspected]
- » [CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings]
- » COVID-19 is a notifiable disease; report all confirmed cases to your local health authorities.
- » The WHO recommends that patients should remain in isolation for 2 weeks after symptoms disappear, and visitors should not be allowed until the end of this period.[237] Guidance

Acute

on when to stop isolation depends on local circumstances and may differ between countries; consult local guidelines.

plus treatment and care planning

Treatment recommended for ALL patients in selected patient group

» Assess all adults for frailty on admission to hospital, irrespective of age and COVID-19 status, using the Clinical Frailty Scale.[241] [Clinical frailty scale]

» Discuss the risks, benefits, and potential outcomes of treatment options with patients and their families, and allow them to express preferences about their management. Take their wishes and expectations into account when considering the ceiling of treatment. Use decision support tools if available. Put treatment escalation plans in place, and discuss any existing advance care plans or advance decisions to refuse treatment with patients who have preexisting advanced comorbidities.[240]

» Involve critical care teams in discussions about admission to critical care.[241]

plus monitoring

Treatment recommended for ALL patients in selected patient group

» Monitor patients closely for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis, and immediately start general supportive care interventions as indicated (e.g., hemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[3]

adjunct supportive care

Treatment recommended for SOME patients in selected patient group

» Immediately start supportive care, if necessary.

» Oxygen: give supplemental oxygen at a rate of 5 L/minute to patients with severe acute respiratory infection and respiratory distress, hypoxemia, shock, or SpO₂ <90%. [3] [242] Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation. Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition. Once the patient is stable, the target SpO₂ is >90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[3] Some guidelines recommend that SpO₂ should be

Acute

maintained no higher than 96%.^[242] Some locations may recommend different targets in order to support prioritization of oxygen flow for the most severely ill patients in hospital. For example, NHS England recommends a target of 92% to 95% in adults in the first instance (or 90% to 94% if clinically appropriate).^[243]

» Intravenous fluids: manage fluids conservatively in adults and children with severe acute respiratory infection when there is no evidence of shock as aggressive fluid resuscitation may worsen oxygenation.^[3]

» Managing breathlessness: keep the room cool, and encourage relaxation, breathing techniques, and changing body positions. Identify and treat any reversible causes of breathlessness (e.g., pulmonary edema). Consider a trial of oxygen, if available. Consider an opioid and benzodiazepine combination in patients with moderate to severe breathlessness or patients who are distressed.^[240]

» Managing anxiety, delirium, and agitation: identify and treat any reversible causes (e.g., offer reassurance, treat hypoxia). Consider a benzodiazepine for the management of anxiety or agitation. Consider haloperidol or a phenothiazine for the management of delirium.^[240]

» Implement standard interventions to prevent complications associated with critical illness.^[3]

adjunct empiric antimicrobials

Treatment recommended for SOME patients in selected patient group

» Patients with severe illness may require continued antimicrobial therapy once COVID-19 has been confirmed depending on the clinical circumstances.

adjunct antipyretic

Treatment recommended for SOME patients in selected patient group

Primary options

» **acetaminophen**: children: 10-15 mg/kg orally every 4-6 hours when required, maximum 75 mg/kg/day; adults: 325-1000 mg orally (immediate-release) every 4-6 hours when required, maximum 4000 mg/day

OR

Acute

» **ibuprofen**: children 6 months to 11 years of age: 5-10 mg/kg orally every 6-8 hours when required, maximum 40 mg/kg/day; children ≥12 years of age and adults: 200-400 mg orally every 4-6 hours when required, maximum 2400 mg/day

» Guidelines recommend an antipyretic for the relief of fever.[3] [242] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[244] If used, these drugs should be taken only when necessary while symptoms are present.

» Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[245] There is currently no strong evidence to support this. The European Medicines Agency, the Food and Drug Administration, the Commission of Human Medicines, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated.[246] [247] [248] [249] However, the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.[240] [250]

» Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <6 months of age (age cut-offs vary by country).

adjunct antitussive

Treatment recommended for SOME patients in selected patient group

Primary options

» **codeine sulfate**: 10-20 mg orally every 4-6 hours when required, maximum 120 mg/day

Secondary options

» **morphine sulfate**: adults: 2.5 to 5 mg orally every 4 hours when required initially, increase to 5-10 mg every 4 hours when required if necessary

» Advise patients to avoid lying on their back as this makes coughing ineffective.

» Use simple measures first (e.g., a teaspoon of honey in patients ages 1 year and older).

Acute

» Consider short-term use of an oral opioid in adults if the cough is distressing to the patient. Codeine (linctus or tablet) is the preferred first-line option, with oral morphine solution reserved as a second-line option.[240]

adjunct advanced oxygen/ventilatory support

Treatment recommended for SOME patients in selected patient group

» Provide advanced oxygen/ventilatory support in patients who are deteriorating and failing to respond to standard oxygen therapy.[3] Follow local infection prevention and control procedures to prevent transmission to healthcare workers, especially when performing aerosol-generating procedures. Novel methods to protect clinicians without access to standard personal protective equipment during aerosol-generating procedures have been suggested (e.g., aerosol box, plastic drapes, helmet devices).[251] [252] [253]

» Consider a trial of high-flow nasal oxygen or noninvasive ventilation (e.g., continuous positive airway pressure [CPAP] or bilevel positive airway pressure [BiPAP]) in patients with hypoxemic respiratory failure.[3] [242] These procedures may avoid the need for intubation and mechanical ventilation; however, they have a higher risk of aerosol generation.[254] There is ongoing debate about the optimal mode of respiratory support before mechanical ventilation, and you should check local guidelines for preferred options.[255] NHS England recommends CPAP as the preferred form of noninvasive ventilation, and doesn't advocate the use of high-flow nasal oxygen based on a lack of efficacy, oxygen use, and infection spread. High-flow oxygen delivery can place a strain on oxygen supplies with the risk of site supply failure. Early CPAP may provide a bridge to invasive mechanical ventilation. Use of BiPAP should be reserved for patients with hypercapnic acute or chronic ventilatory failure.[256] Despite the trend to avoid high-flow nasal oxygen, it has been shown to have a similar risk of aerosol generation to standard oxygen masks.[257] Monitor patients closely for clinical deterioration that could result in the need for urgent intubation.[3] Patients with lower PaO₂/fraction of inspired oxygen (FiO₂) were more likely to experience failure with high-flow nasal oxygen and require ventilation in one study.[258]

» Consider intubation and mechanical ventilation in patients who are acutely deteriorating.[3] Endotracheal intubation should be performed

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by an experienced provider using airborne precautions. Young children, or adults who are obese or pregnant, may desaturate quickly during intubation and therefore require preoxygenation with 100% FiO₂ for 5 minutes.[3] Patients who fit standard acute respiratory distress syndrome criteria should receive a lung-protective, low tidal volume/low inspiratory pressure ventilation strategy (lower targets are recommended in children). A higher positive end-expiratory pressure (PEEP) strategy is preferred over a lower PEEP strategy.[3] [242] However, Italian clinicians have warned that protocol-driven ventilator use may be causing lung injury in some patients, and that ventilator settings should be based on physiologic findings rather than using standard protocols. They note that many COVID-19 patients have an atypical presentation, showing a dissociation between well-preserved lung mechanics and the severity of hypoxemia.[260] [261] [262] High PEEP may have a detrimental effect on patients with normal compliance, and a lower PEEP strategy should be considered in these patients. NHS England recommends a low PEEP strategy in patients with normal compliance where recruitment may not be required.[263] You should consult an intensivist with experience in treating COVID-19 patients for more detailed guidance.

» Consider prone ventilation in patients with persistent severe hypoxic failure.[3] [242] [264] Pregnant women may benefit from being placed in the lateral decubitus position.[3] A small cohort study of 12 patients in Wuhan, China, with COVID-19-related acute respiratory distress syndrome suggests that spending periods of time in the prone position may improve lung recruitability.[265]

» A trial of an inhaled pulmonary vasodilator may be considered in adults who have severe acute respiratory distress syndrome and hypoxemia despite optimizing ventilation. Lung recruitment maneuvers are suggested, but staircase recruitment maneuvers are not recommended.[242]

» Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise if the above methods fail.[3] [242] [264] However, ECMO is not suitable for all patients, and only those who meet certain inclusion criteria may be considered for ECMO.[267] Preliminary data on the use

Acute

| | | |
|---|--|--|
| | | of ECMO in patients with COVID-19 is not promising.[268] |
| | adjunct | experimental therapies Treatment recommended for SOME patients in selected patient group » Consider using experimental drug therapies. Antivirals and other drugs are being used in patients with COVID-19; however, unlicensed or experimental treatments should only be administered in the context of ethically-approved clinical trials.[3] See the Emerging section for more information about these treatments. |
| ■ | mild illness with no risk factors | 1st isolation in nontraditional facility or at home » Patients with mild illness and no risk factors (i.e., age >60 years, presence of comorbidities) can be isolated in nontraditional facilities (e.g., repurposed hotels or stadiums) or at home when management in a healthcare facility is not possible. This will depend on guidance from local health authorities and available resources.[219] Forced quarantine orders are being used in some countries. » Home care can be considered when the patient can be cared for by family members and follow-up with a healthcare provider or public health personnel is possible. The decision requires careful clinical judgment and should be informed by an assessment of the patient's home environment.[219] » Consider home care in pregnant women with asymptomatic or mild illness, provided the patient has no signs of potentially severe illness (e.g., breathlessness, hemoptysis, new chest pain/pressure, anorexia, dehydration, confusion), no comorbidities, and no obstetric issues; the patient is able to care for herself; and monitoring and follow-up is possible.[161] [276] [277] » Patients and household members should follow appropriate infection prevention and control measures. Detailed guidance is available from the WHO and the CDC: » [WHO: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts] » [CDC: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19)] |

Acute

» Two negative test results (on samples collected at least 24 hours apart) are required before the patient can be released from home isolation. If testing is not possible, the patient should remain in isolation for an additional 2 weeks after symptoms resolve.[219] Guidance on when to stop isolation depends on local circumstances and may differ between countries; consult local guidelines.

plus monitoring

Treatment recommended for ALL patients in selected patient group

» Monitor patients closely and advise them to seek medical care if symptoms worsen as mild illness can rapidly progress to lower respiratory tract disease.

» Ultrasound fetal surveillance is recommended every 2 weeks in pregnant women.[277]

plus supportive care

Treatment recommended for ALL patients in selected patient group

» Advise patients to keep hydrated but not to take too much fluid as this can worsen oxygenation.[219]

» Advise patients to improve air circulation by opening a window or door (fans can spread infection and should not be used).[240]

adjunct antipyretic

Treatment recommended for SOME patients in selected patient group

Primary options

» **acetaminophen**: children: 10-15 mg/kg orally every 4-6 hours when required, maximum 75 mg/kg/day; adults: 325-1000 mg orally (immediate-release) every 4-6 hours when required, maximum 4000 mg/day

OR

» **ibuprofen**: children 6 months to 11 years of age: 5-10 mg/kg orally every 6-8 hours when required, maximum 40 mg/kg/day; children ≥12 years of age and adults: 200-400 mg orally every 4-6 hours when required, maximum 2400 mg/day

» Guidelines recommend an antipyretic for the relief of fever.[3] However, current evidence does not support routine antipyretic administration to

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treat fever in acute respiratory infections.[244] If used, these drugs should only be taken when necessary while symptoms are present.

» Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[245] There is currently no strong evidence to support this. The European Medicines Agency, the Food and Drug Administration, the Commission of Human Medicines, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated.[246] [247] [248] [249] However, the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.[240] [250]

» Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <6 months of age (age cut-offs vary by country).

adjunct antitussive

Treatment recommended for SOME patients in selected patient group

Primary options

» **codeine sulfate**: 10-20 mg orally every 4-6 hours when required, maximum 120 mg/day

Secondary options

» **morphine sulfate**: adults: 2.5 to 5 mg orally every 4 hours when required initially, increase to 5-10 mg every 4 hours when required if necessary

» Advise patients to avoid lying on their back as this makes coughing ineffective.

» Use simple measures first (e.g., a teaspoon of honey in patients ages 1 year and older).

» Consider short-term use of an oral opioid in adults if the cough is distressing to the patient. Codeine (linctus or tablet) is the preferred first-line option, with oral morphine solution reserved as a second-line option.[240]

Emerging

Introduction

No treatments have been approved or shown to be safe and effective for the treatment of COVID-19. However, there are several treatments being used off-label (use of a licensed medication for an indication that has not been approved by a national drug regulatory authority), on a compassionate-use basis, or as part of a randomized controlled trial.[281] [282] It is important to note that there may be serious adverse effects associated with these drugs, and that these adverse effects may overlap with the clinical manifestations of COVID-19. These drugs may also increase the risk of death in an older patient or a patient with an underlying health condition. For example, chloroquine/hydroxychloroquine, azithromycin, and lopinavir/ritonavir are all potentially associated with an increased risk of cardiac death.[283] The World Health Organization (WHO) and its partners have launched the Solidarity trial, a large international study to compare different treatments and ensure clear evidence of which treatments are most effective. The study will have five arms: standard of care; remdesivir; lopinavir/ritonavir; lopinavir/ritonavir plus interferon beta; and chloroquine.[284] [WHO: off-label use of medicines for COVID-19]

Chloroquine and hydroxychloroquine

Chloroquine and hydroxychloroquine are oral drugs that have been used for the prophylaxis and treatment of malaria, and the treatment of certain autoimmune conditions such as rheumatoid arthritis and systemic lupus erythematosus. Both drugs have in vitro activity against SARS-CoV-2, with hydroxychloroquine having relatively higher potency.[285] [286] They are being trialed in patients for the treatment of mild to severe COVID-19.[287] [288] [289] They are also being trialed for prevention and post-exposure prophylaxis in the healthcare setting.[290] [291] Initial data is promising, but is currently limited. A small randomized controlled trial found that hydroxychloroquine (with or without azithromycin) was efficient in reducing viral nasopharyngeal carriage of SARS-CoV-2 in 3 to 6 days in most patients.[292] However, this trial has been criticized for its limitations, and results from a similar trial could not replicate these findings.[293] [294] Another randomized trial in 62 patients in China found that hydroxychloroquine may shorten time to clinical recovery (in terms of resolution of fever and cough, and improvement of pneumonia on computed tomographic imaging); however, this study has not been peer reviewed as yet.[295] Early results from the largest randomized controlled trial completed so far of 150 people in China found that the overall 28-day negative conversion rate was not significantly different between patients who received hydroxychloroquine and those who received standard of care. However, addition of hydroxychloroquine led to more rapid normalization of C-reactive protein levels and recovery of baseline lymphopenia, which may be important. The time to alleviation of symptoms was shorter compared with standard of care in the subgroup of patients who did not receive antiviral treatment in the post-hoc analysis. The rate of adverse effects was higher in the hydroxychloroquine group (diarrhea being the most common adverse effect). This study has not been peer reviewed yet and has several limitations (e.g., delay between symptom onset and starting treatment, inclusion of other antiviral therapies in the standard of care group).[296] Caution is recommended with the dosing regimen used for chloroquine due to the risk of chloroquine poisoning.[297] Hydroxychloroquine has similar therapeutic effects to chloroquine, but fewer adverse effects, is considered safe in pregnancy, and is more readily available in some countries.[298] Both drugs must be used with caution in patients with preexisting cardiovascular disease due to the risk of arrhythmias.[299] Guidelines in China and Italy recommend these drugs for the treatment of COVID-19; however, this is based on weak evidence.[300] Surviving Sepsis Campaign guidelines concluded that there is insufficient evidence to offer any recommendation on use of these drugs in the intensive care unit.[242] The American Thoracic Society recommends that either drug may be used on a case-by-case basis provided the patient's condition is severe enough to warrant investigational therapy, the benefits and risks of treatment are discussed with the patient, data is collected on outcomes, and the drug is not in short supply.[264] The European Medicines Agency (EMA) has stressed that these drugs have not been shown to be effective in treating COVID-19 as yet, and should only be used in the context of clinical trials or emergency-use programs.[301] The Food and Drug Administration (FDA) has granted an emergency-use authorization for chloroquine and hydroxychloroquine to treat patients when a clinical trial is not available or participation is not feasible.[302] There is currently no strong evidence of efficacy of hydroxychloroquine or chloroquine in the treatment or prevention of COVID-19. [Centre for Evidence-Based Medicine: hydroxychloroquine for COVID-19 - what do the clinical trials tell us?]

Remdesivir (GS-5734®)

A novel, investigational, intravenous nucleoside analog with broad antiviral activity that shows in vitro activity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Clinical trials with remdesivir have started in patients with mild to severe COVID-19.[285] [303] [304] [305] [306] [307] [308] It has been used on a compassionate-use basis in areas where clinical trials are not available; however, the manufacturer has paused access to the drug via this route due to overwhelming demand while they transition to an expanded access program. Exceptions will be made for patients with severe illness, and pregnant women and children with confirmed infection.[309] It appears to be safe to use in pregnancy.[274] The EMA has published recommendations on compassionate use of remdesivir for COVID-19.[310] Early results from one trial of patients treated with remdesivir on a compassionate-use basis indicated that approximately two-thirds of patients showed signs of clinical improvement (68% of patients had an improvement in oxygen support requirements); however, the study had no control arm and the majority of patients reported adverse effects.[311]

Lopinavir/ritonavir

An oral antiretroviral protease inhibitor currently approved for the treatment of HIV Infection. Lopinavir/ritonavir has been used in clinical trials for the treatment of COVID-19. Results from one small case series found that evidence of clinical benefit with lopinavir/ritonavir was equivocal.[312] A randomized controlled trial of approximately 200 patients in China found that treatment with lopinavir/ritonavir was not beneficial compared with standard care alone (primary outcome was time to improvement) in hospitalized patients with severe COVID-19.[313] It is considered safe in pregnancy.[274] There is currently no strong evidence of efficacy of lopinavir/ritonavir in the treatment of COVID-19. [Centre for Evidence-Based Medicine: lopinavir/ritonavir - a rapid review of effectiveness in COVID-19]

Convalescent plasma

Convalescent plasma from patients who have recovered from viral infections has been used as a treatment in previous virus outbreaks including SARS, avian influenza, and Ebola virus infection.[314] Clinical trials to determine the safety and efficacy of convalescent plasma that contains antibodies to SARS-CoV-2 in patients with COVID-19 have started.[315] A small preliminary case series of five critically ill patients reported clinical improvement after treatment with convalescent plasma; however, this study had many limitations.[316] Another study of 10 patients with severe illness in China noted symptomatic improvement within 3 days. Viral load was undetectable within 7 days in 70% of patients. No serious adverse reactions were noted.[317] The FDA is facilitating access to COVID-19 convalescent plasma for use in patients with serious or immediately life-threatening COVID-19 infections through the process of single patient emergency investigational new drug applications, and has issued guidance for its use. The FDA is encouraging patients who have recovered (for at least 2 weeks) to donate their plasma.[318] [319] [320]

Stem cell therapy

Stem cell therapy is being investigated to treat patients with COVID-19 in clinical trials. It is thought that mesenchymal stem cells can reduce the pathologic changes that occur in the lungs, and inhibit the cell-mediated immune inflammatory response.[321]

Intravenous immune globulin

Intravenous immune globulin (IVIG) is being trialed in some patients with COVID-19; however, there are no data to support this.[21] [322] Novel multi-antibody cocktail therapies are also in development for prophylaxis or treatment.[323] A retrospective study of 58 patients with severe COVID-19 found that IVIG, when used as an adjuvant treatment within 48 hours of admission, may reduce the use of mechanical ventilation, reduce hospital/intensive care unit stay, and reduce 28-day mortality; however, this study had several limitations.[324]

Treatments for cytokine release syndrome

Interleukin-6 receptor antagonist monoclonal antibodies (e.g., tocilizumab, sarilumab, siltuximab) are being trialed in COVID-19 patients for the treatment of virus-induced cytokine release syndrome.[\[325\]](#) [\[326\]](#) [\[327\]](#) [\[328\]](#) [\[329\]](#) [\[330\]](#) [\[331\]](#) [\[332\]](#) Tocilizumab and sarilumab are already approved in some countries for the treatment of rheumatologic conditions, siltuximab is approved in some countries for Castleman disease, and tocilizumab is approved in some countries for the treatment of chimeric antigen receptor (CAR) T-cell-induced severe or life-threatening cytokine release syndrome. However, the decision to suppress the immune system of a critically unwell patient with COVID-19 is a difficult one; the beneficial anti-inflammatory effects of anti-inflammatory drugs must be weighed against the possibly detrimental effects of impairment of immunity.[\[333\]](#) Other drugs currently in clinical trials for the treatment of COVID-19-associated cytokine release syndrome include anakinra, the Janus kinase inhibitor fedratinib, and the C-C chemokine receptor type 5 (CCR5) antagonist leronlimab.[\[334\]](#) [\[335\]](#) [\[336\]](#)

Bacille Calmette-Guerin (BCG) vaccine

The BCG vaccine is being trialed in some countries for the prevention of COVID-19, including in healthcare workers. However, there is no evidence to support its use, and the WHO does not recommend it for the prevention of COVID-19.[\[337\]](#)

Angiotensin-II receptor antagonists

Angiotensin-II receptor antagonists such as losartan are being investigated as a potential treatment because it is thought that the angiotensin-converting enzyme-2 (ACE2) receptor is the main binding site for the virus.[\[338\]](#) [\[339\]](#) [\[340\]](#) However, some experts believe that these drugs may worsen COVID-19 due to overexpression of ACE2 in people taking these drugs. See Management Approach for a discussion of the controversy.

Other antivirals

Various other antiviral drugs (monotherapy and combination therapy) are being trialed in patients with COVID-19 (e.g., oseltamivir, darunavir, ganciclovir, favipiravir, baloxavir marboxil, umifenovir, ribavirin, interferon alfa, nebulized interferon beta).[\[341\]](#) [\[342\]](#) [\[343\]](#) [\[344\]](#) [\[345\]](#) [\[346\]](#) [\[347\]](#) [\[348\]](#) [\[349\]](#) Umifenovir monotherapy may be superior to lopinavir/ritonavir in treating COVID-19 in terms of reduced viral load and shorter duration of positive molecular tests.[\[350\]](#)

Intravenous vitamin C

High-dose intravenous vitamin C is being trialed in China for the treatment of severe COVID-19.[\[351\]](#)

Traditional Chinese medicine

Traditional Chinese medicine is being used in patients with COVID-19 in China according to local guidelines and as part of clinical trials.[\[352\]](#)

Recommendations

Monitoring

Monitor vital signs (i.e., temperature, respiratory rate, heart rate, blood pressure, oxygen saturation) and perform hematology and biochemistry laboratory testing and ECG as clinically indicated during admission. Utilize medical early warning scores that facilitate early recognition and escalation of treatment of deteriorating patients (e.g., National Early Warning Score 2 [NEWS2]) where possible.[3] However, there are no data on the value of using these scores in patients with COVID-19 in the primary care setting.[453] A new prediction score for COVID-19 progression risk has been proposed (the CALL score), but it has not been validated as yet.[454]

Monitor vital signs three to four times daily and fetal heart rate in pregnant women with confirmed infection who are symptomatic and admitted to hospital. Perform fetal growth ultrasounds and Doppler assessments to monitor for potential intrauterine growth restriction in pregnant women with confirmed infection who are asymptomatic.[277]

Perform molecular testing regularly during admission. Two consecutive negative tests (at least 24 hours apart) are required in a clinically recovered patient before discharge.[3] However, it is important to note that the rate of false-negative tests appears to be high, and patients are retesting positive after discharge; therefore, these measures may not be stringent enough to ensure patients are no longer contagious.[455]

Patient instructions

General prevention measures

- Wash hands often with soap and water for at least 20 seconds or an alcohol-based hand sanitizer (that contains at least 60% alcohol), especially after being in a public place, blowing your nose, or coughing/sneezing. Avoid touching the eyes, nose, and mouth with unwashed hands.
- Avoid close contact with people (i.e., maintain a distance of at least 3 feet [1 meter]) including shaking hands, particularly those who are sick, have a fever, or are coughing or sneezing. It is important to note that recommended distances differ between countries (for example, 6 feet [2 meters] is recommended in the US and UK) and you should consult local guidance.
- Practice respiratory hygiene (i.e., cover mouth and nose when coughing or sneezing, discard tissue immediately in a closed bin, and wash hands).
- Stay at home if you are sick, even with mild symptoms, until you recover (except to get medical care)
- Clean and disinfect frequently touched surfaces daily (e.g., light switches, door knobs, countertops, handles, phones).[109] [110]
- [\[BMJ Learning: Covid-19 - handwashing technique and PPE videos\]](#)
- [\[WHO: coronavirus disease \(COVID-19\) advice for the public\]](#)

Face masks

- The World Health Organization recommends that people with symptoms should wear a medical mask, self-isolate, and seek medical advice as soon as possible. Masks are also recommended for those caring for a sick person at home when in the same room. Use of a mask alone is insufficient to provide adequate protection, and they should be used in conjunction with other infection prevention and control measures such as frequent hand hygiene and social distancing. It is important to wash your hands with soap and water (or an alcohol-based sanitizer) prior to putting on a face mask, and to remove it correctly. Used masks should be disposed of properly.[112] [116]
- The Centers for Disease Control and Prevention recommends that homemade cloth face coverings can be worn in public settings where social distancing measures are difficult to maintain

(e.g., pharmacies, grocery stores), especially in areas where there is significant community transmission.[113]

- [CDC: use of cloth face coverings to help slow the spread of COVID-19 (includes instructions on how to make masks)]

Travel advice

- Many countries have implemented international travel bans/closed their borders, have issued advice for domestic travel, and are requesting that citizens traveling abroad should come home immediately if they are able to. Some countries are restricting entry to foreign nationals who have been to affected areas in the preceding 14 days, or are enforcing 14-day quarantine periods where the person's health should be closely monitored (e.g., twice-daily temperature readings).
- Consult local guidance for specific travel restriction recommendations in your country:
 - [WHO: coronavirus disease (COVID-19) travel advice]
 - [CDC: coronavirus disease 2019 (COVID-19) – travel]
 - [NaTHNaC: travel health pro]
 - [Public Health England: travel advice - coronavirus (COVID-19)]
 - [Smartraveller Australia: coronavirus (COVID-19)]
 - [Government of Canada: coronavirus disease (COVID-19) - travel restrictions and exemptions]
 - [Ministry of Manpower Singapore: advisories on COVID-19]

Pets

- At this time, there is no evidence that companion animals (including pets and other animals) can spread COVID-19 or that they might be a source of infection, but caution is advised until more information is available.[456]
- A very small number of pets have been reported to be infected with the virus after close contact with people with confirmed COVID-19; however, thousands of pets have been tested in the US with none testing positive. A tiger tested positive in a zoo in New York.[456] [457] There is emerging evidence that cats and ferrets are highly susceptible to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection, while dogs and other livestock have no or low susceptibility.[458]
- Advise patients to limit their contact with their pets and other animals, especially while they are symptomatic. Advise people to not let pets interact with people or animals outside the household, and if a member of the household becomes unwell to isolate them from everyone else, including pets.[456]
- [CDC: coronavirus disease 2019 (COVID-19) - if you have animals]

Resources

- [WHO: coronavirus disease (COVID-19) pandemic]
- [WHO: stay physically active during self-quarantine]
- [CDC: coronavirus (COVID-19)]
- [NHS UK: advice for everyone - coronavirus (COVID-19)]

Complications

| Complications | Timeframe | Likelihood |
|---|-------------------|---------------|
| acute respiratory distress syndrome (ARDS) | short term | medium |
| <p>Reported in 15% to 33% of patients in case series.[20] [21] [39] [137] [181]</p> <p>Children can quickly progress to ARDS.[15]</p> <p>Factors that increase the risk of developing ARDS and death include older age, neutrophilia, elevated lactate dehydrogenase levels, and elevated D-dimer levels.[407]</p> <p>Lung transplant has been reported in a small number of cases in China as the sole therapy for end-stage pulmonary fibrosis related to ARDS in COVID-19 patients.[408]</p> | | |
| acute respiratory failure | short term | medium |
| <p>Reported in 8% of patients in case series.[21]</p> <p>Leading cause of mortality in patients with COVID-19.[388]</p> <p>Children can quickly progress to respiratory failure.[15]</p> | | |
| cardiovascular complications | short term | medium |
| <p>COVID-19 is associated with a high inflammatory burden that can result in cardiovascular complications with a variety of clinical presentations. Inflammation in the vascular system can result in diffuse microangiopathy with thrombosis. Inflammation in the myocardium can result in myocarditis, heart failure, arrhythmias, acute coronary syndrome, rapid deterioration, and sudden death.[409] [410] [411] These complications can present on presentation or develop as the severity of illness worsens.[412] It is uncertain to what extent acute systolic heart failure is mediated by myocarditis, cytokine storm, small vessel thrombotic complications, microvascular dysfunction, or a variant of stress-induced cardiomyopathy.[413]</p> <p>Acute myocardial injury has been reported in 7% to 20% of patients in case series, and is indicated by elevated cardiac biomarkers.[20] [39] [181] [414] Prevalence is high among patients who are severely or critically ill, and these patients have a higher rate of in-hospital mortality. Patients with cardiac injury were more likely to require noninvasive or invasive ventilation compared with patients without cardiac injury.[414] [415] [412] Patients with underlying cardiovascular disease but without myocardial injury have a relatively favorable prognosis.[416]</p> <p>Cases of fulminant myocarditis, cardiomyopathy, cardiac tamponade, myopericarditis with systolic dysfunction, ST-segment elevation (indicating potential acute myocardial infarction), and takotsubo syndrome have been reported.[386] [388] [417] [418] [419] [420] [421]</p> <p>There are limited data to recommend any specific drug treatments for these patients. Management should involve a multidisciplinary team including intensive care specialists, cardiologists, and infectious disease specialists.[413]</p> <p>Infection may have longer-term implications for overall cardiovascular health; however, further research is required.[422]</p> | | |
| acute liver injury | short term | medium |
| <p>Approximately 76% of patients had abnormal liver test results in one study.[423] Acute liver injury has been reported in 14% to 53% of patients in case series. Occurs more commonly in patients with severe disease.[424] Although data support a higher prevalence of abnormal aminotransferase levels in patients</p> | | |

| Complications | Timeframe | Likelihood |
|---|-------------------|------------|
| with severe illness, evidence suggests that clinically significant liver injury is uncommon.[425] Medications (e.g., lopinavir/ritonavir) may have a detrimental effect on liver injury. | | |
| cytokine release syndrome | short term | low |
| <p>Cytokine release syndrome may cause ARDS or multiple-organ dysfunction, which may lead to death.[426] Elevated serum proinflammatory cytokines (e.g., tumor necrosis factor alpha, interleukin-2, interleukin-6, interleukin-8, interleukin-10, granulocyte-colony stimulating factor, monocyte chemoattractant protein 1) and inflammatory markers (e.g., C-reactive protein, serum ferritin) have been commonly reported in patients with severe COVID-19. This likely represents a type of virus-induced secondary hemophagocytic lymphohistiocytosis, which may be fatal.[20] [392] [427] [206]</p> <p>One study found that patients who require admission to the intensive care unit have significantly higher levels of interleukin-6, interleukin-10, and tumor necrosis factor alpha, and fewer CD4+ and CD8+ T cells.[428]</p> <p>Anti-inflammatory/immunosuppressive treatments (e.g., tocilizumab, hydroxychloroquine/chloroquine, Janus kinase inhibitors) are being trialed in COVID-19 patients.[429] See our Emerging section for more information.</p> | | |
| septic shock | short term | low |
| <p>Reported in 4% to 8% of patients in case series.[20] [21] [39] [181]</p> <p>Guidelines for the management of shock in critically ill patients with COVID-19 recommend a conservative fluid strategy (crystalloids preferred over colloids) and a vasoactive agent. Norepinephrine (noradrenaline) is the preferred first-line agent, with vasopressin or epinephrine (adrenaline) considered suitable alternatives. Vasopressin can be added to norepinephrine if target mean arterial pressure cannot be achieved with norepinephrine alone.[242]</p> | | |
| disseminated intravascular coagulation | short term | low |
| <p>Reported in 71% of nonsurvivors.[204]</p> <p>Anticoagulant therapy with a low molecular weight heparin or unfractionated heparin has been associated with a better prognosis in patients with severe COVID-19 who have a sepsis-induced coagulopathy (SIC) score of ≥ 4 or a markedly elevated D-dimer level.[430]</p> | | |
| venous thromboembolism | short term | low |
| <p>Coagulopathy in COVID-19 has a prothrombotic character, which may explain reports of thromboembolic complications.[431] Venous thromboembolism has been reported in 25% to 31% of patients with severe COVID-19 in the intensive care unit, and may be associated with poor prognosis.[432] [433] Identifying patients with COVID-19 who are at high risk is important so that venous thromboembolism prophylaxis measures (pharmacologic or mechanical thromboprophylaxis) can be instituted.[434] Low molecular weight heparin is preferred over unfractionated heparin in order to reduce patient contact (depending on the patient's bleeding risk and creatinine clearance). Fondaparinux is recommended in patients with a history of heparin-induced thrombocytopenia.[435]</p> | | |
| secondary infection | short term | low |
| <p>Reported in 6% to 10% of patients in case series.[20] [181]</p> <p>A case of <i>Staphylococcus aureus</i> superinfection has been reported.[436]</p> | | |

| Complications | Timeframe | Likelihood |
|---|-------------------|-------------|
| acute kidney injury | short term | low |
| <p>Reported in 3% to 8% of patients in case series.[20] [21] [181] A large prospective cohort study of over 700 patients in China found that over 40% of patients with COVID-19 had proteinuria on admission, and 26% had hematuria. Approximately 13% to 14% of patients had elevated creatinine, elevated blood urea nitrogen, and an estimated glomerular filtration rate <60 mL/minute/1.73 m². During the study, acute kidney injury developed in 5% of patients, and these patients had an increased risk of in-hospital mortality.[437] However, a retrospective study of 116 hospitalized patients in Wuhan found that the few patients who had elevated blood urea nitrogen, serum creatinine, or albuminuria did not meet the diagnostic criteria for acute kidney injury.[438]</p> | | |
| pancreatic injury | short term | low |
| <p>Mild pancreatic injury (defined as elevated serum amylase or lipase levels) has been reported in 17% of patients in one case series. It is unknown whether this is a direct viral effect or due to the harmful immune response that occurs in some patients. Further research is required.[439]</p> | | |
| neurologic complications | short term | low |
| <p>Patients with severe illness commonly have neurologic complications, likely due to viral invasion of the central nervous system (SARS-CoV-2 has been detected in the brain and cerebrospinal fluid). In a case series of 214 patients, neurologic symptoms were seen in 36% of patients, and were more common in patients with severe illness.[440]</p> <p>Complications include acute cerebrovascular disease, impairment of consciousness, ataxia, seizures, neuralgia, skeletal muscle injury, corticospinal tract signs, meningitis, encephalitis, and encephalopathy. Patients may present with these signs/symptoms, or they may develop them during the course of the disease. These patients have a poor prognosis.[440] [441] [442] [443] [444] [445] [446]</p> <p>Cases of COVID-19 initially presenting with acute Guillain-Barre syndrome have been reported in patients with COVID-19.[447] [448]</p> | | |
| rhabdomyolysis | short term | low |
| <p>Reported as a late complication in one case report.[449]</p> | | |
| pregnancy-related complications | short term | low |
| <p>Retrospective reviews of pregnant women with COVID-19 found that women appeared to have fewer adverse maternal and neonatal complications and outcomes than would be expected for those with severe acute respiratory syndrome (SARS) or Middle East respiratory syndrome (MERS). Adverse effects on the newborn including fetal distress, premature labor, respiratory distress, thrombocytopenia, and abnormal liver function have been reported; however, it is unclear whether these effects are related to maternal SARS-CoV-2 infection. No maternal deaths have been reported so far, but miscarriage, ectopic pregnancy, intrauterine growth restriction, perinatal death, and preterm birth have been reported. It is unclear whether this is related to COVID-19.[70] [71] [75] [274] [450] [451] [452]</p> | | |
| comorbidities | variable | high |
| <p>Data on the management of comorbidities in patients with COVID-19 is evolving rapidly. Tailor the management of critical illness to the patient's comorbidities (e.g., decide which chronic therapies should be continued and which therapies should be temporarily stopped, monitor for drug-drug interactions).[3]</p> | | |

Prognosis

Case fatality rate

The overall global case fatality rate (total number of deaths reported divided by the total number of infections reported) is currently estimated to be 7% based on World Health Organization data as of 19 April 2020. The case fatality rate varies considerably between countries; for example, it is currently higher in countries such as France, Italy, and Spain, and lower in countries such as the US, Germany, and Australia.^[377]

The overall case fatality rate in China has been estimated to be 2.3% (0.9% in patients without comorbidities) based on a large case series of 72,314 reported cases from 31 December 2019 to 11 February 2020 (mainly among hospitalized patients).^[7] However, another study estimates the case fatality rate in China to be lower at 1.38% (after adjusting the crude estimate for censoring, demography, and under-ascertainment).^[378]

These figures need to be interpreted with extreme caution. In pandemics, case fatality rates tend to start high and then trend downwards as more data becomes available. For example, at the start of the 2009 H1N1 influenza pandemic the case fatality rate varied from 0.1% to 5.1% (depending on the country), but ended up being around 0.02%.^[379] [\[Centre for Evidence-Based Medicine: global COVID-19 case fatality rates\]](#)

Factors that affect case fatality rates include:

- Increased case detection of patients with severe disease
- Testing limitations (some countries are only testing patients who have severe symptoms)
- Testing rates in each country
- Delays between symptom onset and death
- Local factors (e.g., patient demographics, availability and quality of health care, other endemic diseases).

It is important to note that daily death counts need to be interpreted with caution. The number of deaths reported on a particular day may not accurately reflect the number of deaths from the previous day due to delays associated with reporting deaths. This makes it difficult to know whether deaths are falling over time in the short term.^[380]

In Italy, the case fatality rate may be higher because Italy has the second oldest population in the world, the highest rates of antibiotic resistance deaths in Europe, and a higher incidence of smoking (a known risk factor for more severe disease). The way COVID-19 related deaths are identified and reported in Italy may have also resulted in an overestimation of cases. Patients who die "with" COVID-19 and patients who die "from" COVID-19 are both counted towards the death toll. Only 12% of death certificates have shown direct causality from COVID-19, while 88% of patients who have died had at least one comorbidity.^[379] ^[381]

Estimates that take into account asymptomatic patients and mild cases who have not been tested put the case fatality rate in the total population at around 0.72%; however, this estimate does not take into account exceptional cases (e.g., the current situation in Italy).^[379] The case fatality rate among people on board the Diamond Princess cruise ship, a unique situation where a more accurate assessment of the case fatality rate in a quarantined population can be made, was 0.99%. However, it should be noted that the rate in a younger, healthier population could be lower.^[382]

The overall case fatality rate appears to be less than that reported for severe acute respiratory syndrome coronavirus (SARS) (10%) and Middle East respiratory syndrome (MERS) (37%).^[20] Despite the lower case fatality rate, COVID-19 has so far resulted in more deaths than both SARS and MERS combined.^[383]

Case fatality rate according to age and presence of comorbidities

The case fatality rate increases with age.^[378] The presence of comorbidities is associated with greater disease severity and poor clinical outcomes, and the risk increases with the number of comorbidities a patient has.^[384]

The majority of deaths in China have been in patients ages 60 years and older and/or those who have preexisting underlying health conditions (e.g., hypertension, diabetes, cardiovascular disease). The case fatality rate was highest among critical cases (49%). It was also higher in patients ages 80 years and older (15%), males (2.8% versus 1.7% for females), and patients with comorbidities (10.5% for cardiovascular disease, 7.3% for diabetes, 6.3% for chronic respiratory disease, 6% for hypertension, and 5.6% for cancer).[7] Another study found the case fatality rate in China to be 6.4% in patients ages ≥ 60 years versus 0.32% in patients ages < 60 years, and 13.4% in patients ages ≥ 80 years.[378]

In Italy, the case fatality rate was 8.5% in patients ages 60 to 69 years, 35.5% in patients ages 70 to 79 years, and 52.5% in patients ages ≥ 80 years.[98] In a case series of 1591 critically ill patients in Lombardy, the majority of patients were older men, a large proportion required mechanical ventilation and high levels of positive end-expiratory pressure, and the mortality rate in the intensive care unit was 26%.[385]

In the US, the case fatality rate was highest among patients ages ≥ 85 years (10% to 27%), followed by those ages 65 to 84 years (3% to 11%), 55 to 64 years (1% to 3%), 20 to 54 years ($< 1\%$), and ≤ 19 years (no deaths). Patients ages ≥ 65 years accounted for 80% of deaths.[9] The case fatality rate among critically ill patients admitted to the intensive care unit reached 67% in one hospital in Washington state. Most of these patients had underlying health conditions, with congestive heart failure and chronic kidney disease being the most common.[386] The case fatality rate in residents in a long-term care facility in Washington was reported to be 34%.[387]

Children have a better prognosis than adults, and deaths have been extremely rare.[10] Three deaths have been reported in children in the US.[11]

Prognostic factors

The leading cause of death in patients with COVID-19 is respiratory failure from acute respiratory distress syndrome.[388] The other most common complications in deceased patients are myocardial injury, liver or kidney injury, and multi-organ dysfunction.[389] In one retrospective study of 52 critically ill patients in Wuhan City, 61.5% of patients died by 28 days, and the median time from admission to the intensive care unit to death was 7 days for patients who didn't survive.[390]

Prognostic factors that have been associated with severe disease include:[88] [102] [391]

- Older age
- Smoking
- Maximum body temperature on admission
- Decreased serum albumin level
- Elevated C-reactive protein level
- Elevated lactate dehydrogenase level
- Liver or kidney impairment
- Thrombocytopenia
- D-dimer level > 1 microgram/L
- Higher Sequential Organ Failure Assessment (SOFA) score
- Respiratory failure.

Prognostic factors that have been associated with death include:[200] [202] [203] [392] [393] [390] [394] [395] [396] [397] [398] [399]

- Older age ≥ 65 years
- Male sex
- Dyspnea and higher respiratory rate
- Hypertension
- Cardiovascular or cerebrovascular disease
- Elevated cardiac biomarkers (e.g., cardiac troponin I)
- Lymphopenia and leukocytosis

- High neutrophil-to-lymphocyte ratio
- Thrombocytopenia
- Elevated lactate dehydrogenase
- Elevated inflammatory markers
- Decreased CD3+CD8+ T cells
- Acute respiratory distress syndrome
- Use of mechanical ventilation
- Use of high-dose corticosteroids
- Multi-organ dysfunction.

However, this data is mainly based on case series and better studies are required.

Refractory disease

Refractory disease (patients who do not reach obvious clinical and radiologic remission within 10 days after hospitalization) has been reported in nearly 50% of hospitalized patients in one retrospective single-center study of 155 patients in China. Risk factors for refractory disease include older age, male sex, and the presence of comorbidities. These patients generally require longer hospital stays as their recovery is slower.[400]

Infectivity of recovered cases

Potential infectivity of recovered cases is still unclear. There have been case reports of patients testing positive again after being discharged (i.e., after symptom resolution and two consecutive negative test results two days apart). This suggests that some patients in convalescence may still be contagious, although this is yet to be confirmed.[401] [402]

Reinfection/relapse/reactivation

Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) reactivation has been reported in patients after hospital discharge. In a retrospective review of 55 patients in China, 9% of patients presented with SARS-CoV-2 reactivation. The clinical characteristics were similar to those of nonreactivated patients.[403] Other studies have shown that 10% to 21% of patients return a positive reverse-transcription polymerase chain reaction (RT-PCR) test again after two negative RT-PCR tests and after hospital discharge.[404] [405] [406] It is unclear whether these cases are reinfections/relapses/reactivations, or whether the test result was a false-negative at the time of discharge. Further research is required.

Diagnostic guidelines

International

Information for laboratories [223]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings [224]

Published by: Centers for Disease Control and Prevention

Last published: 2020

COVID-19: resource center [225]

Published by: Infectious Diseases Society of America

Last published: 2020

Country & technical guidance - coronavirus disease (COVID-19) [226]

Published by: World Health Organization

Last published: 2020

Laboratory testing strategy recommendations for COVID-19 [227]

Published by: World Health Organization

Last published: 2020

Laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases [156]

Published by: World Health Organization

Last published: 2020

Global surveillance for COVID-19 caused by human infection with COVID-19 virus [93]

Published by: World Health Organization

Last published: 2020

Infection prevention and control during health care when COVID-19 is suspected [133]

Published by: World Health Organization

Last published: 2020

COVID-19: guidance for health professionals [228]

Published by: Public Health England

Last published: 2020

COVID-19 [229]

Published by: European Centre for Disease Prevention and Control

Last published: 2020

A rapid advice guideline for the diagnosis and treatment of 2019 novel coronavirus (2019-nCoV) infected pneumonia [230]

Published by: Zhongnan Hospital of Wuhan University Novel Coronavirus Management and Research Team; Evidence-Based Medicine Chapter of China International Exchange and Promotive Association for Medical and Health Care

Last published: 2020

International

Diagnosis and clinical management of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection [231]

Published by: Peking Union Medical College Hospital

Last published: 2020

Treatment guidelines

International

Coronavirus disease 2019 (COVID-19): for healthcare professionals [353]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Interim clinical guidance for management of patients with confirmed coronavirus disease (COVID-19) [354]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Information for clinicians on investigational therapeutics for COVID-19 patients [355]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19) [356]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Discontinuation of in-home isolation for immunocompromised persons with COVID-19 (interim guidance) [357]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Discontinuation of isolation for persons with COVID-19 not in healthcare settings (interim guidance) [358]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Interim U.S. guidance for risk assessment and public health management of healthcare personnel with potential exposure in a healthcare setting to patients with coronavirus disease (COVID-19) [359]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Coronavirus disease 2019 (COVID-19): considerations for inpatient obstetric healthcare settings [280]

Published by: Centers for Disease Control and Prevention

Last published: 2020

Infectious Diseases Society of America guidelines on the treatment and management of patients with COVID-19 infection [271]

Published by: Infectious Diseases Society of America

Last published: 2020

COVID#19: interim guidance on management pending empirical evidence [264]

Published by: American Thoracic Society

Last published: 2020

COVID-19 resource center [225]

Published by: Infectious Diseases Society of America

Last published: 2020

International

Management of infants born to mothers with COVID-19 [279]

Published by: American Academy of Pediatrics

Last published: 2020

Novel coronavirus 2019 (COVID-19) [276]

Published by: American College of Obstetricians and Gynecologists

Last published: 2020

Coronavirus disease (COVID-19): outbreak update [360]

Published by: Government of Canada

Last published: 2020

Country & technical guidance - coronavirus disease (COVID-19) [226]

Published by: World Health Organization

Last published: 2020

Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected [3]

Published by: World Health Organization

Last published: 2020

Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts [219]

Published by: World Health Organization

Last published: 2020

Advice on the use of masks in the context of COVID-19 [112]

Published by: World Health Organization

Last published: 2020

COVID-19 guidance and the latest research in the Americas [361]

Published by: Pan American Health Organization

Last published: 2020

Surviving Sepsis Campaign: guidelines on the management of critically ill adults with coronavirus disease 2019 (COVID-19) [242]

Published by: Surviving Sepsis Campaign

Last published: 2020

Global interim guidance on coronavirus disease 2019 (COVID-19) during pregnancy and puerperium from FIGO and allied partners: information for healthcare professionals [161]

Published by: International Federation of Gynecology and Obstetrics

Last published: 2020

ISUOG interim guidance on 2019 novel coronavirus infection during pregnancy and puerperium: information for healthcare professionals [362]

Published by: International Society of Ultrasound in Obstetrics and Gynecology

Last published: 2020

Coronavirus specialty guides [363]

Published by: NHS England

Last published: 2020

International

COVID-19 rapid guideline: critical care in adults [241]

Published by: National Institute for Health and Care Excellence (UK) **Last published:** 2020

Coronavirus (COVID-19): rapid guidelines and evidence reviews [364]

Published by: National Institute for Health and Care Excellence (UK) **Last published:** 2020

COVID-19: guidance for health professionals [228]

Published by: Public Health England **Last published:** 2020

BMJ's coronavirus (covid-19) hub [365]

Published by: BMJ **Last published:** 2020

COVID-19 [229]

Published by: European Centre for Disease Prevention and Control **Last published:** 2020

Coronavirus (COVID-19) infection in pregnancy [275]

Published by: Royal College of Obstetricians and Gynaecologists (UK) **Last published:** 2020

Guideline for the treatment of people with COVID-19 disease [366]

Published by: Italian Society of Infectious and Tropical Diseases **Last published:** 2020

Recommendations for COVID-19 clinical management [367]

Published by: National Institute for the Infectious Diseases (Italy) **Last published:** 2020

Recommendations on the clinical management of the COVID-19 infection by the new coronavirus SARS-CoV2 [368]

Published by: Spanish Paediatric Association **Last published:** 2020

Coronavirus disease [369]

Published by: Chinese Center for Disease Control and Prevention **Last published:** 2020

Handbook of COVID-19 prevention and treatment [370]

Published by: First Affiliated Hospital, Zhejiang University School of Medicine **Last published:** 2020

A rapid advice guideline for the diagnosis and treatment of 2019 novel coronavirus (2019-nCoV) infected pneumonia [230]

Published by: Zhongnan Hospital of Wuhan University Novel Coronavirus Management and Research Team; Evidence-Based Medicine Chapter of China International Exchange and Promotive Association for Medical and Health Care **Last published:** 2020

International

Diagnosis and treatment protocol for novel coronavirus pneumonia (trial version 7) [371]

Published by: National Health Commission of the People's Republic of China; National Administration of Traditional Chinese Medicine of the People's Republic of China

Last published: 2020

Diagnosis and clinical management of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection [231]

Published by: Peking Union Medical College Hospital

Last published: 2020

Updates on COVID-19 (coronavirus disease 2019) local situation [372]

Published by: Ministry of Health Singapore

Last published: 2020

New coronavirus (COVID-19) [373]

Published by: National Institute of Infectious Diseases Japan

Last published: 2020

New coronavirus infection [374]

Published by: Japanese Association for Infectious Diseases

Last published: 2020

Perinatal and neonatal management plan for prevention and control of SARS-CoV-2 infection (2nd edition) [375]

Published by: Working Group for the Prevention and Control of Neonatal SARS-CoV-2 Infection in the Perinatal Period of the Editorial Committee of Chinese Journal of Contemporary Pediatrics

Last published: 2020

Coronavirus disease 2019 (COVID-19) [376]

Published by: Department of Health Australia

Last published: 2020

Online resources

1. [Johns Hopkins University: coronavirus COVID-19 global cases \(external link\)](#)
2. [BMJ talk medicine podcast: Covid-19 update \(external link\)](#)
3. [WHO: coronavirus disease \(COVID-19\) emergency dashboard \(external link\)](#)
4. [WHO: coronavirus disease \(COVID-2019\) situation reports \(external link\)](#)
5. [CDC: coronavirus disease 2019 \(COVID-19\) – cases in US \(external link\)](#)
6. [CDC: COVIDView \(external link\)](#)
7. [GenBank \(external link\)](#)
8. [BMJ Learning: Covid-19 - handwashing technique and PPE videos \(external link\)](#)
9. [WHO: coronavirus disease \(COVID-19\) advice for the public \(external link\)](#)
10. [BMJ: facemasks for the prevention of infection in healthcare and community settings \(external link\)](#)
11. [BMJ: analysis - face masks for the public during the covid-19 crisis \(external link\)](#)
12. [WHO: coronavirus disease \(COVID-19\) advice for the public - when and how to use masks \(external link\)](#)
13. [Public Health England: guidance on social distancing for everyone in the UK \(external link\)](#)
14. [Public Health England: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19 \(external link\)](#)
15. [BMJ: covid-19 in primary care \(UK\) \(external link\)](#)
16. [BMJ: covid-19 - a remote assessment in primary care \(external link\)](#)
17. [BMJ: covid-19 - PPE guidance \(external link\)](#)
18. [WHO: infection prevention and control during health care when COVID-19 is suspected \(external link\)](#)
19. [CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 \(COVID-19\) in healthcare settings \(external link\)](#)
20. [CDC: strategies to optimize the supply of PPE and equipment \(external link\)](#)
21. [BSTI: radiology decision support tool for suspected COVID-19 \(external link\)](#)
22. [WHO: global surveillance for COVID-19 caused by human infection with COVID-19 virus \(external link\)](#)

23. [CDC: evaluating and testing persons for coronavirus disease 2019 \(COVID-19\) \(external link\)](#)
24. [CDC: priorities for testing patients with suspected COVID-19 infection \(external link\)](#)
25. [IDSA: COVID-19 prioritization of diagnostic testing \(external link\)](#)
26. [BMJ talk medicine podcast: coping with Covid-19 - advice from a New York City intensivist \(external link\)](#)
27. [Clinical frailty scale \(external link\)](#)
28. [WHO: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts \(external link\)](#)
29. [CDC: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 \(COVID-19\) \(external link\)](#)
30. [ACOG: outpatient assessment and management for pregnant women with suspected or confirmed novel coronavirus \(COVID-19\) \(external link\)](#)
31. [WHO: off-label use of medicines for COVID-19 \(external link\)](#)
32. [Centre for Evidence-Based Medicine: hydroxychloroquine for COVID-19 - what do the clinical trials tell us? \(external link\)](#)
33. [Centre for Evidence-Based Medicine: lopinavir/ritonavir - a rapid review of effectiveness in COVID-19 \(external link\)](#)
34. [Centre for Evidence-Based Medicine: global COVID-19 case fatality rates \(external link\)](#)
35. [CDC: use of cloth face coverings to help slow the spread of COVID-19 \(includes instructions on how to make masks\) \(external link\)](#)
36. [WHO: coronavirus disease \(COVID-19\) travel advice \(external link\)](#)
37. [CDC: coronavirus disease 2019 \(COVID-19\) – travel \(external link\)](#)
38. [NaTHNaC: travel health pro \(external link\)](#)
39. [Public Health England: travel advice - coronavirus \(COVID-19\) \(external link\)](#)
40. [Smartraveller Australia: coronavirus \(COVID-19\) \(external link\)](#)
41. [Government of Canada: coronavirus disease \(COVID-19\) - travel restrictions and exemptions \(external link\)](#)
42. [Ministry of Manpower Singapore: advisories on COVID-19 \(external link\)](#)

43. [CDC: coronavirus disease 2019 \(COVID-19\) - if you have animals](#) (*external link*)
44. [WHO: coronavirus disease \(COVID-19\) pandemic](#) (*external link*)
45. [WHO: stay physically active during self-quarantine](#) (*external link*)
46. [CDC: coronavirus \(COVID-19\)](#) (*external link*)
47. [NHS UK: advice for everyone - coronavirus \(COVID-19\)](#) (*external link*)

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Images

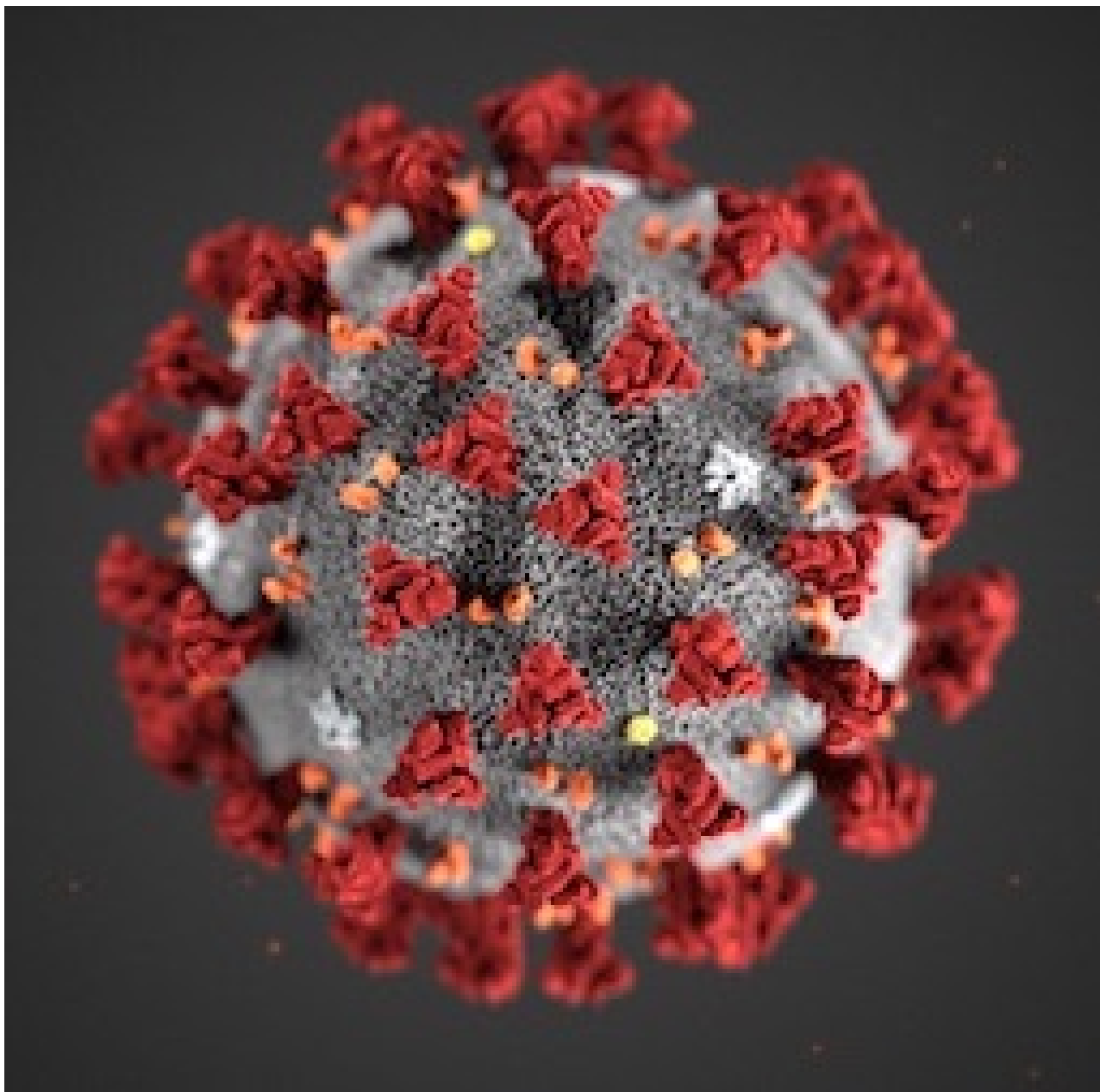


Figure 1: Illustration revealing ultrastructural morphology exhibited by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) when viewed with electron microscopically

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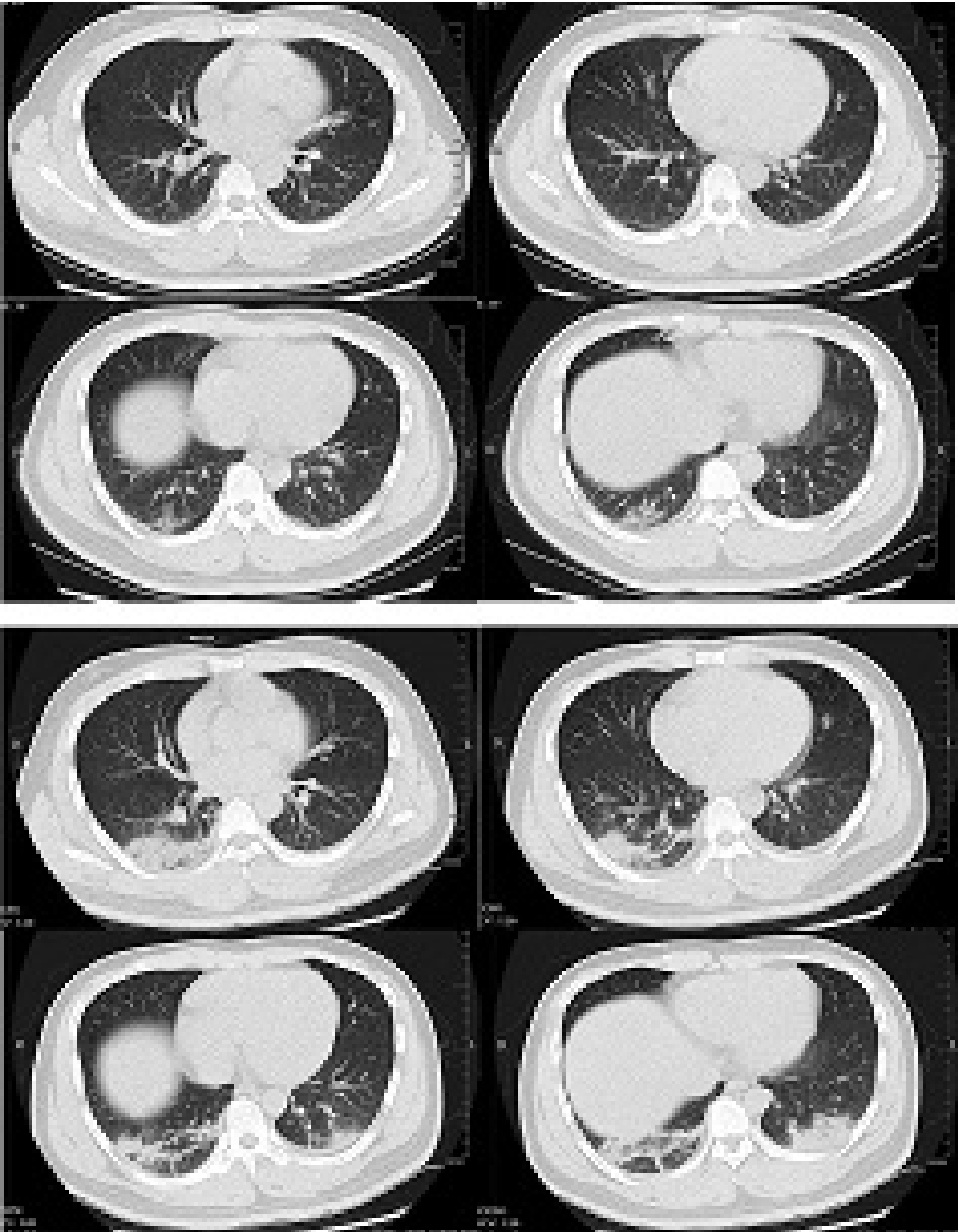


Figure 2: Transverse CT scans from a 32-year-old man, showing ground-glass opacity and consolidation of lower lobe of right lung near the pleura on day 1 after symptom onset (top panel), and bilateral ground-glass opacity and consolidation on day 7 after symptom onset

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