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The situation is evolving rapidly with global case counts and deaths increasing each day. The World Health Organization declared the COVID-19 outbreak a pandemic on 11 March 2020 and rates the global risk assessment as very high. Community transmission is occurring in many countries, but it is uncertain how easily the virus spreads between people. Clinical trials and investigations to learn more about the virus, its origin, and how it affects humans are ongoing.
**Definition**

Coronavirus disease 2019 (COVID-19) is a potentially severe acute respiratory infection caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The virus was identified as the cause of an outbreak of pneumonia of unknown cause in Wuhan City, Hubei Province, China, in December 2019.[1] 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.

The International Committee on Taxonomy of Viruses has confirmed SARS-CoV-2 as the name of the virus owing to the virus’s genetic similarity to the SARS-CoV virus, but taking into account that there may be differences in disease spectrum and transmission.[2][3] The World Health Organization has confirmed COVID-19 (a shortened version of coronavirus disease 2019) as the name of the disease that SARS-CoV-2 infection causes.[4] Prior to this, the virus and/or disease was known by various names including novel coronavirus (2019-nCoV), 2019-nCoV, or variations on this.

**Epidemiology**

The World Health Organization (WHO) was informed of 44 cases of pneumonia of unknown microbial aetiology 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).[17] 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.[18]

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. The outbreak spread rapidly from a single city in China to the entire country in only 30 days.[16]

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

- [WHO: novel coronavirus (COVID-19) situation dashboard]
- [WHO: coronavirus disease (COVID-2019) situation reports]
- [CDC: locations with confirmed COVID-19 cases, by WHO region]

The Chinese Center for Disease Control and Prevention recently published data from the largest case series to date (72,314 cases from 31 December 2019 to 11 February 2020). The majority of confirmed cases (87%) were aged 30 to 79 years, 1% were aged 9 years or younger, 1% were aged 10 to 19 years, and 3% were aged 80 years or older. Approximately 51% of patients were male and 49% were female. Nearly 4% of cases were in healthcare workers.[16]

In the US, older patients (aged ≥65 years) accounted for 31% of all cases, 45% of hospitalisations, 53% of intensive care unit admissions, and 80% of deaths, with the highest incidence of severe outcomes in patients aged ≥85 years.[24]

Infection in children is being reported much less commonly than among adults, and all cases so far have been in family clusters or in children who have a history of close contact with an infected patient.[12][13]
Coronavirus disease 2019 (COVID-19) Basics

a case series of 2143 paediatric patients in China, the median age of children was 7 years, and 56.6% of cases were in boys although this gender difference was not considered significant.[25]

Aetiology

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.[1]

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 severe acute respiratory syndrome (SARS)-like coronaviruses from bats, but it is distinct from SARS-CoV and Middle East respiratory syndrome (MERS)-CoV.[26] [27] 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.[28]

Coronaviruses are a large family of enveloped RNA viruses, some of which cause illness in people (e.g., common cold, SARS, MERS), and others that circulate among mammals (e.g., bats, camels) and birds. Rarely, animal coronaviruses can spread to humans and subsequently spread between people, as was the case with SARS and MERS.

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.[6] [7] [29] 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.[26] [27] [30] [31] Pangolins have been suggested as an intermediate host as they have been found to be a natural reservoir of SARS-CoV-2-like coronaviruses.[32]

Transmission dynamics of the virus are currently unknown and the situation is rapidly evolving. Person-to-person spread has been confirmed in community and healthcare settings, with local transmission reported 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. One study of a family cluster of five patients in Shenzhen who had a history of travel to Wuhan City (with one other family member who did not travel to Wuhan City) found that person-to-person spread is possible in both hospital and family settings.[29] Nosocomial transmission in healthcare workers and patients has been reported in 41% of patients in one case series.[8] Transmission has been reported in long-term care facilities.[33]

It is uncertain how easily the virus spreads between people, but transmission in chains involving several links is increasingly recognised. Similar to SARS and MERS, it is thought that human transmission occurs via respiratory droplets produced when a person sneezes or coughs.[34] The contribution to transmission by the
presence of the virus in other body fluids is unknown; however, the virus has been detected in blood, saliva, tears, and conjunctival secretions, and faecal transmission may also be possible.[35] [36] [37] [38] [39]

There is mounting evidence that spread from asymptomatic carriers can occur and this has been observed in endemic areas.[40] [41] [42] [43] [44] [45] Presymptomatic transmission has been reported in 12.6% of cases in one study.[46]

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.[47] 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.[48] [49] 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 behavioural and environmental factors.[48]

It is unknown whether perinatal transmission or transmission via breastfeeding is possible; however perinatal transmission has been suspected in one case.[50] [51] Retrospective reviews of pregnant women with COVID-19 found that there is no evidence for intrauterine infection caused by vertical transmission in women who develop the infection late in pregnancy. However, there is currently a lack of data about the risk of transmission to the newborn during vaginal delivery.[52] [53] [54]

Pathophysiology

Current estimates of the incubation period range from 1 to 14 days, according to the World Health Organization and the US Centers for Disease Control and Prevention.[55] [56] The median incubation period has been estimated to be approximately 5 days.[29] [57] Transmission may be possible during the incubation period.[58]

Preliminary reports suggest that the reproductive number (R₀), the number of people who acquire the infection from an infected person, is approximately 2.2.[29] [59] However, as the situation is still evolving, the R₀ may actually be higher or lower. The secondary attack rate for SARS-CoV-2 is estimated to be 0.45% for close contacts of US patients.[60]

While the pathophysiology of this condition is currently unknown, it is thought that the virus binds to the angiotensin-converting enzyme-2 (ACE2) receptor in humans, which suggests that it may have a similar pathogenesis to SARS.[27] [61] 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 to SARS-CoV.[62] A furin-like cleavage site has been identified in the spike protein of the virus; this does not exist in other SARS-like coronaviruses.[63]

Based on an analysis of single-cell RNA sequencing datasets derived from major human physiological systems, the organs considered more vulnerable to SARS-CoV-2 infection due to their ACE2 expression levels include the lungs, heart, oesophagus, kidneys, bladder, and ileum.[64]

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.[65] The median duration of viral shedding is approximately 20 days in survivors.[66]
Classification


Mild illness

- Patients with uncomplicated upper respiratory tract viral infection may have non-specific symptoms such as fever, fatigue, cough (with or without sputum production), anorexia, malaise, muscle pain, sore throat, dyspnoea, nasal congestion, or headache. Rarely, patients may also present with diarrhoea, nausea, and vomiting.
- Older and/or immunosuppressed patients may present with atypical symptoms.
- Symptoms due to physiological adaptations of pregnancy or adverse pregnancy events (e.g., dyspnoea, 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:
  - Wash hands often with soap and water or an alcohol-based hand sanitiser and avoid touching the eyes, nose, and mouth with unwashed hands
  - Avoid close contact with people (i.e., maintain a distance of at least 1 metre [3 feet]), particularly those who have a fever or are coughing or sneezing
  - 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 with their healthcare provider
  - Avoid direct unprotected contact with live animals and surfaces in contact with live animals when visiting live markets in affected areas
  - Avoid the consumption of raw or undercooked animal products, and handle raw meat, milk, or animal organs with care as per usual good food safety practices.

- [WHO: coronavirus disease (COVID-19) advice for the public]

Medical masks

- The World Health Organization (WHO) does not recommend that people wear a medical mask in community settings if they do not have respiratory symptoms as there is no evidence available on their usefulness to protect people who are not ill. However, masks may be worn in some countries according to local cultural habits. Individuals with fever and/or respiratory symptoms are advised to wear a mask and seek medical care as soon as possible. However, 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.

- It is mandatory to wear a medical mask in public in certain areas of China, and local guidance should be consulted for more information.

- It is important to wash your hands with soap and water (or an alcohol-based sanitiser) prior to putting on a face mask.

- [BMJ: facemasks for the prevention of infection in healthcare and community settings]

Screening and quarantine

- People travelling 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 modelled to miss up to 50% of cases of COVID-19, particularly those with no symptoms during an incubation period, which may exceed 10 days. 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.

- Enforced quarantine has been used in some countries to isolate easily identifiable cohorts of people at potential risk of recent exposure (e.g., groups evacuated by aeroplane from affected areas, or groups
Coronavirus disease 2019 (COVID-19) prevention on cruise ships with infected people on board).[75] The psychosocial effects of enforced quarantine may have long-lasting repercussions.[76] [77]

### Social distancing

- Many countries are implementing mandatory social distancing measures in order to reduce and delay transmission (e.g., city lockdowns, school and university closures, screening measures at airports and train stations, restriction of movement, remote working, quarantine of exposed people). 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.[20]

### Vaccine

- There is currently no vaccine available. Vaccines are in development, but it may take some time before a vaccine is available.[78] [79] 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.[80] The vaccine includes a short segment of genetic code copied from the virus. The trial started in humans on 16 March 2020. Clinical trials in humans have also started on an experimental adenoviral vector vaccine in China.[81]

### 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:[120]

- Face-to-face contact with a COVID-19 patient within 1 metre (3 feet) 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
- Travelling in close proximity within 1 metre (3 feet) 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 travelling 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 travellers

Exit and entry screening may be recommended in countries where borders are still open, particularly when repatriating nationals from affected areas. Travellers returning from affected areas should self-monitor for symptoms for 14 days and follow local protocols of the receiving country. Some countries may require returning travellers to enter quarantine. Travellers who develop symptoms are advised to contact their local health care provider, preferably by phone.[121]

#### Drive-through screening centres

Drive-through screening centres 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, examination, 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.[122]
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.[83] 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 hospital on 3 March 2020 with fever, cough, and difficulty breathing. He also reports feeling very tired and unwell. He has a history of congestive heart failure, which is controlled with medication. On examination, his pulse is 120 bpm and his temperature is 38.7°C (101.6°F). Chest x-ray shows bilateral lung infiltrates. He is admitted to hospital in an isolation room and is started on oxygen, intravenous fluids, empirical antibiotics, and paracetamol. Later that day, he tests positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) on real-time reverse transcriptase polymerase chain reaction testing. The patient develops respiratory distress 7 days after admission and is started on mechanical ventilation.

Case history #2

A 30-year-old man presents to his general practitioner on 14 January 2020 with a bad cough. He has had the cough for 4 days and now feels a little short of breath. He also has a headache and reports that his muscles ache. On examination, his pulse is 100 bpm and his temperature is 38.5°C (101.3°F). The patient reports that he returned from a business trip in mainland China 6 days ago.

Other presentations

Other non-specific mild symptoms may include anorexia, confusion, dizziness, sore throat, rhinorrhea, and sputum production. Some patients may present with chest pain or haemoptysis. Gastrointestinal symptoms such as diarrhoea, nausea, vomiting, and abdominal pain have been reported rarely, although this may be underestimated.[6] [7] [8] [9] [10] There is anecdotal evidence that patients with mild illness may develop anosmia/hyposmia or ageusia/dysgeusia in the absence of other symptoms.[11] Some patients may be minimally symptomatic or asymptomatic, especially children.[12] [13] [14] [15] Approximately 80% of patients present with mild illness, 14% present with severe illness, and 5% present with critical illness.[16] Patients with severe illness may have signs and symptoms of viral pneumonia, or complications including acute distress syndrome, acute cardiac injury, arrhythmias, acute kidney injury, secondary infection, sepsis, or shock.[6] [7] [8]

Atypical presentations may occur, especially in older patients or patients who are immunocompromised.

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 report a travel history to an affected area 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 general practitioners avoid in-person assessment of patients with suspected COVID-19 in primary care when possible.[82] Algorithms for dealing with these patients are available:

- [BMJ: covid-19 in primary care (UK)]

**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 1 metre (3 feet) from other suspected patients. 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.

The World Health Organization (WHO) recommends the following basic principles:[83]

- 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 sterilisation 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.

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.[84] The median half-life of the virus is approximately 1 hour as an aerosol, 4 hours on copper, 24 hours on cardboard, and 72 hours on stainless steel and plastic, based on initial data.[85]

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

Take a detailed history to ascertain the level of risk for COVID-19 and assess the possibility of other causes. Travel history may be key; it is crucial for timely diagnosis and to prevent further transmission.

Diagnosis should be suspected in:[67]

- 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.[16] Atypical presentations may occur, especially in older patients or patients who are immunocompromised.

Illness severity is associated with older age and the presence of underlying health conditions.[16] Older patients and/or those with comorbidities may present with mild symptoms, but have a high risk of deterioration.[5] The most prevalent comorbidities in patients with COVID-19 are hypertension, diabetes, cardiovascular disease, and respiratory disease.[86] Initial data suggest that immunosuppressed patients are not at increased risk of severe illness from coronaviruses; however, further research is required on this patient group.[87]

The most common symptoms are:[6] [7] [8] [9] [88] [89]

- Fever
- Cough
- Dyspnoea
- Myalgia
- Fatigue.

Less common symptoms include:

- Anorexia
- Sputum production
- Sore throat
• Confusion
• Dizziness
• Headache
• Rhinorrhoea
• Chest pain
• Haemoptysis
• Diarrhoea
• Nausea/vomiting
• Abdominal pain
• Loss of smell/taste
• Conjunctival congestion.

Some patients may be minimally symptomatic or asymptomatic. Mild illness is defined as patients with an uncomplicated upper respiratory tract infection with non-specific symptoms such as fever, cough (with or without sputum production), fatigue, anorexia, malaise, myalgia, sore throat, dyspnoea, nasal congestion, or headache. Rarely patients may have gastrointestinal symptoms. The most common diagnosis in patients with severe COVID-19 is severe pneumonia.[5]

Approximately 90% of patients present with more than one symptom, and 15% of patients present with fever, cough, and dyspnoea.[7] It appears that fewer patients have prominent upper respiratory tract or gastrointestinal symptoms compared with severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), or influenza.[6][7] Patients may present with nausea or diarrhoea 1 to 2 days prior to onset of fever and breathing difficulties.[8]

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 MERS.[90]

Co-infections (e.g., influenza, human metapneumovirus) have been reported. Patients with influenza co-infection showed similar characteristics to those patients with COVID-19 only.[66][91][92]

Perform a physical examination. 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, tachypnoea, or cyanosis accompanying hypoxia.

**Children**

Children are typically asymptomatic or present with mild symptoms (e.g., brief and rapidly resolving fever, mild cough, sore throat, congestion, rhinorrhoea).[12][13][14][15][93] Polypnoea has been reported in children with severe illness.[94] In a case series of 2143 paediatric patients in China, over 90% of children were asymptomatic or had a mild or moderate illness; 16% were asymptomatic and had no radiological evidence of pneumonia.[25] However, it is important to note that children may have signs of pneumonia on chest imaging despite having minimal or no symptoms.[95] There is one case report of an infant who
Coronavirus disease 2019 (COVID-19) had mainly gastrointestinal symptoms.\[96\] Moderate to severe illness has been reported in children.\[97\] Co-infections may be more common in children.\[95\]

**Pregnant women**

Retrospective reviews of pregnant women with COVID-19 found that the clinical characteristics in pregnant women were similar to those reported for non-pregnant adults.\[53\] It is important to note that symptoms such as fever, dyspnoea, and fatigue may overlap with symptoms due to physiological adaptations of pregnancy or adverse pregnancy events.\[5\]

**Initial investigations**

Order the following investigations in all patients with severe illness:

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

The most common laboratory abnormalities in patients hospitalised with pneumonia include leukopenia, lymphopenia, leukocytosis, elevated liver transaminases, elevated lactate dehydrogenase, and elevated C-reactive protein. Other abnormalities include neutrophilia, thrombocytopenia, decreased haemoglobin, decreased albumin, and renal impairment.\[6\] \[7\] \[8\] \[89\] \[98\]

Pulse oximetry may reveal low oxygen saturation (SpO₂ <90%).

**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 epidemiological history. Specimens should be collected prior to starting empirical antimicrobials if possible.\[5\]

**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.

**Priorities for testing**
• Decisions about who to test should be based on clinical and epidemiological factors. Prioritise people with a likelihood of infection. Consider testing asymptomatic or mildly symptomatic contacts of confirmed COVID-19 cases. Consult local health authorities for guidance as testing priorities will depend on local guidelines and available resources.[5]
• The CDC recommends that the following people are prioritised for testing:[99]
  • Hospitalised patients with signs and symptoms of COVID-19
  • Other symptomatic people aged 65 years and older and/or those with a chronic medical condition or who are immunocompromised
  • Symptomatic people who have had close contact with a suspected or confirmed case, or have a history of travel from an affected geographical area, within 14 days of symptom onset.
  • Symptomatic pregnant women should also be prioritised in order to enable access to specialised care.[5]

Perform a nucleic acid amplification test, such as real-time reverse-transcription polymerase chain reaction (RT-PCR), for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in appropriate patients with suspected infection, with confirmation by nucleic acid sequencing when necessary.[100]
• 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 aerolisation 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.[100] 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.[101]

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 co-infections can occur, and a positive test for a non-COVID-19 pathogen does not rule out COVID-19.[5] [102]

Serological testing is not available as yet, but assays are in development.[103] Serum samples can be stored to retrospectively define cases when validated serology tests become available.

**Imaging**

All imaging procedures should be performed according to local infection prevention and control procedures to prevent transmission.

**Chest x-ray**

• 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.[6] [7] [104]
Coronavirus disease 2019 (COVID-19)

Diagnosis

- Consider ordering a CT scan of the chest. Abnormal chest CT findings have been reported in up to 97% of patients in one meta-analysis of 50,466 hospitalised patients.[88] CT is the primary imaging modality in China.[105]

- CT imaging generally shows bilateral multiple lobular and subsegmental areas of ground-glass opacity or consolidation 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. Other atypical features include interlobular or septal thickening (smooth or irregular), thickening of the adjacent pleura, subpleural involvement, crazy paving pattern, and air bronchograms. Some patients may rarely present with pleural effusion, pericardial effusion, bronchiectasis, cavititation, pneumothorax, lymphadenopathy, and round cystic changes. Atypical features appear to be more common in the later stages of disease, or on disease progression. None of these findings appear to be specific or diagnostic for COVID-19.[6] [90] [106] Abnormalities can rapidly evolve from focal unilateral to diffuse bilateral ground-glass opacities that progress to, or co-exist with, consolidations within 1 to 3 weeks.[107] 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. [106] 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.[108]

- Small nodular ground-glass opacities are the most common finding in children.[109] Consolidation with surrounding halo signs is a typical finding in children.[95]

- Evidence of viral pneumonia on CT may precede a positive RT-PCR result for SARS-CoV-2 in some patients.[103] However, CT imaging abnormalities may be present in minimally symptomatic or asymptomatic patients.[43] [107] Some patients may present with a normal chest finding despite a positive RT-PCR.[110]

- 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.[111]

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.[67]

- [WHO: novel coronavirus (COVID-19) situation dashboard]

- [CDC: locations with confirmed COVID-19 cases, by WHO region]
**Coronavirus disease 2019 (COVID-19)**

**Diagnosis**

- 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.\[67\]

**Weak smoking**

- Active smoking is not significantly associated with an increased risk of severe disease according to preliminary results from a meta-analysis.\[68\]

---

**History & examination factors**

**Key diagnostic factors**

**fever (common)**

- Reported in 83% to 98% of patients in case series.\[6\] \[7\] \[8\] \[88\] \[89\] \[112\] In one case series, 44% of patients had a fever on presentation, but it developed in 89% of patients after hospitalisation.\[9\]
- Less common in children.\[15\]
- Children may not present with fever, or may have a brief and rapidly resolving fever.\[12\] \[93\]
- 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.\[6\] \[7\] \[8\] \[9\] \[88\] \[89\] \[112\]
- Less common in children.\[15\]
- Cough is usually dry.

**dyspnoea (common)**

- Reported in 18% to 55% of patients in case series.\[6\] \[7\] \[8\] \[9\] \[89\] \[112\]
- Median time from onset of symptoms to development of dyspnoea is 5 to 8 days.\[6\] \[7\] \[8\]
- Polypnoea has been reported in children with severe illness.\[94\]

**Other diagnostic factors**

**fatigue (common)**

- Reported in 29% to 69% of patients in case series.\[6\] \[8\] \[9\] \[89\] \[112\]
- Patients may also report malaise.

**myalgia (common)**

- Reported in 11% to 44% of patients in case series.\[6\] \[7\] \[8\] \[9\] \[88\] \[112\]

**anorexia (common)**

- Reported in 40% of patients in case series.\[8\]

**sputum production/expectoration (common)**

- Reported in 26% to 33% of patients in case series.\[6\] \[8\] \[9\] \[112\]
sore throat (common)
  • Reported in 5% to 17% of patients in case series, and usually presents early in the clinical course.[7] [8] [9] [112]
  • Children may have pharyngeal erythema.[15]

confusion (uncommon)
  • Reported in 9% of patients in case series.[7]

dizziness (uncommon)
  • Reported in 9% to 12% of patients in case series.[8] [89]

headache (uncommon)
  • Reported in 6% to 14% of patients in case series.[6] [7] [8] [9] [89] [112]

haemoptysis (uncommon)
  • Reported in 1% to 5% of patients in case series.[6] [9]

rhinorrhoea (uncommon)
  • Reported in 4% to 5% of patients in case series.[7] [9]

chest pain (uncommon)
  • Reported in 2% to 5% of patients in case series.[6] [7]
  • May indicate pneumonia.

gastrointestinal symptoms (uncommon)
  • Nausea, vomiting, and diarrhoea have been reported in 1% to 10% of patients in case series, although this may be underestimated.[6] [7] [8] [9] [89] [112] One case series reported gastrointestinal symptoms in nearly 40% of patients.[10]
  • Abdominal pain has been reported in 2% of patients in case series.[8]
  • Patients may present with nausea or diarrhoea 1 to 2 days prior to onset of fever and breathing difficulties.[8]

conjunctival congestion (uncommon)
  • Reported in <1% of patients in case series.[9]

loss of smell/taste (uncommon)
  • There is anecdotal evidence that patients with mild illness may develop anosmia/hyposmia or ageusia/dysgeusia in the absence of other symptoms. It is possible that these patients may be hidden carriers, but further research is required.[11]

bronchial breath sounds (uncommon)
  • May indicate pneumonia.

tachypnoea (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

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>pulse oximetry</td>
<td>may show low oxygen saturation (SpO₂ &lt;90%)</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• Recommended in patients with respiratory distress and cyanosis.</td>
<td></td>
</tr>
<tr>
<td>ABG</td>
<td>may show low partial oxygen pressure</td>
</tr>
<tr>
<td>• Order in patients with severe illness as indicated to detect hypercarbia or acidosis.</td>
<td></td>
</tr>
<tr>
<td>• Recommended in patients with respiratory distress and cyanosis who have low oxygen saturation (SpO₂ &lt;90%).</td>
<td></td>
</tr>
<tr>
<td>FBC</td>
<td>leukopenia; lymphopenia; leukocytosis</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• The most common laboratory abnormalities in patients hospitalised with pneumonia include leukopenia, lymphopenia, and leukocytosis. Other abnormalities include neutrophilia, thrombocytopenia, and decreased haemoglobin.[6] [7] [8] [98]</td>
<td></td>
</tr>
<tr>
<td>• Thrombocytopenia has been associated with increased risk of severe disease and mortality and may be useful as a clinical indicator for monitoring disease progression.[113]</td>
<td></td>
</tr>
<tr>
<td>coagulation screen</td>
<td>elevated D-dimer; prolonged prothrombin time</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• The most common abnormalities are elevated D-dimer and prolonged prothrombin time.[6] [7] [8]</td>
<td></td>
</tr>
<tr>
<td>• Non-survivors had significantly higher D-dimer levels and longer prothrombin time and activated partial thromboplastin time compared with survivors in one study.[114]</td>
<td></td>
</tr>
<tr>
<td>comprehensive metabolic panel</td>
<td>elevated liver transaminases; decreased albumin; renal impairment.</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• The most common laboratory abnormalities in patients hospitalised with pneumonia include elevated liver transaminases. Other abnormalities include decreased albumin and renal impairment.[6] [7]</td>
<td></td>
</tr>
<tr>
<td>• Liver function abnormalities may be more common in patients with COVID-19 compared with other types of pneumonia.[108]</td>
<td></td>
</tr>
<tr>
<td>serum procalcitonin</td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• May be elevated in patients with secondary bacterial infection.[6] [7] May be more common in children.[95]</td>
<td></td>
</tr>
<tr>
<td>serum C-reactive protein</td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• May be elevated in patients with secondary bacterial infection.[6] [7]</td>
<td></td>
</tr>
<tr>
<td>serum lactate dehydrogenase</td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• Elevated lactate dehydrogenase has been reported in 73% to 76% of patients.[6] [7] May be more common in patients with COVID-19 compared with other types of pneumonia.[108]</td>
<td></td>
</tr>
<tr>
<td>• Indicates liver injury or lysis of blood erythrocytes.</td>
<td></td>
</tr>
</tbody>
</table>
### Test

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>serum creatine kinase</strong></td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• Elevated creatine kinase has been reported in 13% to 33% of patients. [6] [7]</td>
<td></td>
</tr>
<tr>
<td>• Indicates muscle or myocardium injury.</td>
<td></td>
</tr>
<tr>
<td><strong>serum troponin level</strong></td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with severe illness.</td>
<td></td>
</tr>
<tr>
<td>• May be elevated in patients with cardiac injury. [6]</td>
<td></td>
</tr>
<tr>
<td><strong>blood and sputum cultures</strong></td>
<td>negative for bacterial infection</td>
</tr>
<tr>
<td>• 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 epidemiological history. [5]</td>
<td></td>
</tr>
<tr>
<td>• Specimens should be collected prior to starting empirical antimicrobials if possible.</td>
<td></td>
</tr>
<tr>
<td><strong>real-time reverse transcription polymerase chain reaction (RT-PCR)</strong></td>
<td>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</td>
</tr>
<tr>
<td>• Molecular testing is required to confirm the diagnosis. Nucleic acid sequencing may be required to confirm the diagnosis. [100] Priorities for testing depend on local guidelines and available resources.</td>
<td></td>
</tr>
<tr>
<td>• 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 aerosolisation when collecting lower respiratory specimens. [100]</td>
<td></td>
</tr>
<tr>
<td>• 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. [100]</td>
<td></td>
</tr>
<tr>
<td>• Many tests are available under the US Food and Drug Administration’s emergency-use authorisation scheme. [115] 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.</td>
<td></td>
</tr>
<tr>
<td>• Collect nasopharyngeal swabs to rule out influenza and other respiratory infections according to local guidance. It is important to note that co-infections can occur, and a positive test for a non-COVID-19 pathogen does not rule out COVID-19. [5] [102]</td>
<td></td>
</tr>
<tr>
<td><strong>chest x-ray</strong></td>
<td>unilateral or bilateral lung infiltrates</td>
</tr>
<tr>
<td>• Order in all patients with suspected pneumonia.</td>
<td></td>
</tr>
<tr>
<td>• Unilateral lung infiltrates are found in 25% of patients, and bilateral lung infiltrates are found in 75% of patients. [6] [7] [104]</td>
<td></td>
</tr>
<tr>
<td><strong>computed tomography (CT) chest</strong></td>
<td>bilateral ground-glass opacity or consolidation</td>
</tr>
<tr>
<td>• Consider a CT scan of the chest. Abnormal chest CT findings have been reported in up to 97% of patients in one meta-analysis of 50,466 hospitalised patients. [88] CT is the primary imaging modality in China. [105]</td>
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</table>
Coronavirus disease 2019 (COVID-19) / Diagnosis

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<td>CT imaging generally shows bilateral multiple lobular and subsegmental areas of ground-glass opacity or consolidation 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. Other atypical features include interlobular or septal thickening (smooth or irregular), thickening of the adjacent pleura, subpleural involvement, crazy paving pattern, and air bronchograms. 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. None of these findings appear to be specific or diagnostic for COVID-19.[6] [90] [106] Abnormalities can rapidly evolve from focal unilateral to diffuse bilateral ground-glass opacities that progress to, or co-exist with, consolidations within 1 to 3 weeks.[107] 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.[106] 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.[108] • Small nodular ground-glass opacities are the most common finding in children.[109] Consolidation with surrounding halo signs is a typical finding in children.[95] • Evidence of viral pneumonia on CT may precede a positive RT-PCR result for SARS-CoV-2 in some patients.[103] However, CT imaging abnormalities may be present in minimally symptomatic or asymptomatic patients.[43] [107] • 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.[111]</td>
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</table>

**Emerging tests**

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>serology</td>
<td>Serological testing is not available as yet, but assays are in development.[103] Serum samples can be stored to retrospectively define cases when validated serology tests become available.</td>
</tr>
</tbody>
</table>
# Differential diagnosis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Differentiating signs / symptoms</th>
<th>Differentiating tests</th>
</tr>
</thead>
</table>
| Middle East respiratory syndrome (MERS) | • Lack of travel history to mainland China or other affected areas, or of close contact with an infected person in the 14 days prior to symptom onset.  
• Initial reports suggest that the clinical course of COVID-19 is less severe and the case fatality rate is lower compared with MERS (approximately 2% to 3% for COVID-19 versus 37% for MERS); however, there are no data to confirm this and the situation is rapidly evolving.[116]  
• Gastrointestinal symptoms and upper respiratory tract symptoms appear to be less common in COVID-19 based on early data.[116] [117] | • Reverse-transcriptase polymerase chain reaction (RT-PCR): positive for MERS-CoV viral RNA. |
| Severe acute respiratory syndrome (SARS) | • There have been no cases of SARS reported since 2004.  
• Lack of travel history to mainland China or other affected areas, or of close contact with an infected person in the 14 days prior to symptom onset.  
• Initial reports suggest that the clinical course of COVID-19 is less severe and the case fatality rate is lower compared with SARS (approximately 2% to 3% for COVID-19 versus 10% for SARS); however, there are no data to confirm this and the situation is rapidly evolving.[116]  
• Gastrointestinal symptoms and upper respiratory tract symptoms appear to be less common in COVID-19 based on early data.[116] [117] | • RT-PCR: positive for SARS-CoV viral RNA. |
<p>| Community-acquired pneumonia       | • Lack of travel history to mainland China or other affected areas, or of close contact with an infected person in the 14 days prior to symptom onset. | • Blood or sputum culture or molecular testing: positive for causative organism. |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Differentiating signs / symptoms</th>
<th>Differentiating tests</th>
</tr>
</thead>
</table>
| Influenza infection                   | • Lack of travel history to mainland China or other affected areas, or of close contact with an infected person in the 14 days prior to symptom onset.  
• Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms.  
However, early reports suggest that sore throat is less common in COVID-19.\[117\] | • RT-PCR: positive for influenza A or B viral RNA.                                           |
| Common cold                           | • Lack of travel history to mainland China or other affected areas, or of close contact with an infected person in the 14 days prior to symptom onset.  
• Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms. However, early reports suggest that coryza and sore throat are less common in COVID-19.\[117\] | • RT-PCR: positive for causative organism, or negative for SARS-CoV-2 viral RNA.          |
| Avian influenza A (H7N9) virus infection | • May be difficult to differentiate based on epidemiological 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.  
• Early reports suggest that sore throat is less common in COVID-19.\[117\] | • RT-PCR: positive for H7-specific viral RNA.                                                |
| Avian influenza A (H5N1) virus infection | • Lack of travel history to mainland China or other affected areas, or of close contact with an infected person in the 14 days prior to symptom onset.  
• Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms. However, early reports suggest that coryza and sore throat are less common in COVID-19.\[117\] | • RT-PCR: positive for H51 viral RNA.                                                       |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Differentiating signs / symptoms</th>
<th>Differentiating tests</th>
</tr>
</thead>
</table>
| contact with an infected person 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.  
  • Early reports suggest that sore throat is less common in COVID-19.[117] |                                                                                           |                                                                                        |
| Other viral or bacterial respiratory infections | • Lack of travel history to mainland China or other affected areas, or of close contact with an infected person 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 *Mycoplasma* should be considered in clusters of pneumonia patients, especially in closed settings such as military camps and schools. | • Blood or sputum culture of molecular testing: positive for causative organism.        |
| Pulmonary tuberculosis                | • 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. | • 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 *Mycoplasma tuberculosis*. |                                                                                        |
| Febrile neutropenia                   | • 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.[118]  
  • Symptoms of COVID-19 and neutropenic sepsis may be | • CBC: neutropenia.                                                                     |                                                                                        |
## Diagnostic criteria

### World Health Organization: case definitions[^67]

**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 hospitalisation 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 1 metre (3 feet) 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.

[^67]: World Health Organization: global surveillance for human infection with coronavirus disease (COVID-19)

### Centers for Disease Control and Prevention: criteria to guide evaluation of patients under investigation (PUI) for COVID-19[^119]

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[^67]: World Health Organization: global surveillance for human infection with coronavirus disease (COVID-19)

[^119]: Centers for Disease Control and Prevention: criteria to guide evaluation of patients under investigation (PUI) for COVID-19
Clinicians should use their judgement to determine whether a patient has signs and symptoms compatible with COVID-19 and whether the patient should be tested. Decisions on which patients receive testing should be based on the local epidemiology of COVID-19, as well as the clinical course of illness.

Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough, difficulty breathing). Epidemiological factors that may help guide decisions on whether to test include: any persons, including healthcare workers, who have had close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset, or a history of travel from affected geographical areas (international areas with sustained/ongoing transmission) within 14 days of symptom onset. [CDC: coronavirus disease 2019 (COVID-19) – travel]

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)]
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 optimised 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.

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 1 metre (3 feet) from other suspected cases. Implement appropriate infection prevention and control procedures. COVID-19 is a notifiable disease; report all suspected and confirmed cases to your local health authorities.

Detailed guidance on infection prevention and control procedures are available from the World Health Organization (WHO) and the US 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 for optimizing the supply of PPE]

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

Severe COVID-19

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.[16] The median time from onset of symptoms to hospital admission is reported to be approximately 7 days.[6][8]

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]
- Discuss the risks, benefits, and potential outcomes of available treatment options with patients and their families using decision support tools where available. Take patient wishes and expectations into account when considering the ceiling of treatment.
- 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.[124]

Supportive therapies

• Oxygen and airway management: give supplemental oxygen at a rate of 5 L/minute to patients with severe acute respiratory infection and respiratory distress, hypoxaemia, or shock. Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation.[5] 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 non-pregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[5]

• 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.[5]

• Prevention of complications: implement standard interventions to prevent complications associated with critical illness.[5] 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.

Antimicrobials

• Start empirical 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 empirical 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 empirical therapy based on microbiology results and clinical judgement.[5]

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

Antipyretic/analgesic

• Guidelines recommend an antipyretic/analgesic for the relief of fever and pain.[5] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[125]

• Some clinicians have suggested that non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[126] There is currently no strong evidence to support this. The European Medicines Agency, the US Food and Drug Administration, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated. However, NHS UK recommends paracetamol as the drug of choice until there is more information available.[127][128][129]

• Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <3 months of age (age cut-offs vary by country).

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., haemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[5]

Mechanical ventilation

- It is important to follow local infection prevention and control procedures to prevent transmission to healthcare workers.
- Intubation and mechanical ventilation are recommended in patients who are deteriorating and failing to respond to standard oxygen therapy. 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 pre-oxygenation with 100% fraction of inspired oxygen (FiO₂) for 5 minutes.[5] Some patients may develop severe hypoxic respiratory failure, requiring a high fraction of inspired oxygen, and high air flow rates to match inspiratory flow demand. Patients may also have increased work of breathing, demanding positive pressure breathing assistance.
- High-flow nasal oxygen and non-invasive ventilation are recommended in select patients. Mechanically ventilated patients with acute respiratory distress syndrome should receive a lung-protective, low tidal volume/low inspiratory pressure ventilation strategy (lower targets are recommended in children). Those with persistent severe hypoxic failure should be considered for prone ventilation (pregnant women may benefit from being placed in the lateral decubitus position).[5]
- The risk of treatment failure is high in patients with non-acutely reversible conditions, and there is also concern about nosocomial transmission with open ventilation systems and suboptimal non-invasive face mask or nasal pillow seals. More research to define the balance of benefits and risks to patients and health workers is needed.
- Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise.[5]

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.[5] See our Emerging section for more information about these treatments.

Corticosteroids

- Corticosteroids are being used in some patients with COVID-19; however, they have been found to be ineffective and are not recommended.[6][130]
- The WHO (as well as other international pneumonia guidelines) do not routinely recommend systemic corticosteroids for the treatment of viral pneumonia or acute respiratory distress syndrome unless they are indicated for another reason.[5]
- A randomised controlled trial investigating the use of corticosteroids in patients with COVID-19 is in progress.[131]
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 prioritised for hospital admission.[120] 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 non-traditional 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.[120]

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 judgement and should be informed by an assessment of the patient's home environment.[120]

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)]

Advise patients to limit their interaction, and avoid direct contact with their pets and other animals, especially while they are symptomatic. At this time, there is no evidence that pets and other animals can spread COVID-19; however, caution is advised.[132]

Recommend symptomatic therapies such as an antipyretic/analgesic (taking the precautions above into account), and advise patients to keep hydrated but not to take too much fluid as this can worsen oxygenation.

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.[120] 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 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 physiological changes that occur with pregnancy.[5]

Location of care
• Manage symptomatic pregnant women with confirmed infection in a hospital setting with appropriate maternal and fetal monitoring; women with severe illness or complications may require admission to an intensive care unit.[50]
• Isolate and monitor asymptomatic pregnant women with confirmed infection at home, if appropriate, with ultrasound fetal surveillance every 2 weeks.[50]

Delivery

• Choice of delivery and timing should be individualised based on gestational age, as well as maternal, fetal, and delivery conditions. Induction of labour and vaginal delivery is preferred in pregnant women with confirmed COVID-19 infection to avoid unnecessary surgical complications; however, an emergency caesarean delivery may be required if medically justified (e.g., in patients with complications such as sepsis or if there is fetal distress).[5] [50]
• Corticosteroid therapy may be considered in women who are at risk of preterm birth from 24 to 37 weeks’ gestation for fetal lung maturation.[5] [50] [133]

Newborns and breastfeeding

• Babies born to mothers with suspected or confirmed infection should be tested after birth.
• 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).[5] However, the CDC recommends that temporary separation of the mother and baby should be considered on a case-by-case basis, 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 carer.[134] Consult local guidelines for specific recommendations.

Management of comorbidities

Data on the management of comorbidities in patients with COVID-19 is limited. 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).[5]

Cardiovascular disease

• The American Heart Association, the American College of Cardiology, the Heart Failure Society of America, and the European Society of Cardiology Council on Hypertension recommend that patients with COVID-19 who have underlying hypertension, heart failure, or ischaemic heart disease should continue taking their ACE inhibitors or angiotensin-II receptor antagonists as there is no evidence to suggest that these drugs increase the risk of developing severe COVID-19 despite theoretical concerns of increased expression of ACE2 in these patients.[135] [136] [137]

Asthma

• There is currently no evidence of a relationship between the use of inhaled corticosteroids and COVID-19, and these agents are still considered safe to use. However, there is some evidence that
Coronavirus disease 2019 (COVID-19)

Treatment

inhaled corticosteroids may increase the risk of some respiratory infections in patients with asthma, and there is uncertainty over whether higher doses increase the risk of pneumonia.\[138\]

Cancer

- In patients who require systemic anticancer treatment, take into account: the level of immunosuppression associated with cancer types and individual treatments, as well as any other patient-specific factors; resource issues; and balancing the risk of not treating cancer optimally versus the risk of the patient being immunosuppressed and becoming severely ill from COVID-19.\[118\]

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

<table>
<thead>
<tr>
<th>Initial</th>
<th>1st isolation and infection prevention and control procedures</th>
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<tbody>
<tr>
<td></td>
<td>plus empirical antimicrobials</td>
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<td></td>
<td>plus monitoring</td>
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<td></td>
<td>adjunct supportive care</td>
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<td></td>
<td>adjunct antipyretic/analgesic</td>
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<tr>
<td>Acute confirmed COVID-19</td>
<td>(summary)</td>
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<td>-------------------------</td>
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<tr>
<td><strong>severe illness; mild illness with risk factors</strong></td>
<td>1st hospital admission</td>
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<tr>
<td>plus infection prevention and control procedures</td>
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<tr>
<td>plus assess adults for frailty</td>
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<td>adjunct tailor management to comorbidities</td>
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<td>adjunct experimental therapies</td>
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<td><strong>mild illness with no risk factors</strong></td>
<td>1st isolation in non-traditional facility or at home</td>
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<td>plus monitoring</td>
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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.
Coronavirus disease 2019 (COVID-19)  

Treatment

**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 1 metre (3 feet) from other suspected cases. 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.[5] [50]

plus empirical antimicrobials

Treatment recommended for ALL patients in selected patient group

- Start empirical 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 empirical antimicrobials should be based on the clinical diagnosis, and local epidemiology and susceptibility data.[5]

  - Consider treatment with a neuraminidase inhibitor until influenza is ruled out.[5]

  - De-escalate empirical therapy based on microbiology results and clinical judgement.

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
Coronavirus disease 2019 (COVID-19)

TREATMENT

**Initial**

**adjunct supportive care**

Start general supportive care interventions as indicated (e.g., haemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[5]

**adjunct antipyretic/analgesic**

Treatment recommended for SOME patients in selected patient group

- Immediate start supportive care based on the clinical presentation if necessary.
- Oxygen and airway management: give supplemental oxygen at a rate of 5 L/minute to patients with severe acute respiratory infection and respiratory distress, hypoxaemia, or shock. 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 non-pregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[5]
- 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.[5]

**Primary options**

- **paracetamol**: children: consult local drug formulary for guidance on dose; adults: 500-1000 mg orally every 4-6 hours when required, maximum 4000 mg/day

  OR

- **ibuprofen**: children: consult local drug formulary for guidance on dose; adults: 300-600 mg orally (immediate-release) every 6-8 hours when required, maximum 2400 mg/day

- Guidelines recommend an antipyretic/analgesic for the relief of fever and pain.[5] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[125]

- Some clinicians have suggested that non-steroidal anti-inflammatory drugs (NSAIDs)
such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[126] There is currently no strong evidence to support this. The European Medicines Agency, the Food and Drug Administration, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated. However, NHS UK recommends paracetamol as the drug of choice until there is more information available.[127] [128] [129]

- Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <3 months of age (age cut-offs vary by country).
### Acute confirmed COVID-19

<table>
<thead>
<tr>
<th>Severe illness; mild illness with risk factors</th>
<th>1st hospital admission</th>
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<tbody>
<tr>
<td>» 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. [5]</td>
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<tr>
<td>» Patients with mild illness who have risk factors for poor outcomes (i.e., age &gt;60 years, presence of comorbidities) should also be prioritised for hospital admission when possible. [120]</td>
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<tr>
<td>» Symptomatic pregnant women with confirmed infection should be managed in a hospital setting with appropriate maternal and fetal monitoring; women with severe illness or complications may require admission to an intensive care unit. [50] 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. [5] [50]</td>
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<tr>
<td>Plus</td>
<td>Infection prevention and control procedures</td>
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<tr>
<td>Treatment recommended for ALL patients in selected patient group</td>
<td></td>
</tr>
<tr>
<td>» Immediately isolate all confirmed cases in an area separate from other patients, and implement appropriate infection prevention and control procedures. Detailed guidance is available from the WHO and the CDC:</td>
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<tr>
<td>Plus</td>
<td>Assess adults for frailty</td>
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</table>
### Acute

**Treatment**

<table>
<thead>
<tr>
<th>Treatment recommended for ALL patients in selected patient group</th>
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- Assess all adults for frailty on admission to hospital, irrespective of age and COVID-19 status, using the Clinical Frailty Scale. [Clinical frailty scale]
- Discuss the risks, benefits, and potential outcomes of available treatment options with patients and their families using decision support tools where available. Involve critical care teams in discussions about admission to critical care.[124]

**plus monitoring**

<table>
<thead>
<tr>
<th>Treatment recommended for ALL patients in selected patient group</th>
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</table>

- 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., haemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[5]

**adjunct supportive care**

<table>
<thead>
<tr>
<th>Treatment recommended for SOME patients in selected patient group</th>
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</table>

- Immediately start supportive care, if necessary.
- Oxygen and airway management: give supplemental oxygen at a rate of 5 L/minute to patients with severe acute respiratory infection and respiratory distress, hypoxaemia, or shock. 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 non-pregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[5]
- 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.[5]
- Implement standard interventions to prevent complications associated with critical illness.[5]

**adjunct empirical antimicrobials**

<table>
<thead>
<tr>
<th>Treatment recommended for SOME patients in selected patient group</th>
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</thead>
</table>
### Acute

**adjunct** **antipyretic/analgesic**

Treatment recommended for SOME patients in selected patient group

**Primary options**

- **paracetamol**: children: consult local drug formulary for guidance on dose; adults: 500-1000 mg orally every 4-6 hours when required, maximum 4000 mg/day

- **ibuprofen**: children: consult local drug formulary for guidance on dose; adults: 300-600 mg orally (immediate-release) every 6-8 hours when required, maximum 2400 mg/day

**Guidelines recommend an antipyretic/analgesic for the relief of fever and pain**.[5] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[125]

- Some clinicians have suggested that non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[126] There is currently no strong evidence to support this. The European Medicines Agency, the Food and Drug Administration, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated. However, NHS UK recommends paracetamol as the drug of choice until there is more information available.[127] [128] [129]

- Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <3 months of age (age cut-offs vary by country).

**adjunct** **mechanical ventilation**

Treatment recommended for SOME patients in selected patient group

- Intubation and mechanical ventilation are recommended in patients who are deteriorating and failing to respond to standard oxygen therapy.[5] Some patients may develop severe hypoxic respiratory failure, requiring a high fraction of inspired oxygen, and high air flow...
rates to match inspiratory flow demand. Patients may also have increased work of breathing, demanding positive pressure breathing assistance.

- 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 pre-oxygenation with 100% fraction of inspired oxygen (FiO₂) for 5 minutes.[5]

- High-flow nasal oxygen and non-invasive ventilation are recommended in select patients. Mechanically ventilated patients with acute respiratory distress syndrome should receive a lung-protective, low tidal volume/low inspiratory pressure ventilation strategy (lower targets are recommended in children). Those with persistent severe hypoxic failure should be considered for prone ventilation (pregnant women may benefit from being placed in the lateral decubitus position).[5]

- The risk of treatment failure is high in patients with non-acutely reversible conditions, and there is also concern about nosocomial transmission with open ventilation systems and suboptimal non-invasive face mask or nasal pillow seals. More research to define the balance of benefits and risks to patients and health workers is needed.

- Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise.[5]

- It is important to follow local infection prevention and control procedures to prevent transmission to healthcare workers.

**adjunct tailormanagement to comorbidities**

Treatment recommended for SOME patients in selected patient group

- 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).[5]

- Cardiovascular disease: the American Heart Association, the American College of Cardiology, the Heart Failure Society of America, and the European Society of Cardiology Council on Hypertension recommend that patients with COVID-19 who have underlying hypertension,
**Coronavirus disease 2019 (COVID-19)**

### Treatment

**Acute**

<table>
<thead>
<tr>
<th>mild illness with no risk factors</th>
<th>1st isolation in non-traditional facility or at home</th>
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</table>

- Heart failure, or ischaemic heart disease should continue taking their ACE inhibitors or angiotensin-II receptor antagonists as there is no evidence to suggest that these drugs increase the risk of developing severe COVID-19 despite theoretical concerns of increased expression of ACE2 in these patients.[135] [136] [137]

- **Asthma**: there is currently no evidence of a relationship between the use of inhaled corticosteroids and COVID-19, and these agents are still considered safe to use. However, there is some evidence that inhaled corticosteroids may increase the risk of some respiratory infections in patients with asthma, and there is uncertainty over whether higher doses increase the risk of pneumonia.[138]

- **Cancer**: in patients who require systemic anticancer treatment, take into account the following: the level of immunosuppression associated with cancer types and individual treatments, as well as any other patient-specific factors; resource issues; and balancing the risk of not treating cancer optimally versus the risk of the patient being immunosuppressed and becoming severely ill from COVID-19.[118]

### 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.[5] See the Emerging section for more information about these treatments.

- Patients with mild illness and no risk factors (i.e., age >60 years, presence of comorbidities) can be isolated in non-traditional 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.[120] 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 judgement and should
**Acute**

<table>
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<tbody>
<tr>
<td>be informed by an assessment of the patient’s home environment.[120]</td>
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<td>» Asymptomatic pregnant women with confirmed infection can be managed at home, if appropriate.[50]</td>
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<td>» 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)]</td>
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<td>» Advise patients to limit their interaction, and avoid direct contact with their pets and other animals, especially while they are symptomatic. At this time, there is no evidence that pets and other animals can spread COVID-19; however, caution is advised.[132]</td>
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<tr>
<td>» 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.[120] Guidance on when to stop isolation depends on local circumstances and may differ between countries; consult local guidelines.</td>
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</tbody>
</table>

**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.[50] |

**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.[120] |

**adjunct antipyretic/analgesic**

Treatment recommended for SOME patients in selected patient group

Primary options
### Acute

- **paracetamol**: children: consult local drug formulary for guidance on dose; adults: 500-1000 mg orally every 4-6 hours when required, maximum 4000 mg/day
- **ibuprofen**: children: consult local drug formulary for guidance on dose; adults: 300-600 mg orally (immediate-release) every 6-8 hours when required, maximum 2400 mg/day

- Guidelines recommend an antipyretic/analgesic for the relief of fever and pain.[5] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[125]

- Some clinicians have suggested that non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[126] There is currently no strong evidence to support this. The European Medicines Agency, the Food and Drug Administration, and the WHO do not recommend avoiding NSAIDs in COVID-19 when clinically indicated. However, NHS UK recommends paracetamol as the drug of choice until there is more information available.[127] [128] [129]

- Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <3 months of age (age cut-offs vary by country).
Emerging

Remdesivir
An investigational intravenous drug 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 the US and in China.\[139\] [140] [141] [142] [143] It has been used on a compassionate-use basis in areas where clinical trials are not available.

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.\[144\] A randomised 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 hospitalised patients with severe COVID-19.\[145\]

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 inflammatory conditions such as rheumatoid arthritis and systemic lupus erythematosus. They are being trialled in patients with mild to severe COVID-19 in many countries.\[146\] [147] [148] Both drugs have in vitro activity against SARS-CoV-2, with hydroxychloroquine having relatively higher potency against SARS-CoV-2.\[140\] [149] An expert consensus guideline in China recommends chloroquine in mild to severe cases of COVID-19 as it may improve the success rate of treatment, shorten hospital stay, and improve patient outcome.\[150\] The US Food and Drug Administration is currently investigating the use of chloroquine for treating patients with COVID-19. Hydroxychloroquine has similar therapeutic effects, but fewer adverse effects, is considered safe in pregnancy, and is more readily available in some countries.\[151\]

Intravenous immunoglobulin
Intravenous immunoglobulin is being trialled in some patients with COVID-19; however, there are no data to support this.\[7\]

Traditional Chinese Medicine
Traditional Chinese Medicine is being trialled in some patients with COVID-19 (e.g., Xue-Bi-Jing, Shuang-Huang-Lian, Xin-Guan-2); however, there are no data to support this.\[152\] [153] [154] These medicines are commonly used in China to treat COVID-19 patients and are recommended in local guidelines.\[155\]

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 pathological changes that occur in the lungs, and inhibit the cell-mediated immune inflammatory response.\[156\]

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.\[157\]

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.[158] A clinical trial to determine the safety and efficacy of convalescent plasma in patients with COVID-19 has started in China; however, there is no data on its use as yet.[159]

Other drugs

Other drugs that may show promise for the treatment of COVID-19 include teicoplanin and camostat mesylate.[160] [161] Sarilumab is being trialled in patients with severe COVID-19.[162] Gimsilumab is in development for the treatment of acute respiratory distress syndrome associated with COVID-19.[163] 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).[164] [165] [166] [167] [168] [169] [170] [171] [172]
Recommendations

Monitoring

Monitor vital signs (i.e., temperature, respiratory rate, heart rate, blood pressure, oxygen saturation) and perform haematology and biochemistry laboratory testing and ECG as clinically indicated during admission. Utilise 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.[5]

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.[50]

Perform molecular testing regularly during admission. Two consecutive negative tests (at least 24 hours apart) are required in a clinically recovered patient before discharge.[5]

Patient instructions

General prevention measures

• Wash hands often with soap and water or an alcohol-based hand sanitiser and avoid touching the eyes, nose, and mouth with unwashed hands.

• Avoid close contact with people (i.e., maintain a distance of at least 1 metre [3 feet]), particularly those who are sick.

• Stay at home if sick and isolate yourself from other people.

• Practice respiratory hygiene (i.e., cover mouth and nose when coughing or sneezing, discard tissue immediately in a closed bin, and wash hands).

• Regularly clean and disinfect frequently touched objects and surfaces.[69] [70]

• [WHO: coronavirus disease (COVID-19) advice for the public]

Travel advice

• Many countries have implemented international travel bans/closed their borders, have issued advice for domestic travel, and are requesting that citizens travelling 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 advice]
  • [Ministry of Manpower Singapore: advisories on COVID-19]

Resources

• [WHO: coronavirus disease (COVID-19) outbreak]
Follow up

- [WHO: staying physically active during self-quarantine]
- [CDC: coronavirus (COVID-19)]
- [NHS UK: coronavirus (COVID-19)]
## Complications

<table>
<thead>
<tr>
<th>Complications</th>
<th>Timeframe</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>acute respiratory distress syndrome (ARDS)</strong></td>
<td>short term</td>
<td>medium</td>
</tr>
<tr>
<td>Reported in 15% to 33% of patients in case series.</td>
<td></td>
<td></td>
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<tr>
<td>Children can quickly progress to ARDS.</td>
<td></td>
<td></td>
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<tr>
<td>Factors that increase the risk of developing ARDS and death include older age, neutrophilia, elevated lactate dehydrogenase level, and elevated D-dimer level. Treatment with methylprednisolone may be beneficial and decrease the risk of death in these patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>acute liver injury</strong></td>
<td>short term</td>
<td>medium</td>
</tr>
<tr>
<td>Reported in 14% to 53% of patients in case series.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occurs more commonly in patients with severe disease.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>acute cardiac injury</strong></td>
<td>short term</td>
<td>low</td>
</tr>
<tr>
<td>Reported in 7% to 13% of patients in case series.</td>
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<tr>
<td>Arrhythmias have been reported in 16% of patients in case series.</td>
<td></td>
<td></td>
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<tr>
<td>Prevalence is high among patients who are severely or critically ill, and these patients have a higher rate of in-hospital mortality.</td>
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<tr>
<td>Fulminant myocarditis has been reported. Early corticosteroid therapy and immunoglobulin may be beneficial in these patients.</td>
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<tr>
<td>Infection may have longer-term implications for overall cardiovascular health; however, further research is required.</td>
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<td></td>
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<tr>
<td><strong>secondary infection</strong></td>
<td>short term</td>
<td>low</td>
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<tr>
<td>Reported in 6% to 10% of patients in case series.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>acute respiratory failure</strong></td>
<td>short term</td>
<td>low</td>
</tr>
<tr>
<td>Reported in 8% of patients in case series.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children can quickly progress to respiratory failure.</td>
<td></td>
<td></td>
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<tr>
<td><strong>acute kidney injury</strong></td>
<td>short term</td>
<td>low</td>
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<tr>
<td>Reported in 3% to 8% of patients in case series.</td>
<td></td>
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<tr>
<td><strong>septic shock</strong></td>
<td>short term</td>
<td>low</td>
</tr>
<tr>
<td>Reported in 4% to 8% of patients in case series.</td>
<td></td>
<td></td>
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<tr>
<td>A systemic inflammatory response syndrome (SIRS) can sometimes accompany viral sepsis. Elevations in inflammatory chemokines and cytokines have been reported in COVID-19 patients.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>disseminated intravascular coagulation</strong></td>
<td>short term</td>
<td>low</td>
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</table>
Coronavirus disease 2019 (COVID-19)

Follow up

### Complications

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<tbody>
<tr>
<td>Reported in 71% of non-survivors.</td>
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<tr>
<td>pregnancy-related complications</td>
<td>short term</td>
<td>low</td>
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<tr>
<td>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 labour, 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 or neonatal deaths, stillbirths, or abortions have been reported so far. [52] [53] [54] [190]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rhabdomyolysis</td>
<td>short term</td>
<td>low</td>
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<tr>
<td>Reported as a late complication in one case report. [191]</td>
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</table>

### Prognosis

#### Case fatality rate

The overall global case fatality rate is approximately 4% based on World Health Organization data as of 22 March 2020. The case fatality rate varies between countries. For example, in Italy, the case fatality rate is approximately 9%. In the US, the case fatality rate is approximately 1%. [173]

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 hospitalised patients). [16]

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 0.125%; however, this estimate does not take into account exceptional cases (e.g., the current situation in Italy). [174]

It is important to note that estimated case fatality rates should be treated with extreme caution as the situation is evolving rapidly, and case fatality rates are often overestimated at the onset of outbreaks owing to increased case detection of patients with severe disease. [175] 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%. Other factors that can affect case fatality rates include testing rates in each country, delays between symptom onset and death, and local factors (e.g., patient demographics, availability and quality of health care, other endemic diseases). For example, the case fatality rate in Italy may be higher than in other countries 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. [174]

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%). [6] Despite the lower case fatality rate, COVID-19 has so far resulted in more deaths than both SARS and MERS combined. [176]

#### Case fatality rate according to age

The majority of deaths in China have been in patients aged 60 years and older and/or those who have pre-existing 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 aged 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).[16]

In the US, the case fatality rate was highest among patients aged ≥85 years (10% to 27%), followed by those aged 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 aged ≥65 years accounted for 80% of deaths.[24]

**Causes of death**

The leading cause of death in patients with COVID-19 is respiratory failure from acute respiratory distress syndrome.[177]

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. Non-survivors were more likely to develop acute respiratory distress syndrome and require mechanical ventilation. Non-survivors were older (>65 years of age) and more likely to have chronic medical illnesses.[178]

**Prognostic factors**

Factors associated with disease progression and a poorer prognosis in one retrospective analysis of 78 patients in Wuhan City include older age, history of smoking, maximum body temperature on admission, respiratory failure, significantly decreased serum albumin level, and significantly elevated C-reactive protein.[179]

Thrombocytopenia has been associated with increased risk of severe disease and mortality and may be useful as a clinical indicator for monitoring disease progression.[113]

Other factors associated with a poor prognosis include higher Sequential Organ Failure Assessment (SOFA) score and a D-dimer level >1 microgram/L. Viral shedding continued until death in non-survivors.[66]

**Refractory disease**

Refractory disease (patients who do not reach obvious clinical and radiological remission within 10 days after hospitalisation) has been reported in nearly 50% of hospitalised patients in one retrospective single-centre 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.[180]

**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.[181] [182]

**Disease 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 non-reactivated patients. Further research is required on these patients.[183]
## Diagnostic guidelines

### Europe

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<td>COVID-19</td>
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### International

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<td>World Health Organization</td>
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<tr>
<td>Infection prevention and control during health care when COVID-19 is suspected</td>
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### North America

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<td>Information for laboratories</td>
<td>Centers for Disease Control and Prevention</td>
<td>2020</td>
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<tr>
<td>Interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings</td>
<td>Centers for Disease Control and Prevention</td>
<td>2020</td>
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## Asia

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

*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

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

*Published by:* Peking Union Medical College Hospital  
*Last published:* 2020

## Treatment guidelines

### Europe

**COVID-19 rapid guideline: critical care**

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

**Coronavirus (COVID-19): rapid guidelines and evidence reviews**

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

**COVID-19: guidance for health professionals**

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

**Coronavirus (covid-19): latest news and resources**

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

**COVID-19**

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

**Guideline for the treatment of people with COVID-19 disease**

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

**Recommendations for COVID-19 clinical management**

*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**

*Published by:* Spanish Paediatric Association  
*Last published:* 2020
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<td><strong>Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected</strong></td>
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<td><strong>Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts</strong></td>
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<td><strong>Advice on the use of masks in the community, during home care, and in health care settings in the context of COVID-19</strong></td>
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<td><strong>ISUOG interim guidance on 2019 novel coronavirus infection during pregnancy and puerperium: information for healthcare professionals</strong></td>
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<tr>
<td>Published by: International Society of Ultrasound in Obstetrics and Gynecology</td>
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# North America

## Information for healthcare professionals

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

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

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

### Information for clinicians on therapeutic options for COVID-19 patients

**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)

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

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

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

### Discontinuation of home isolation for persons with COVID-19 (interim guidance)

**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)

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

### Interim considerations for infection prevention and control of coronavirus disease 2019 (COVID-19) in inpatient obstetric healthcare settings

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

### Coronavirus disease (COVID-19): outbreak update

**Published by:** Government of Canada  
**Last published:** 2020
### Asia

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<tr>
<td><strong>Handbook of COVID-19 prevention and treatment</strong></td>
<td>First Affiliated Hospital, Zhejiang University School of Medicine</td>
<td>2020</td>
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<td><strong>A rapid advice guideline for the diagnosis and treatment of 2019 novel coronavirus (2019-nCoV) infected pneumonia</strong></td>
<td>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</td>
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<td><strong>Diagnosis and clinical management of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection</strong></td>
<td>Peking Union Medical College Hospital</td>
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<td><strong>Updates on COVID-19 (coronavirus disease 2019) local situation</strong></td>
<td>Ministry of Health Singapore</td>
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<td><strong>New coronavirus (COVID-19)#</strong></td>
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<td><strong>Coronavirus disease 2019 (COVID-19)</strong></td>
<td>Department of Health Australia</td>
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Online resources

1. WHO: novel coronavirus (COVID-19) situation dashboard (external link)
2. WHO: coronavirus disease (COVID-2019) situation reports (external link)
4. CDC: locations with confirmed COVID-19 cases, by WHO region (external link)
5. GenBank (external link)
6. WHO: coronavirus disease (COVID-19) advice for the public (external link)
7. BMJ: facemasks for the prevention of infection in healthcare and community settings (external link)
8. BMJ: covid-19 in primary care (UK) (external link)
9. WHO: infection prevention and control during health care when COVID-19 is suspected (external link)
10. CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings (external link)
11. CDC: strategies for optimizing the supply of PPE (external link)
12. WHO: global surveillance for human infection with coronavirus disease (COVID-19) (external link)
15. Clinical frailty scale (external link)
16. WHO: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts (external link)
17. CDC: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19) (external link)
18. WHO: coronavirus disease (COVID-19) travel advice (external link)
19. NaTHNac: travel health pro (external link)
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<td>27.</td>
<td>NHS UK: coronavirus (COVID-19) (external link)</td>
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Key articles

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11. ENT UK. Loss of sense of smell as marker of COVID-19 infection. March 2020 [internet publication]. Full text


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76. Mahase E. China coronavirus: what do we know so far? BMJ. 2020 Jan 24;368:m308. Full text Abstract


126. Day M. Covid-19: ibuprofen should not be used for managing symptoms, say doctors and scientists. BMJ. 2020 Mar 17;368:m1086. Full text  Abstract


128. NHS. Stay at home advice. March 2020 [internet publication]. Full text

129. US Food and Drug Administration. FDA advises patients on use of non-steroidal anti-inflammatory drugs (NSAIDs) for COVID-19. March 2020 [internet publication]. Full text


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<tr>
<th>Reference</th>
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<tbody>
<tr>
<td>132.</td>
<td>Centers for Disease Control and Prevention. Interim guidance for public health professionals managing people with COVID-19 in home care and isolation who have pets or other animals. March 2020 [internet publication]. <a href="#">Full text</a></td>
</tr>
<tr>
<td>135.</td>
<td>American Heart Association; Heart Failure Society of America; American College of Cardiology. Patients taking ACE-i and ARBs who contract COVID-19 should continue treatment, unless otherwise advised by their physician. March 2020 [internet publication]. <a href="#">Full text</a></td>
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<thead>
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<tr>
<td>176.</td>
<td>Mahase E. Coronavirus covid-19 has killed more people than SARS and MERS combined, despite lower case fatality rate. BMJ. 2020 Feb 18;368:m641. <a href="#">Full text</a> Abstract</td>
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Figure 1: Illustration revealing ultrastructural morphology exhibited by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) when viewed with electron microscopically

Centers for Disease Control and Prevention
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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