COVID-19 Clinical Summary

Based on ‘Kings Clinical Summary guidelines’ on Kwiki.
Information from EMCRIT.com

Education Fellows, Kings College Hospital
• **Fever** 43-98%
  - Often high and sustained for 10 days but may be intermittent
  - Absence of fever does not rule out diagnosis

• **Cough** 68-82%
  - Sputum 14-56%

• **Breathless** 3-64%
  - Onset around day 6
  - May be *silent hypoxia* (especially elderly)
    - No increased work of breathing but severe hypoxia

• **Less common:**
  - GI (diarrhoea, nausea, may precede fever) – up to 10%
  - Runny nose – 4-24%
  - Sore throat - 14%
  - Myalgia - 11-15%
  - Headache - 6-34%

• **Anosmia - ENT UK press release:**
  - Up to 2/3rd of patients with covid have anosmia
  - Significant amounts of patients presenting with anosmia with NO other symptoms
Disease Progression

- Key feature: Acute Respiratory Distress Syndrome with a cytokine storm
- Expect admission 7-10 days
- Patients can seem relatively ok, then rapidly deteriorate
  - Severe hypoxia
  - May be minimal work of breathing
  - Normal CO2
- Ward nasal cannula O2 2L → Intubated 12 hours later
- Fulminant cardiomyopathy can be a late feature as patients recover from ARDS

BE VIGILANT OF PATIENTS WITH INCREASING O2 REQUIREMENT
Diagnosis

- **Swabs (PCR)**
  - Take a single combined swab (throat then nose)
  - Sensitivity up to 80%
  - False negatives early in disease – repeat test a few days later (repeat swabs positive in 23%)
  - Positive for other respiratory viruses doesn’t prove COVID-19 negative, but might reduce index of suspicion substantially
  - CXR / CT changes may be present before swab positive

If high clinical suspicion continue isolation and PPE
<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>WCC</td>
<td>Normal</td>
<td>N:L ratio &gt; 3 poor prognosis</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>Low</td>
<td>Low in 80% of cases</td>
</tr>
<tr>
<td>Neutrophils</td>
<td>Normal / High</td>
<td></td>
</tr>
<tr>
<td>Platelets</td>
<td>Mildly low</td>
<td>&lt; 100 poor prognosis</td>
</tr>
<tr>
<td>CRP</td>
<td>High</td>
<td>&gt; 125 poor prognosis. If normal consider alternate diagnosis eg heart failure</td>
</tr>
<tr>
<td>Lactate</td>
<td>Mildly High</td>
<td></td>
</tr>
<tr>
<td>Troponin</td>
<td>High</td>
<td>Poor prognosis. Not MI - ECG</td>
</tr>
<tr>
<td>Urea / Creat</td>
<td>Mildly High</td>
<td>AKI usually mild</td>
</tr>
<tr>
<td>Albumen</td>
<td>Low</td>
<td></td>
</tr>
<tr>
<td>CK</td>
<td>High</td>
<td>Rhabdomyolysis may contribute to renal failure late in disease</td>
</tr>
<tr>
<td>AST/ALT</td>
<td>High</td>
<td>5 times normal, transient, no fulminant hepatitis; rise day 14</td>
</tr>
<tr>
<td>Ferritin</td>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>
Imaging: CXR

- **Request information** – ensure COVID-19 + respiratory history + smoking history

- Typically patchy ground glass opacities peripheral and basal (unilateral in 25%)

- Number of lung segments increases with more severe disease

- Over time, patches coalesce into more dense consolidation

- May be subtle / appear normal (40%)

- Do not tend to see: effusions (5%), cavitation, mass, lymphadenopathy
Imaging: CT

- **Consultant request**
  - Sensitivity around 80% - may be normal in early stages
  - Peripheral ground-glass opacities
  - ‘Crazy paving’ may be present
  - Diffuse alveolar damage
  - Organising pneumonia
  - Less likely: non-peripheral, effusions, lymph nodes
  - Not: lobar pneumonia, cavitating Tree-in bud changes
  - Does not change management
  - Deep clean CT 2 hours +
Radiology decision tool for suspected COVID-19

Suspected COVID-19

- Clinical assessment and labs
  - < 50% have fever but > 80% have lymphopenia
  - Sats < 94% or NEWS > 3

- If neither COVID-19 less likely

- If seriously ill

- CXR
  - Bilateral (peripheral) opacification
    - Isolate
  - Uncertain/Normal
    - CT SCAN (Pre-contrast ± CTPA)
    - Isolate
  - Non-COVID-19 disease
    - Don't isolate
  - Abnormal CXR
    - ? COVID-19
      - Self isolate with follow up
    - Normal CXR
      - Home with advice
      - Self isolate

- Stable
  - Sats > 94%, NEWS < 3
  - If clinically required

*94% unless known COPD in which case < 90%
**Unsuspected/unexpected cases may be incidentally discovered on CXR/CT at this stage; should be reviewed in the context of clinical suspicion as to likelihood of COVID-19.
***Classic and indeterminate CTs should be scored either 'mild' or 'moderate/severe'

Please upload all COVID 19 cases to BSTI database: https://www.bsti.org.uk/training-and-education/covid-19-bsti-imaging-database/
Investigations at Kings

- Blood samples from confirmed or suspected patients must be **double-bagged** and delivered by hand only (do not use the pod system).

- Indicate “**special processing required**” clearly on all bags containing confirmed or suspected COVID-19 samples.

- Biochemistry Lab will **NOT accept add-ons**.

- CXRs will need to be portable – phone Radiology to make them aware and state on request form.

- Always think before requesting... **is this investigation essential/will it change management?**
Treatment

- **Fluids**  **CAUTION**
  - Main issue is ARDS, not shock – even if elevated lactate
  - BP usually normal

- **Antibiotics**
  - Consider - 16% secondary bacterial infection

- **Antivirals / HIV meds**
  - Clinical trials ongoing eg Remdesivir

- **Steroids**
  - May be harmful in early stages - increase viral shedding
  - Might be beneficial in ARDS / cytokine storm

- **Chloroquine Phosphate**
  - World Health Organization says that so far there is no definitive evidence of its effectiveness
  - FDA: set up large clinical trial as requested by Trump
Ibuprofen

There is currently no strong evidence that ibuprofen can make coronavirus (COVID-19) worse.

But until we have more information, take paracetamol to treat the symptoms of coronavirus, unless your doctor has told you paracetamol is not suitable for you.

If you are already taking ibuprofen or another non-steroidal anti-inflammatory (NSAID) on the advice of a doctor, do not stop taking it without checking first.
Imobile have highlighted issues with O2 delivery on Covid wards

- Take time to ensure colleagues are confident with oxygen delivery
  eg. maximum through nasal cannula is 4L

<table>
<thead>
<tr>
<th>Color</th>
<th>FiO2</th>
<th>O2 Flow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue</td>
<td>24%</td>
<td>2 L/min</td>
</tr>
<tr>
<td>White</td>
<td>28%</td>
<td>4 L/min</td>
</tr>
<tr>
<td>Orange</td>
<td>31%</td>
<td>6 L/min</td>
</tr>
<tr>
<td>Yellow</td>
<td>35%</td>
<td>8 L/min</td>
</tr>
<tr>
<td>Red</td>
<td>40%</td>
<td>10 L/min</td>
</tr>
<tr>
<td>Green</td>
<td>60%</td>
<td>15 L/min</td>
</tr>
</tbody>
</table>

Target oxygen saturations 94-98% (as per trust guidelines) (unless COPD)

Start with 2-4L O2 via nasal cannula and progress to venturi and then non-rebreath mask if required

Consider humified oxygen (multiple pts complaining of dry mouth)

If patient still hypoxic despite FiO2 > 40% escalate early to ITU on bleep 809
• **Optiflow/CPAP/BiPAP**  **NOT USED ROUTINELY**
  - Aerosol Generating Procedures and likely to require intubation anyway
  - Case by Case basis - Needs discussion with consultant
  - Mainly will be used for NON-covid patients and ITU step downs

• **Intubation**
  - Early intubation in those in which it is indicated
  - See RSI checklist with adaptations for COVID 19

• **Dialysis**
  - Renal failure in 7% - strong predictor of mortality – 92%
  - Acute tubular necrosis as part of multi-organ failure
  - Rhabdomyolysis may contribute

• **ECMO**
  - Considered in young / single organ failure
Prognosis

- **Risk factors for severe disease:**
  - Age over 70
  - Diabetes mellitus
  - Ischaemic Heart Disease
  - Hypertension
  - COPD
  - Immunosuppression
  - Homelessness or vulnerable adults

- **BUT unfortunately young, healthy patients can get severe disease**

- **Overall:**
  - 80% mild
  - 20% severe (admitted)
  - 3-10% Intubated
  - 1-5% die

- **Morbidity:**
  - Lung fibrosis and ventilator dependent
Treatment Escalation Plans and DNARs at King’s

- CPR in fulminant cardiomyopathy / refractory ARDS is likely to be futile

- Ensure **ALL Covid positive** patients have a documented resuscitation status and TEP on EPR

- Conversations about appropriate TEP levels and advance care planning **EARLY** – as patients deteriorate it becomes too late to discuss their wishes

- DNACPR decision-making remains the same – every decision must be made on the basis of a careful assessment of each individual’s situation and expected chances of success

- Any decisions must be communicated to patients (if they have capacity) + those close to them
Palliative Care

- In the acute phase it is important that patients have their symptoms controlled alongside active medical treatment.

- Should their condition deteriorate despite active management then this deterioration is often rapid and acute management of symptoms, in particular breathlessness and cough, is needed.

- **Guidance has been compiled** (Management of the COVID-19 Patient) to support staff to be used alongside the ICARE framework already in use.

- If you are concerned at all then please contact/refer to the palliative care teams for further support and advice.
Look After Yourself and Each Other
Look After Yourself and Each Other

- Dedicated spaces at Denmark Hill and PRUH for all staff to rest and recuperate (8am and 6pm everyday)
  - The Boardroom (Denmark Hill)
  - The Education Centre (PRUH)
- Tea, coffee, biscuits and fruit will be provided.
- Plans will be published this week for on site or near by accommodation for those finding it difficult to get to and from work.
• The situation is evolving **daily**
• Make sure you regularly check your NHS email and KingsWeb for daily updates as policies/guidance are changing regularly.
PHE Guidance:

Suspected or Positive Covid Patients

**STANDARD PPE**

All contact with suspected or positive covid patients

- Apron
- Gloves
- Surgical mask

**FULL PPE**

Aerosol Generating Procedures ONLY eg.
- Intubation
- Cardiac Arrest

- Full length gown
- Gloves
- Visor
- FFP3 respirator
Aerosol Generating Procedures (AGPs)

- Intubation, extubation and related procedures
- Manual ventilation
- Open suctioning
- Bronchoscopy
- Non-invasive ventilation (NIV); High-flow Nasal Oxygen (HFNO)
- Surgery and post-mortem procedures in which high-speed devices are used
- Some dental procedures (e.g. high speed drilling).

Nebulisers and humidified oxygen are not AGPs
Resusitation in Covid suspected or positive patients

Kings Guidance

- Leave cardiac arrest trolley outside
- Bring in AED, BVM, guedel/I-gel only
- Leader stays outside of the room

Please see the Kings video of a resuscitation of a covid patient
Intrahospital Transfer of patients with Suspected or Confirmed COVID-19 disease

Need for transfer to another ward or department risk assessed and agreed by Senior Clinician

Receiving ward/dept aware and ready to accept?

Is Patient Intubated?

NO

Is the patient awake, stable on 0% O2 via nasal cannula under a surgical mask, fully cooperative, and no other concerns?

NO

Is the patient on FiO2 >40% or risk of deterioration?

NO

Can this be managed by non-pharmacologic means, or if not minimum necessary sedation (midazolam/clonidine/haloperidol) by SENIOR clinician

YES

Intermediate PPE to be worn by Staff in contact with bed or patient (2) Standard for forward and rear escorts (spills) (2-3) No PPE for security/others kept at distance

YES

Consider intubating prior to transfer or use PPE in preparation for deterioration

YES

Ful(AGP) PPE to be worn by Staff in contact with bed or patient (2) Standard PPE for forward and rear escort (spills) (2-3) No PPE for security/others kept at distance

This guide incorporates a slight enhancement in PPE during transfer in order to respond to changing clinical needs without having to re-dress

Top Tips
- Arranging to have the nurse who will be looking after the patient coming to collect them may decrease workforce pressures and PPE use during transfer
- Maintaining a 2m cordon around the patient will likely require the forward escort to be much further ahead and block off junctions with other corridors/lifts/stairs
- Try to avoid the busiest routes – see section on recommended routes from ED in full document
- Going from ED to ICU/CCU may require security on hospital street
- Use the forward escort(s) to carry ‘clean’ equipment (notes, transfer bag)
Further reading/resources

Infection prevention and control guidance:

Intensive Care Medicine, Intensive Care Society, Association of Anaesthetists, Royal College of Anaesthetists guidance:
https://icmanaesthesiaacovid-19.org/clinical-guidance

World Health Organization (WHO) – e-learning package on ARDS
https://www.dropbox.com/sh/t25zvm9jb6xvlei/AABQxyRwJMJm09N3eckNvQDpa?dl=0

Webinars:
Association of Anaesthetists:
https://register.gotowebinar.com/recording/viewRecording/4619521543726101772/5332585620774399500/claire.mallinson@gstt.nhs.uk?registrantKey=7487531654179104523&type=ATTENDEEMAILRECORDINGLINK

European Society of Intensive Care Medicine:
https://www.esicm.org/resources/coronavirus-public-health-emergency/
Questions?