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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. 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 etiology associated with Wuhan City, Hubei Province, China on 31 December 2019. Most of the patients in the outbreak reported a link to a large seafood and live animal market (Huanan South China Seafood Market).[6] 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.[7] Since then, the outbreak has escalated rapidly, with the WHO first declaring a public health emergency of international concern on 30 January 2020 and then formally declaring it a pandemic on 11 March 2020.

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

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

Data from the largest case series in China to date (72,314 cases from 31 December 2019 to 11 February 2020) found that the majority of confirmed cases (87%) were ages 30 to 79 years, 1% were ages 9 years or younger, 1% were ages 10 to 19 years, and 3% were ages 80 years or older. Approximately 51% of patients were male and 49% were female. Nearly 4% of cases were in healthcare workers.[10]

In the US, older patients (aged ≥65 years) accounted for 31% of all cases, 45% of hospitalizations, 53% of intensive care unit admissions, and 80% of deaths, with the highest incidence of severe outcomes in patients aged ≥85 years.[11]

Infection in children is being reported much less commonly than among adults. A systematic review found that children accounted for 1% to 5% of confirmed cases (depending on the country) so far.[12] All cases so far have been in family clusters or in children who have a history of close contact with an infected patient.[13]
In a case series of 2143 pediatric 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.[16]

Emerging evidence suggests that cold and dry conditions may facilitate the spread of COVID-19; however, further research is required on how weather conditions influence transmission.[17]

**Etiology**

**Virology**

- Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is a previously unknown betacoronavirus that was discovered in bronchoalveolar lavage samples taken from clusters of patients who presented with pneumonia of unknown cause in Wuhan City, Hubei Province, China, in December 2019.[1] 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.
- 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.[18] [19] 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.[20]

**Origin of virus**

- A majority of patients in the initial stages of this outbreak reported a link to the Huanan South China Seafood Market, a live animal or "wet" market, suggesting a zoonotic origin of the virus.[21] [22] [23]
- 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.[18] [19] [24] [25] Pangolins have been suggested as an intermediate host as they have been found to be a natural reservoir of SARS-CoV-2-like coronaviruses.[26] [27]

**Transmission dynamics**

- 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.
- It is uncertain how easily the virus spreads between people, but transmission in chains involving several links is increasingly recognized. Available evidence indicates that human transmission occurs via close contact with respiratory droplets produced when a person exhales, sneezes, or coughs, or
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BASICS

via contact with fomites. Airborne transmission has not been reported; however, it may be possible during aerosol-generating procedures performed in clinical care.[21] [23] [28] [29]

• The virus has been found to be more stable on plastic and stainless steel (up to 72 hours) compared with copper (up to 4 hours) and cardboard (up to 24 hours).[30] This study also found that the virus was viable in aerosol particles for up to 3 hours; however, aerosols were generated using high-powered apparatus that do not reflect normal human cough conditions or a clinical setting where aerosol-generating procedures are performed. The World Health Organization has confirmed that there have been no reports of airborne transmission.[31]

• The contribution to transmission by the presence of the virus in other body fluids is unknown; however, the virus has been detected in blood, saliva, tears, cerebrospinal fluid, and conjunctival secretions. Fecal-oral transmission may be possible, although it has not been reported yet.[32] [33] [34] [35] [36] [37]

• An initial assessment of the transmission dynamics in the first 425 confirmed cases found that 55% of cases before the 1st 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.[23]

• Nosocomial transmission in healthcare workers and patients has been reported in 41% of patients in one case series.[38]

• Widespread transmission has been reported in long-term care facilities and on cruise ships (19% of 3700 passengers and crew were infected aboard the Diamond Princess).[39] [40]

Asymptomatic transmission

• Estimating the prevalence of asymptomatic cases in the population is difficult. The best evidence so far comes from the Diamond Princess cruise ship, which was quarantined with all passengers and crew members repeatedly tested and closely monitored. A modeling study found that approximately 700 people with confirmed infection (18%) were asymptomatic.[41] However, a Japanese study of citizens evacuated from Wuhan City estimates the rate to be closer to 31%.[42] Early data from an isolated village of 3000 people in Italy estimates the figure to be higher at 50% to 75%.[43]

• The proportion of asymptomatic cases in children is thought to be significant, and children may play a role in community spread.[44]

• There is mounting evidence that spread from asymptomatic carriers can occur and this has been observed in endemic areas, although it is thought that transmission is greatest when people are symptomatic.[45] [46] [47] [48] [49] [50] [51]

• Presymptomatic transmission has been reported in 12.6% of cases in China.[52] A study in Singapore identified 6.4% of patients among seven clusters of cases in which presymptomatic transmission was likely to have occurred 1 to 3 days before symptom onset.[53]

Superspreading events

• Multiple superspreading events have been reported with COVID-19. These events are associated with explosive growth early in an outbreak and sustained transmission in later stages.[54]

• 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.[55] [56]
• Some of these individuals are also supershedders of virus, but the reasons underlying superspreader events are often more complex than just excess virus shedding and can include a variety of behavioral and environmental factors.[55]

Perinatal transmission

• It is unknown whether perinatal transmission (including transmission via breastfeeding) is possible. Retrospective reviews of pregnant women with COVID-19 found that there is no evidence for intrauterine infection in women with COVID-19.[57] [58] However, vertical transmission cannot be ruled out. There have been case reports of infection in neonates born to mothers with COVID-19, and virus-specific antibodies have also been detected in neonatal serum samples.[59] [60] [61] [62] [63]

Pathophysiology

Incubation period

• Current estimates of the incubation period range from 1 to 14 days, according to the World Health Organization and the Centers for Disease Control and Prevention.[64] [65]  
• The median incubation period has been estimated to be approximately 5 days.[23] [66] However, a preprint study (not peer reviewed) suggests that the median incubation period may be longer (7 days in adults and 9 days in children with a range of 0 to 33 days).[67]  
• Transmission may be possible during the incubation period.[68]

Reproductive number

• Preliminary reports suggest that the reproductive number (R₀), the number of people who acquire the infection from an infected person, is approximately 2.2.[23] [69] 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.[29]

Angiotensin-converting enzyme-2 receptor

• 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.[19] [70] However, a unique structural feature of the spike glycoprotein receptor binding domain of SARS-CoV-2 (which is responsible for the entry of the virus into host cells) confers potentially higher binding affinity for ACE2 on host cells compared with SARS-CoV.[71] A furin-like cleavage site has been identified in the spike protein of the virus; this does not exist in other SARS-like coronaviruses.[72]

• Based on an analysis of single-cell RNA sequencing datasets derived from major human physiologic systems, the organs considered more vulnerable to SARS-CoV-2 infection due to their ACE2 expression levels include the lungs, heart, esophagus, kidneys, bladder, and ileum.[73]

• Mechanistic evidence from other coronaviruses suggests that SARS-CoV-2 may downregulate ACE2, leading to a toxic overaccumulation of angiotensin-II, which may induce acute respiratory distress syndrome and fulminant myocarditis.[74]

Viral load and shedding
• High viral loads have been detected in nasal and throat swabs soon after symptom onset, and it is thought that the viral shedding pattern may be similar to that of patients with influenza. An asymptomatic patient was found to have a similar viral load compared with symptomatic patients.[75] [76]
• Pharyngeal viral shedding is high during the first week of symptoms when symptoms are mild or prodromal, peaking on day 4. This suggests active virus replication in upper respiratory tract tissues.[77]
• The duration of viral shedding has been estimated to be between 8 and 20 days after symptoms resolve. Also, the virus has been detected in sputum and feces for up to 39 days after pharyngeal swabs became negative. However, it is unclear whether the virus is capable of transmission later in the course of the disease or after negative pharyngeal swabs.[78] [79] [80] [81]

Classification


Mild illness

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

Pneumonia

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

Severe pneumonia in adults and adolescents

• Fever or suspected respiratory infection plus one of the following:
  • Respiratory rate >30 breaths/minute
  • Severe respiratory distress
  • SpO₂ ≤93% on room air.

Severe pneumonia in children

• Cough or difficulty breathing plus at least one of the following:
  • Central cyanosis or SpO₂ <90%
  • Severe respiratory distress (e.g., grunting, very severe chest indrawing)
• Signs of pneumonia with a general danger sign (i.e., inability to breastfeed or drink, lethargy or unconsciousness, or convulsions).

• Other signs of pneumonia may be present in children including chest indrawing or fast breathing (i.e., <2 months of age: ≥60 breaths/minute; 2-11 months of age: ≥50 breaths/minute; 1-5 years 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 sanitizer and avoid touching the eyes, nose, and mouth with unwashed hands.
  - Avoid close contact with people (i.e., maintain a distance of at least 3 feet [1 meter]), particularly those who have a fever or are coughing or sneezing. It is important to note that recommended distances differ between countries (for example, 6 feet [2 meters] is recommended in the US and UK) and you should consult local guidance.
  - Practice respiratory hygiene (i.e., cover mouth and nose when coughing or sneezing, discard tissue immediately in a closed bin, and wash hands).
  - Seek medical care early if they have a fever, cough, and difficulty breathing, and share their previous travel and contact history 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

- Recommendations on the use of face masks in community settings vary between countries.
  - 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. 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 sanitizer) prior to putting on a face mask.

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

Screening and quarantine

- People traveling from areas with a high risk of infection may be screened using questionnaires about their travel, contact with ill persons, symptoms of infection, and/or measurement of their temperature. Combined screening of airline passengers on exit from an affected area and on arrival elsewhere has been relatively ineffective when used for other infections such as Ebola virus infection, and has been modeled to miss up to 50% of cases of COVID-19, particularly those with no symptoms during 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.
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Prevention

- Contact tracing and 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 on cruise ships with infected people on board).[98] The psychosocial effects of enforced quarantine may have long-lasting repercussions.[99] [100]

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.[101] [102]
- Researchers in Singapore found that social distancing measures (isolation of infected individuals and family quarantine, school closures, and workplace distancing) significantly decrease the number of infections in simulation models.[103]
- [Public Health England: guidance on social distancing for everyone in the UK]

Shielding extremely vulnerable people

- Shielding is a measure used to protect vulnerable people (including children) who are at very high risk of severe illness from COVID-19 because they have an underlying health condition. Shielding involves minimizing all interactions between those who are extremely vulnerable and other people to protect them from coming into contact with the virus.
- Extremely vulnerable groups include:[104]
  - Solid organ transplant recipients
  - People with specific cancers
  - People with severe respiratory conditions (e.g., cystic fibrosis, severe asthma, or COPD)
  - People with rare diseases or inborn errors of metabolism that increase the risk of infections (e.g., sickle cell anemia, severe combined immunodeficiency)
  - People on immunosuppression therapies sufficient to significantly increase the risk of infection
  - Women who are pregnant with significant heart disease (congenital or acquired).
- These groups are advised to stay at home at all times, and avoid any face-to-face contact for a period of at least 12 weeks (this time period is subject to change). Visits from people who provide essential support should continue provided these people do not have symptoms and follow hand hygiene measures.
- Consult local health authorities for more guidance as recommendations, procedures, and resources differ between countries.
- [Public Health England: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19]

Vaccine

- There is currently no vaccine available. Vaccines are in development, but it may take some time before a vaccine is available.[105] [106] [107] 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.[108] The vaccine includes a short segment of genetic code copied from the virus. The trial started in humans on 16 March 2020. The vaccine is being fast-tracked and has skipped the animal testing stage. Clinical trials in humans have also started on an experimental adenoviral vector vaccine in China.[109]
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:[173]

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

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

**Screening of travelers**

Exit and entry screening may be recommended in countries where borders are still open, particularly when repatriating nationals from affected areas. Travelers returning from affected areas should self-monitor for symptoms for 14 days and follow local protocols of the receiving country. Some countries may require returning travelers to enter quarantine. Travelers who develop symptoms are advised to contact their local health care provider, preferably by phone.[174]

**Drive-through screening centers**

Drive-through screening centers have been set up in some countries for safer and more efficient screening. The testee does not leave their car throughout the entire process, which includes registration and questionnaire, exam, specimen collection, and instructions on what to do after. This method has the advantage of increased testing capacity and prevention of cross-infection between testees in the waiting space.[175]

**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.[355] COVID-19 is a notifiable disease; report all suspected and confirmed cases to your local health authorities.

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

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

Case history #1

A 61-year-old man presents to the hospital 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 exam, his pulse is 120 bpm and his temperature is 101.6°F (38.7°C). Chest x-ray shows bilateral lung infiltrates. He is admitted to hospital in an isolation room and is started on oxygen, intravenous fluids, empiric antibiotics, and acetaminophen. 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 seven 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 exam, his pulse is 100 bpm and his temperature is 101.3°F (38.5°C). The patient reports that he returned from a business trip in mainland China 6 days ago.

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 primary care physicians avoid in-person assessment of patients with suspected COVID-19 in primary care when possible.[110] Most patients can be managed remotely by telephone or video consultations.[111] Algorithms for dealing with these patients are available:

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

Infection prevention and control

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

The World Health Organization (WHO) recommends the following basic principles:[112]
• Immediately isolate all suspected cases in an area that is separate from other patients

• Implement standard precautions at all times:
  • Practice hand and respiratory hygiene
  • Offer a medical mask to patients who can tolerate one
  • Wear personal protective equipment
  • Practice safe waste management, environmental cleaning, and sterilization of patient care equipment and linen

• Implement additional contact and droplet precautions until the patient is asymptomatic:
  • Place patients in adequately ventilated single rooms; when single rooms are not available, place all suspected cases together in the same ward
  • Wear a medical mask, gloves, an appropriate gown, and eye/facial protection (e.g., goggles or a face shield)
  • Use single-use or disposable equipment
  • Consider limiting the number of healthcare workers, family members, and visitors in contact with the patient, ensuring optimal patient care and psychosocial support for the patient
  • Consider placing patients in negative pressure rooms, if available

• Implement airborne precautions when performing aerosol-generating procedures

  All specimens collected for laboratory investigations should be regarded as potentially infectious.

Some countries and organizations recommend airborne precautions for any situation involving the care of a COVID-19 patient.[113] [114]

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.[115]

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

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

**History**

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

Diagnosis should be suspected in:[82]
• 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.[10] Severe illness is associated with older age and the presence of
underlying health conditions.[10] [83] Older patients and/or those with comorbidities may present with mild
symptoms, but have a high risk of deterioration.[5] Atypical presentations may occur, especially in older
patients or patients who are immunocompromised.

Approximately 5% of patients with a mild influenza-like illness (and no risk factors for COVID-19) who
presented to a Los Angeles emergency department tested positive for severe acute respiratory syndrome
coronavirus 2 (SARS-CoV-2), although this study was limited by the brief sampling period at one medical
center.[116]

The most common symptoms are:[21] [22] [38] [117] [118] [119]

• Fever
• Cough
• Dyspnea
• Myalgia
• Fatigue.

Less common symptoms include:

• Anorexia
• Sputum production
• Conjunctivitis
• Sore throat
• Confusion
• Dizziness
• Headache
• Rhinorrhea
• Chest pain
• Hemoptysis
• Diarrhea
• Nausea/vomiting
• Abdominal pain
• Anosmia/dysgeusia
• Cutaneous manifestations.

Approximately 90% of patients present with more than one symptom, and 15% of patients present with fever, cough, and dyspnea.[22] Some patients may be minimally symptomatic or asymptomatic. Mild illness is defined as patients with an uncomplicated upper respiratory tract infection with nonspecific symptoms such as fever, cough (with or without sputum production), fatigue, anorexia, malaise, myalgia, sore throat, dyspnea, nasal congestion, or headache. Patients may have gastrointestinal symptoms. The most common diagnosis in patients with severe COVID-19 is severe pneumonia.[5]

Initial impressions from cases in the US note that the clinical presentation may be broader than that observed in China and Italy, with chest pain, headaches, altered mental status, and gastrointestinal symptoms all observed on initial presentation. Severe hepatic and renal dysfunction that spares the lungs has also been observed.[120]

A retrospective case series of 62 patients in Zhejiang province found that the clinical features were less severe than those of the primary infected patients from Wuhan City, indicating that second-generation infection may result in milder infection. This phenomenon was also reported with Middle East respiratory syndrome.[121]

Coinfections (e.g., influenza, human metapneumovirus) have been reported. Patients with influenza coinfection showed similar characteristics to those patients with COVID-19 only.[78] [122] [123]

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

**Children**

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

Children are typically asymptomatic or present with mild symptoms (e.g., brief and rapidly resolving fever, mild cough, sore throat, congestion, rhinorrhea).[13] [14] [124] [125] [126] However, moderate to severe illness has also been reported in children.[127] Polypnea has been reported in children with severe illness.[128] There are case reports of neonates and infants presenting with predominantly gastrointestinal symptoms.[129] [130]

In a case series of 2143 pediatric patients in China, over 90% of children were asymptomatic or had a mild or moderate illness; 16% were asymptomatic and had no radiologic evidence of pneumonia.[16] However, it is important to note that children may have signs of pneumonia on chest imaging despite having minimal or no symptoms.[131]

Coinfections may be more common in children.[131] It is unknown whether children with underlying health conditions are more at risk of severe illness. Complications in children appear to be milder and more rare.
Pregnant women

Retrospective reviews of pregnant women with COVID-19 found that the clinical characteristics in pregnant women were similar to those reported for nonpregnant adults.[57] [60] It is important to note that symptoms such as fever, dyspnea, and fatigue may overlap with symptoms due to physiologic adaptations of pregnancy or adverse pregnancy events.[5]

Initial investigations

Order the following investigations in all patients with severe illness:

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

The most common laboratory abnormalities in patients hospitalized with pneumonia include leukopenia, lymphopenia, leukocytosis, elevated liver transaminases, elevated lactate dehydrogenase, and elevated C-reactive protein. Other abnormalities include neutrophilia, thrombocytopenia, decreased hemoglobin, decreased albumin, and renal impairment.[21] [22] [38] [119] [132]

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

[VIDEO: Radial artery puncture animated demonstration ]

Blood and sputum cultures

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

Decisions about who to test should be based on clinical and epidemiologic factors. The WHO recommends prioritizing people with a likelihood of infection. Consider testing asymptomatic or mildly symptomatic contacts of confirmed COVID-19 cases. Symptomatic pregnant women should also be prioritized in order to enable access to specialized care.[5] Consult local health authorities for guidance as
Coronavirus disease 2019 (COVID-19)

Diagnosis

Testing priorities will depend on local guidelines and available resources. See our Criteria section for CDC and Infectious Diseases Society of America recommendations on testing priorities.

Perform a nucleic acid amplification test, such as real-time reverse-transcription polymerase chain reaction (RT-PCR), for SARS-CoV-2 in appropriate patients with suspected infection, with confirmation by nucleic acid sequencing when necessary.[133]

- 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 aerosolization 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.[133] 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.[134]

Collect nasopharyngeal swabs for testing to rule out infection with other respiratory pathogens (e.g., influenza, atypical pathogens) according to local guidance. It is important to note that coinfections can occur, and a positive test for a non-COVID-19 pathogen does not rule out COVID-19.[5] [135]

Serologic testing is not available as yet, but assays are in development.[136] Serum samples can be stored to retrospectively define cases when validated serology tests become available. Early data indicate continuous high levels of immunoglobulin M (IgM) during the early/acute phase of infection, with IgM lasting more than 1 month (indicating prolonged virus replication in infected patients). IgG responded later than IgM.[137]

**Chest x-ray**

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

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.[21] [22] [138]

**Computed tomography**

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

The British Society of Thoracic Imaging (BSTI) recommends CT imaging in patients with clinically suspected COVID-19 who are seriously ill if chest x-ray is uncertain or normal. Without the suspicion of COVID-19, the radiology is nonspecific and could represent many other disease processes. The BSTI in
Coronavirus disease 2019 (COVID-19) diagnosis

Collaboration with NHS England have produced a radiology decision support tool to help clinicians decide whether or not chest imaging should be ordered.[139]

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

The American College of Radiology recommends reserving CT for hospitalized, symptomatic patients with specific clinical indications for CT, and emphasizes that a normal chest CT does not mean that a patient does not have COVID-19 and that an abnormal chest CT is not specific for COVID-19 diagnosis.[140]

Abnormal chest CT findings have been reported in up to 97% of COVID-19 patients in one meta-analysis of 50,466 hospitalized patients.[118] Evidence of pneumonia on CT may precede a positive RT-PCR result for SARS-CoV-2 in some patients.[136] CT imaging abnormalities may be present in minimally symptomatic or asymptomatic patients.[48] Some patients may present with a normal chest finding despite a positive RT-PCR.[142] Also, results of RT-PCR testing may be false-negative, so patients with typical CT findings should have repeat RT-PCR testing to confirm the diagnosis.[143]

**Typical features**

- Multiple bilateral lobular and subsegmental areas of ground-glass opacity or consolidation are seen in most patients, usually with a peripheral or posterior distribution, mainly in the lower lobes and less frequently in the right lower lobe. Consolidative opacities superimposed on ground-glass opacity may be found in a smaller number of cases, usually older patients.[21] [121] [144]
- Other classic findings include crazy-paving pattern, air bronchograms, and a reverse halo/perilobular pattern (i.e., organizing pneumonia patterns).[139]
- 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.[145]

**Atypical features**

- Interlobular or septal thickening (smooth or irregular), thickening of the adjacent pleura, and subpleural involvement are atypical features. Some patients may rarely present with pleural effusion, pericardial effusion, bronchiectasis, cavitation, pneumothorax, lymphadenopathy, and round cystic changes. Atypical features appear to be more common in the later stages of disease, or on disease progression.[21] [121] [144]

**Disease progression**

- Abnormalities can rapidly evolve from focal unilateral to diffuse bilateral ground-glass opacities that progress to, or coexist with, consolidations within 1 to 3 weeks.[141]
- 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.[144]

**Children**

- Small nodular ground-glass opacities and consolidation with surrounding halo signs are typical in children.[131] [146]

**Sensitivity of CT**
In a cohort of over 1000 patients in a hyperendemic area in China, chest CT had a higher sensitivity for diagnosis of COVID-19 compared with initial RT-PCR from swab samples (88% versus 59%). Improvement of abnormal CT findings also preceded change from RT-PCR positivity to negativity in this cohort during recovery. The sensitivity of chest CT was 97% in patients who ultimately had positive RT-PCR results. However, in this setting, 75% of patients with negative RT-PCR results also had positive chest CT findings. Of these patients, 48% were considered highly likely cases, while 33% were considered probable cases.[147]

**Lung ultrasound**

There is emerging evidence that lung ultrasound may be a useful aid in the diagnosis of COVID-19. It has the advantages of portability, bedside evaluation, reduced healthcare worker exposure, and repeatability during follow-up. Characteristic ultrasound patterns have been reported in patients with COVID-19 and include B-lines, white lung, pleural line thickening, and consolidations with air bronchograms.[148] [149] [150] [151]

**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.[82]
- [WHO: coronavirus disease (COVID-19) situation dashboard]
- [CDC: locations with confirmed COVID-19 cases, by WHO region]

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.[82]

older age and/or underlying health condition

- People aged 65 years and older, those who live in a nursing home or long-term care facility, and those with a high-risk condition (e.g., chronic respiratory disease, cardiovascular disease, immunocompromised, severe obesity, diabetes, hypertension, renal or liver disease) are at higher risk for severe illness.[83]
- The most prevalent comorbidities in patients with COVID-19 are hypertension, cardiovascular disease, diabetes, smoking, respiratory disease such as COPD, malignancy, and chronic kidney disease.[84] In Italy, the most common comorbidity was obesity.[85]
- 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.[86]

malignancy

- Patients with cancer are thought to be at a higher risk of contracting COVID-19 because treatments such as radiation therapy and chemotherapy are immunosuppressive, and patients with cancer
are often in hospital for treatment and monitoring and so may be at risk of nosocomial infection. A retrospective study of 1524 patients at a single institution in Wuhan City, China, found that the infection rate in patients with cancer was higher than the cumulative incidence of all diagnosed cases reported in the city over the same period of time (i.e., 0.79% versus 0.37%). However, fewer than half of these infected patients were undergoing active treatment, suggesting that recurrent hospital visits and admissions were a potential risk factor.[87]

**Weak smoking**

- Early data on smoking as a risk factor for severe illness appear to be conflicting. Preliminary results from a meta-analysis found that active smoking is not significantly associated with an increased risk of severe disease.[88] However, a systematic review found that smoking is likely associated with negative progression and adverse outcomes.[89] Further research is warranted.

### History & examination factors

#### Key diagnostic factors

**fever (common)**

- Reported in 83% to 98% of patients in case series.[21] [22] [38] [118] [119] [152] In one case series, 44% of patients had a fever on presentation, but it developed in 89% of patients after hospitalization.[117]
- Children may not present with fever, or may have a brief and rapidly resolving fever.[13] [125] [126]
- 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.[21] [22] [38] [117] [118] [119] [152]
- Less common in children.[125]
- Cough is usually dry.

**dyspnea (common)**

- Reported in 18% to 55% of patients in case series.[21] [22] [38] [117] [118] [119] [152]
- Median time from onset of symptoms to development of dyspnea is 5 to 8 days.[21] [22] [38]
- Polypnea has been reported in children with severe illness.[128]

#### Other diagnostic factors

**fatigue (common)**

- Reported in 29% to 69% of patients in case series.[21] [38] [117] [119] [152]
- Patients may also report malaise.

**myalgia (common)**

- Reported in 11% to 44% of patients in case series.[21] [22] [38] [117] [118] [152]
- There is a case report of a patient in Thailand presenting with arthralgia.[153]

**anorexia (common)**
sputum production/expectoration (common)
  • Reported in 26% to 33% of patients in case series.[21] [38] [117] [152]

sore throat (common)
  • Reported in 5% to 17% of patients in case series, and usually presents early in the clinical course.[22] [38] [117] [152]
  • Children may have pharyngeal erythema.[125]

conjunctivitis (uncommon)
  • Ocular manifestations consistent with conjunctivitis (i.e., conjunctival hyperemia, chemosis, epiphora, and increased secretions) have been reported in 32% of patients in one case series. Manifestations are more frequent in patients with severe illness.[154]

confusion (uncommon)
  • Reported in 9% of patients in case series.[22]

dizziness (uncommon)
  • Reported in 9% to 12% of patients in case series.[38] [119]

headache (uncommon)
  • Reported in 6% to 14% of patients in case series.[21] [22] [38] [117] [119] [152]

Gastrointestinal symptoms (uncommon)
  • Nausea, vomiting, abdominal pain, and diarrhea have been reported in 1% to 11% of patients in case series, although this may be underestimated.[21] [22] [38] [117] [119] [152] [155] One case series reported gastrointestinal symptoms in nearly 40% of patients.[156]
  • Some patients may present with predominantly gastrointestinal symptoms, especially children.[129] [130] [157]
  • Patients may present with nausea or diarrhea 1 to 2 days prior to onset of fever and breathing difficulties.[38]
  • Hematochezia has been reported.[158]

hemoptysis (uncommon)
  • Reported in 1% to 5% of patients in case series.[21] [117]

rhinorrhea (uncommon)
  • Reported in 4% to 5% of patients in case series.[22] [117]

chest pain (uncommon)
  • Reported in 2% to 5% of patients in case series.[21] [22]
  • May indicate pneumonia.

anosmia/dysgeusia (uncommon)
  • There is anecdotal evidence that patients with mild illness may develop anosmia/hyposmia or ageusia/ dysgeusia as an early symptom and in the absence of other symptoms. In one small cross-sectional survey in Italy, approximately 53% of hospitalized patients reported at least one taste or olfactory
Coronavirus disease 2019 (COVID-19)  

Diagnosis  

order (or both).[159] It is possible that these patients may be hidden carriers, but further research is required.[160]  

- The American Academy of Otolaryngology - Head and Neck Surgery has proposed adding anosmia and dysgeusia to the list of screening items for potential infection and recommends that clinicians consider testing and self-isolation of these patients (in the absence of other respiratory diseases such as rhinosinusitis or allergic rhinitis).[161]  

**cutaneous manifestations (uncommon)**  

- Cutaneous manifestations (e.g., erythematous rash, petechiae, urticaria, vesicles) have been reported in some patients; however, further data is required to better understand skin involvement.[162] [163]  

**bronchial breath sounds (uncommon)**  

- May indicate pneumonia.  

**tachypnea (uncommon)**  

- May be present in patients with acute respiratory distress.  

**tachycardia (uncommon)**  

- May be present in patients with acute respiratory distress.  

**cyanosis (uncommon)**  

- May be present in patients with acute respiratory distress.  

**crackles/rales on auscultation (uncommon)**  

- May be present in patients with acute respiratory distress.
## Diagnostic tests

### 1st test to order

<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</td>
<td></td>
</tr>
<tr>
<td>severe illness.</td>
<td></td>
</tr>
<tr>
<td>• Recommended in patients</td>
<td></td>
</tr>
<tr>
<td>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</td>
<td></td>
</tr>
<tr>
<td>severe illness as indicated to detect hypercarbia or acidosis.</td>
<td></td>
</tr>
<tr>
<td>• Recommended in patients</td>
<td></td>
</tr>
<tr>
<td>with respiratory distress and cyanosis who have low oxygen saturation (SpO₂ &lt;90%).</td>
<td></td>
</tr>
<tr>
<td>CBC</td>
<td></td>
</tr>
<tr>
<td>• Order in patients with</td>
<td></td>
</tr>
<tr>
<td>severe illness.</td>
<td></td>
</tr>
<tr>
<td>• The most common laboratory abnormalities in patients hospitalized with pneumonia include leukopenia, lymphopenia, and leukocytosis. Other abnormalities include neutrophilia, thrombocytopenia, and decreased hemoglobin.[21] [22] [38] [132]</td>
<td></td>
</tr>
<tr>
<td>• Lymphopenia and thrombocytopenia have been associated with increased risk of severe disease and may be useful as clinical indicators for monitoring disease progression.[164] [165]</td>
<td></td>
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<tr>
<td>coagulation screen</td>
<td>elevated D-dimer; prolonged prothrombin time</td>
</tr>
<tr>
<td>• Order in patients with</td>
<td></td>
</tr>
<tr>
<td>severe illness.</td>
<td></td>
</tr>
<tr>
<td>• The most common abnormalities are elevated D-dimer and prolonged prothrombin time.[21] [22] [38]</td>
<td></td>
</tr>
<tr>
<td>• Nonsurvivors had significantly higher D-dimer levels and longer prothrombin time and activated partial thromboplastin time compared with survivors in one study.[166]</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</td>
<td></td>
</tr>
<tr>
<td>severe illness.</td>
<td></td>
</tr>
<tr>
<td>• The most common laboratory abnormalities in patients hospitalized with pneumonia include elevated liver transaminases. Other abnormalities include decreased albumin and renal impairment.[21] [22]</td>
<td></td>
</tr>
<tr>
<td>• Liver function abnormalities may be more common in patients with COVID-19 compared with other types of pneumonia.[145]</td>
<td></td>
</tr>
<tr>
<td>serum procalcitonin</td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with</td>
<td></td>
</tr>
<tr>
<td>severe illness.</td>
<td></td>
</tr>
<tr>
<td>• May be elevated in patients with secondary bacterial infection.[21] [22] May be more common in children.[131]</td>
<td></td>
</tr>
<tr>
<td>serum C-reactive protein</td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with</td>
<td></td>
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<tr>
<td>severe illness.</td>
<td></td>
</tr>
<tr>
<td>• May be elevated in patients with secondary bacterial infection.[21] [22]</td>
<td></td>
</tr>
<tr>
<td>serum lactate dehydrogenase</td>
<td>may be elevated</td>
</tr>
<tr>
<td>• Order in patients with</td>
<td></td>
</tr>
<tr>
<td>severe illness.</td>
<td></td>
</tr>
<tr>
<td>• Elevated lactate dehydrogenase has been reported in 73% to 76% of patients.[21] [22] May be more common in patients with COVID-19 compared with other types of pneumonia.[145]</td>
<td></td>
</tr>
</tbody>
</table>
### Test

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>serum creatine kinase</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.[21] [22]</td>
<td></td>
</tr>
<tr>
<td>• Indicates muscle or myocardium injury.</td>
<td></td>
</tr>
<tr>
<td>serum troponin level</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.[21]</td>
<td></td>
</tr>
<tr>
<td>blood and sputum cultures</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 epidemiologic history,[5]</td>
<td></td>
</tr>
<tr>
<td>• Specimens should be collected prior to starting empiric antimicrobials if possible.</td>
<td></td>
</tr>
<tr>
<td>real-time reverse transcription polymerase chain reaction (RT-PCR)</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.[133] 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 aerosolization when collecting lower respiratory specimens.[133]</td>
<td></td>
</tr>
<tr>
<td>• There are little data available on the rates of false-positive and false-negative results for the various RT-PCR tests available; however, both have been reported. If a negative result is obtained from a patient with a high index of suspicion for COVID-19, additional specimens should be collected and tested, especially if only upper respiratory tract specimens were collected initially.[133]</td>
<td></td>
</tr>
<tr>
<td>• Many tests are available under the Food and Drug Administration’s emergency-use authorization scheme.[167] A point-of-care test that provides results within hours has been approved and will be available soon.[168] 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 coinfections can occur, and a positive test for a non-COVID-19 pathogen does not rule out COVID-19.[5] [135]</td>
<td></td>
</tr>
<tr>
<td>chest x-ray</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.[21] [22] [138]</td>
<td></td>
</tr>
<tr>
<td>computed tomography (CT) chest</td>
<td>typical features: multiple bilateral lobular and</td>
</tr>
</tbody>
</table>
**Test** | **Result**
--- | ---
- Consider a CT scan of the chest. Consult local guidance on whether to perform a CT scan. | subsegmental areas of ground-glass opacity or consolidation (usually peripheral or posterior, mainly in the lower lobes, less frequently in right lower lobe), crazy-paving pattern, air bronchograms, reverse halo/perilobular pattern; atypical features: interlobular or septal thickening (smooth or irregular), thickening of the adjacent pleura, subpleural involvement, pleural effusion, pericardial effusion, bronchiectasis, cavitation, pneumothorax, lymphadenopathy, round cystic changes
- The British Society of Thoracic Imaging (BSTI) recommends CT imaging in patients with clinically suspected COVID-19 who are seriously ill if chest x-ray is uncertain or normal. [BSTI: radiology decision support tool for suspected COVID-19]. The American College of Radiology recommends reserving CT for hospitalized, symptomatic patients with specific clinical indications for CT, and emphasizes that a normal chest CT does not mean that a patient does not have COVID-19 and that an abnormal chest CT is not specific for COVID-19 diagnosis.[140]
- Abnormal chest CT findings have been reported in up to 97% of hospitalized patients.[118] Evidence of pneumonia on CT may precede a positive RT-PCR result for SARS-CoV-2 in some patients.[136] CT imaging abnormalities may be present in minimally symptomatic or asymptomatic patients.[48] [141] Some patients may present with a normal chest finding despite a positive RT-PCR.[142] Also, results of RT-PCR testing may be false-negative, so patients with typical CT findings should have repeat RT-PCR testing to confirm the diagnosis.[143]
- Atypical features appear to be more common in the later stages of disease, or on disease progression.[21] [121] [144]
- Abnormalities can rapidly evolve from focal unilateral to diffuse bilateral ground-glass opacities that progress to, or coexist with, consolidations within 1 to 3 weeks.[141] 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.[144]
- Small nodular ground-glass opacities and consolidation with surrounding halo signs are typical in children.[131] [146]
- 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.[147]
### Emerging tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>serology</strong></td>
<td>positive for SARS-CoV-2 virus antibodies</td>
</tr>
<tr>
<td>• Serologic testing is not available as yet, but assays are in development.[136] Serum samples can be stored to retrospectively define cases when validated serology tests become available.</td>
<td><img src="image" alt="Image" /></td>
</tr>
<tr>
<td>• Early data indicate continuous high levels of IgM during the acute phase of infection, with IgM lasting more than 1 month (indicating prolonged virus replication in infected patients). IgG responded later than IgM.[137]</td>
<td><img src="image" alt="Image" /></td>
</tr>
<tr>
<td><strong>lung ultrasound</strong></td>
<td>B-lines; white lung; pleural line thickening; consolidations with air bronchograms</td>
</tr>
<tr>
<td>• There is emerging evidence that lung ultrasound may be a useful aid in the diagnosis of COVID-19. It has the advantages of portability, bedside evaluation, reduced healthcare worker exposure, and repeatability during follow-up.[148] [149] [150] [151]</td>
<td><img src="image" alt="Image" /></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.[21]  
• Gastrointestinal symptoms and upper respiratory tract symptoms appear to be less common in COVID-19 based on early data.[21][22] | • 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.[21]  
• Gastrointestinal symptoms and upper respiratory tract symptoms appear to be less common in COVID-19 based on early data.[21][22] | • 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 | • 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>
<tbody>
<tr>
<td><strong>Coronavirus disease 2019 (COVID-19)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>person in the 14 days prior to symptom onset.</td>
<td></td>
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<tr>
<td></td>
<td>• Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms.</td>
<td></td>
</tr>
<tr>
<td><strong>Influenza infection</strong></td>
<td></td>
<td>• RT-PCR: positive for influenza A or B viral RNA.</td>
</tr>
<tr>
<td></td>
<td>• Lack of travel history to mainland China or other affected areas, or close contact with an infected person in the 14 days prior to symptom onset.</td>
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<tr>
<td></td>
<td>• 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.[22]</td>
<td></td>
</tr>
<tr>
<td><strong>Common cold</strong></td>
<td></td>
<td>• RT-PCR: positive for causative organism, or negative for SARS-CoV-2 viral RNA.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
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</tr>
<tr>
<td></td>
<td>• 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.[22]</td>
<td></td>
</tr>
<tr>
<td><strong>Avian influenza A (H7N9) virus infection</strong></td>
<td>• May be difficult to differentiate based on epidemiologic history as avian influenza H7N9 is endemic in China.</td>
<td>• RT-PCR: positive for H7-specific viral RNA.</td>
</tr>
<tr>
<td></td>
<td>• Close contact with infected birds (e.g., farmer or visitor to a live market in endemic areas), or living in an area where avian influenza is endemic.</td>
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<tr>
<td></td>
<td>• Early reports suggest that sore throat is less common in COVID-19.[22]</td>
<td></td>
</tr>
<tr>
<td><strong>Avian influenza A (H5N1) virus infection</strong></td>
<td>• 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.</td>
<td>• RT-PCR: positive for H5N1 viral RNA.</td>
</tr>
</tbody>
</table>
## Diagnosis

<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.\[22\] |                                                                                                                                                      |
| **Other viral or bacterial respiratory infections** |                                                                                                 | Blood or sputum culture of molecular testing: positive for causative organism. |
| 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. |                                                                                                                                                      |
| **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.\[169\]  
- Symptoms of COVID-19 and neutropenic sepsis may be | CBC: neutropenia.                                                                                          |
Coronavirus disease 2019 (COVID-19)

**Diagnosis**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Differentiating signs / symptoms</th>
<th>Differentiating tests</th>
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<tbody>
<tr>
<td></td>
<td>difficult to differentiate at initial presentation.</td>
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</table>

**Diagnostic criteria**

**World Health Organization: case definitions[170]**

**Suspect case**

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

**Probable case**

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

**Confirmed case**

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

**Definition of contact**

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

  *Note: for confirmed asymptomatic cases, the period of contact is measured as the 2 days before through the 14 days after the date on which the sample was taken that led to confirmation.*

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

**Centers for Disease Control and Prevention: criteria to guide evaluation and laboratory testing for COVID-19[171]**
Coronavirus disease 2019 (COVID-19)

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

Priorities for testing

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

- **Priority 2**
  - Patients in long-term care facilities with symptoms
  - Patients 65 years of age and older with symptoms
  - Patients with underlying conditions with symptoms
  - First responders with symptoms

- **Priority 3**
  - Critical infrastructure workers with symptoms
  - Individuals who do not meet any of the above categories with symptoms
  - Healthcare workers and first responders
  - Individuals with mild symptoms in communities experiencing high COVID-19 hospitalizations

- **Nonpriority**
  - Individuals without symptoms

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

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

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

**Infectious Diseases Society of America (IDSA): COVID-19 prioritization of diagnostic testing[172]**

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

**Tier 1**

- Critically ill patients in the intensive care unit with unexplained viral pneumonia or respiratory failure, regardless of travel history or close contact with a suspected or confirmed COVID-19 patient.
- Any person, including healthcare workers, with fever or signs/symptoms of a lower respiratory tract illness and close contact with a laboratory-confirmed COVID-19 patient within 14 days of symptom onset (including all residents of a long-term care facility that has a laboratory-confirmed COVID-19 case).
Coronavirus disease 2019 (COVID-19)

Diagnosis

• Any person, including healthcare workers, with fever or signs/symptoms of a lower respiratory tract illness and a history of travel within 14 days of symptom onset to geographic regions where sustained community transmission has been identified.

• Individuals with fever or signs/symptoms of a lower respiratory tract illness who also are immunosuppressed (including patients with HIV), are older, or have underlying chronic health conditions.

• Individuals with fever or signs/symptoms of a lower respiratory tract illness who are critical to pandemic response including healthcare workers, public health officials, and other essential leaders.

Tier 2

• Hospitalized (non-intensive care unit) patients and long-term care facility residents with unexplained fever and signs/symptoms of a lower respiratory tract illness. The number of confirmed COVID-19 cases in the community should be considered.

• As testing becomes more widely available, routine testing of hospitalized patients may be important for infection prevention and management at discharge.

Tier 3

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

Tier 4

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

[IDSA: COVID-19 prioritization of diagnostic testing]
Coronavirus disease 2019 (COVID-19)

TREATMENT

Step-by-step treatment approach

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

Rationing of medical resources may be required during the pandemic if healthcare infrastructures are overwhelmed. This raises many ethical questions on how to best triage patients to save the most lives. Recommendations have been suggested, but there is no international guidance on this issue as yet.[184] [185] [186]

Infection prevention and control

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

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

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

The WHO recommends that patients should remain in isolation for 2 weeks after symptoms disappear, and visitors should not be allowed until the end of this period.[187] 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.[10] The most common reasons for intensive care unit admission are hypoxemic respiratory failure leading to mechanical ventilation and hypotension.[188] The median time from onset of symptoms to hospital admission is reported to be approximately 7 days.[21] [38]

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.
Coronavirus disease 2019 (COVID-19)

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.[189]

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, hypoxemia, shock, or SpO₂ <90%.[5] 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 nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[5] Some guidelines recommend that SpO₂ should be maintained no higher than 96%.[190]

• 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 empiric antimicrobials to cover other potential bacterial pathogens that may cause respiratory infection, according to local protocols. Give within 1 hour of initial patient assessment for patients with suspected sepsis. Choice of empiric antimicrobials should be based on the clinical diagnosis, and local epidemiology and susceptibility data. Consider treatment with a neuraminidase inhibitor until influenza is ruled out. De-escalate empiric therapy based on microbiology results and clinical judgment.[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] [190] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[191]

• Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[192] 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, extra caution is advised, and NHS UK recommends acetaminophen as the drug of choice until there is more information available.[193] [194] [195] [196]
• Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children <6 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., hemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[5]

Advanced oxygen/ventilatory support

• Follow local infection prevention and control procedures to prevent transmission to healthcare workers, especially when performing aerosol-generating procedures.
• Provide advanced oxygen/ventilatory support 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.
• Consider a trial of high-flow nasal oxygen, or noninvasive ventilation (including continuous positive airway pressure [CPAP]) if high-flow nasal oxygen is not available, in patients with hypoxemic respiratory failure.[5] [190] Monitor patients closely for clinical deterioration that could result in the need for urgent intubation.[5] These procedures may avoid the need for intubation and mechanical ventilation; however, they have a higher risk of aerosol generation.[197] Patients with lower PaO₂/fraction of inspired oxygen (FiO₂) were more likely to experience failure with high-flow nasal oxygen and require ventilation in one study.[198]
• Consider intubation and mechanical ventilation in patients who are acutely deteriorating. Two-thirds of patients who required critical care in the UK had mechanical ventilation within 24 hours of admission.[199] Endotracheal intubation should be performed by an experienced provider using airborne precautions. Young children, or adults who are obese or pregnant, may desaturate quickly during intubation and therefore require preoxygenation with 100% FiO₂ for 5 minutes. 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). A higher positive end-expiratory pressure (PEEP) strategy is preferred over a lower PEEP strategy.[5] [190]
• Consider prone ventilation in patients with persistent severe hypoxic failure.[5] [190] Pregnant women may benefit from being placed in the lateral decubitus position.[5] A small cohort study of 12 patients in Wuhan City, China, with COVID-19-related acute respiratory distress syndrome suggests that spending periods of time in the prone position may improve lung recruitability.[200]
• A trial of an inhaled pulmonary vasodilator may be considered in adults who have severe acute respiratory distress syndrome and hypoxemia despite optimizing ventilation. Lung recruitment maneuvers are suggested, but staircase recruitment maneuvers are not recommended.[190]
• Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise.[5] [190] [201]
• The risk of treatment failure is high in patients with nonacutely reversible conditions, and there is also concern about nosocomial transmission with open ventilation systems and suboptimal noninvasive face mask or nasal pillow seals. More research to define the balance of benefits and risks to patients and health workers is needed.
• [Surviving Sepsis Campaign: summary of recommendations on the management of patients with COVID-19 and ARDS]
• [Surviving Sepsis Campaign: summary of recommendations on the initial management of hypoxic COVID-19 patients]

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.[21] [202]
• The WHO (as well as other international pneumonia guidelines) does not routinely recommend systemic corticosteroids for the treatment of viral pneumonia or acute respiratory distress syndrome unless they are indicated for another reason.[5] However, Surviving Sepsis Campaign guidelines on the treatment of critically ill patients with COVID-19 suggest that adults with acute respiratory distress syndrome who are receiving mechanical ventilation should receive corticosteroids, although this recommendation is based on weak evidence.[190]
• A randomized controlled trial investigating the use of corticosteroids in patients with COVID-19 is in progress.[203]

Mild COVID-19 with risk factors

Patients with mild illness who have risk factors for poor outcomes (i.e., age >60 years, presence of comorbidities) should also be prioritized for hospital admission.[173] These patients should be managed in the same way as severe COVID-19 (above) depending on the clinical presentation.

Mild COVID-19 without risk factors

All laboratory-confirmed cases, regardless of severity, should be managed in a healthcare facility where possible. In situations where this is not possible, patients with mild illness and no risk factors (i.e., age >60 years, presence of comorbidities) can be isolated in nontraditional facilities (e.g., repurposed hotels or stadiums) or at home. This will depend on guidance from local health authorities and available resources. Forced quarantine orders are being used in some countries.[173]

Home care can be considered when the patient can be cared for by family members and follow-up with a healthcare provider or public health personnel is possible. The decision requires careful clinical judgment and should be informed by an assessment of the patient’s home environment.[173]

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

• [WHO: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts]
• [CDC: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19)]
Recommend symptomatic therapies 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.[173] 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 physiologic changes that occur with pregnancy.[5] [204]

**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.[205]
- Isolate and monitor asymptomatic pregnant women with confirmed infection at home, if appropriate, with ultrasound fetal surveillance every 2 weeks.[205]

**Delivery**

- Choice of delivery and timing should be individualized based on gestational age, as well as maternal, fetal, and delivery conditions. Induction of labor and vaginal delivery is preferred in pregnant women with confirmed COVID-19 infection to avoid unnecessary surgical complications; however, an emergency cesarean delivery may be required if medically justified (e.g., in patients with complications such as sepsis or if there is fetal distress).[5] [205]
- 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] [205] [206]

**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 caregiver.[207] Consult local guidelines for specific recommendations.

Management of comorbidities

Data on the management of comorbidities in patients with COVID-19 is limited.[208] 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

- There is insufficient clinical or scientific evidence to determine how to manage hypertension in patients with COVID-19. There have been advocates for both the use and cessation of ACE inhibitors or angiotensin-II receptor antagonists in patients with hypertension due to theoretical concerns of increased expression of ACE2 in these patients.[209] [210] However, 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 ischemic 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. In patients with cardiovascular disease who are diagnosed with COVID-19, individualized treatment decisions should be made according to the hemodynamic status and clinical presentation of each patient.[211] [212] [213] [214] The European Medicines Agency agrees with these recommendations.[215] A small retrospective study of patients with COVID-19 and hypertension in China found that ACE inhibitors/angiotensin-II receptor antagonists may attenuate the inflammatory response in patients with severe illness and improve clinical outcomes; however, further research is required.[216]

- [Centre for Evidence-Based Medicine: angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers in COVID-19]

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.[217]

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.[169] Guidelines are also available for patients undergoing radiation therapy or hematopoietic stem cell transplantation.[218] [219]

Chronic kidney disease

- The impact of COVID-19 on chronic kidney disease has not been reported as yet; however, there are challenges for patients with suspected or confirmed COVID-19 infection who are on dialysis.
Guidelines for patients on dialysis and for dialysis units have been developed.[220] [221] [222] [223] [224]

Inflammatory bowel disease

- There is a lack of data about COVID-19 in patients with inflammatory bowel disease; however, guidelines have been developed. Patients who are already on treatment should continue their current drug regimen if their disease is stable, and contact their healthcare provider to discuss suitable options during disease flares.[225] [226] [227]
- It has been suggested that patients should be screened for SARS-CoV-2 infection before starting therapy with corticosteroids (for flares) or biologics.[228] [229]

**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>
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<tr>
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<th>( summary )</th>
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<tr>
<td>1st</td>
<td>isolation and infection prevention and control procedures</td>
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<td>plus</td>
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<td>plus</td>
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<td>adjunct</td>
<td>supportive care</td>
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<td>adjunct</td>
<td>antipyretic/analgesic</td>
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<td>Acute confirmed COVID-19</td>
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<tr>
<td>1st hospital admission</td>
<td>- severe illness; mild illness with risk factors</td>
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<tr>
<td>plus infection prevention and control procedures</td>
<td>adjunct supportive care</td>
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<tr>
<td>plus assess adults for frailty</td>
<td>adjunct empiric antimicrobials</td>
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<td>- mild illness with no risk factors</td>
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TREATMENT

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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.
<table>
<thead>
<tr>
<th>Initial suspected COVID-19</th>
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### 1st isolation and infection prevention and control procedures

- Immediately isolate all suspected cases in an area separate from other patients, and implement appropriate infection prevention and control procedures. Suspected cases should be given a mask and kept at least 3 feet (1 meter) from other suspected cases. It is important to note that recommended distances differ between countries and you should consult local guidance. 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](http://www.who.int)
  - [CDC: interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings](http://www.cdc.gov)

- 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] [205]

### plus empiric antimicrobials

Treatment recommended for ALL patients in selected patient group

- Start empiric antimicrobials to cover other potential bacterial pathogens that may cause respiratory infection according to local protocols. Give within 1 hour of initial patient assessment for patients with suspected sepsis. Choice of empiric antimicrobials should be based on the clinical diagnosis, and local epidemiology and susceptibility data.[5]

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

  - De-escalate empiric therapy based on microbiology results and clinical judgment.

### plus monitoring

Treatment recommended for ALL patients in selected patient group
**Initial**

» Monitor patients closely for signs of clinical deterioration, such as rapidly progressive respiratory failure and sepsis, and immediately start general supportive care interventions as indicated (e.g., hemodialysis, vasopressor therapy, fluid resuscitation, ventilation, antimicrobials) as appropriate.[5]

**adjunct supportive care**

Treatment recommended for SOME patients in selected patient group

» Immediately 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, hypoxemia, shock, or SpO₂ <90%.[5] [190] Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation. Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition. Once the patient is stable, the target SpO₂ is >90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[5] Some guidelines recommend that SpO₂ should be maintained no higher than 96%.[190]

» 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]

**adjunct antipyretic/analgesic**

Treatment recommended for SOME patients in selected patient group

**Primary options**

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

OR

» ibuprofen: children 6 months to 11 years of age: 5-10 mg/kg orally every 6-8 hours when required, maximum 40 mg/kg/day; children ≥12 years of age and adults: 200-400 mg orally every 4-6 hours when required, maximum 2400 mg/day
<table>
<thead>
<tr>
<th>Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Guidelines recommend an antipyretic/analgesic for the relief of fever and pain.[5] [190] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[191]</td>
</tr>
<tr>
<td>» Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[192] 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, extra caution is advised, and NHS UK recommends acetaminophen as the drug of choice until there is more information available.[193] [194] [195] [196]</td>
</tr>
<tr>
<td>» Ibuprofen is not recommended in pregnant women (especially in the third trimester) or children &lt;6 months of age (age cut-offs vary by country).</td>
</tr>
</tbody>
</table>
Coronavirus disease 2019 (COVID-19)

TREATMENT

Acute confirmed COVID-19

- severe illness; mild illness with risk factors

1st hospital admission

- Promptly admit patients with pneumonia or acute respiratory distress to an appropriate healthcare facility. Patients with impending or established respiratory failure should be admitted to an intensive care unit. [5]

- Patients with mild illness who have risk factors for poor outcomes (i.e., age >60 years, presence of comorbidities) should also be prioritized for hospital admission when possible. [173]

- 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. [205] 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] [205]

plus infection prevention and control procedures

Treatment recommended for ALL patients in selected patient group

- Immediately isolate all confirmed cases in an area separate from other patients, and implement appropriate infection prevention and control procedures. Detailed guidance is available from the WHO and the CDC:

  - [WHO: infection prevention and control during health care when COVID-19 is suspected]

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

- COVID-19 is a notifiable disease; report all confirmed cases to your local health authorities.

- The WHO recommends that patients should remain in isolation for 2 weeks after symptoms disappear, and visitors should not be allowed until the end of this period. [187] Guidance on when to stop isolation depends on local circumstances and may differ between countries; consult local guidelines.

plus assess adults for frailty
### Acute

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

- 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.[189](#) |

### plus monitoring

<table>
<thead>
<tr>
<th>Treatment recommended for ALL patients in selected patient group</th>
</tr>
</thead>
</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., hemodialysis, 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>
</tr>
</thead>
</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, hypoxemia, shock, or SpO₂ <90%. [5] [190](#) Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation. Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition. Once the patient is stable, the target SpO₂ is >90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[5](#) Some guidelines recommend that SpO₂ should be maintained no higher than 96%. [190](#) |
- 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 empiric antimicrobials
### Acute

**Treatment recommended for SOME patients in selected patient group**

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

**Adjunct antipyretic/analgesic**

Treatment recommended for SOME patients in selected patient group

**Primary options**

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

OR

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

» Guidelines recommend an antipyretic/analgesic for the relief of fever and pain.\[5\]\[190\] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.\[191\]

» Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.\[192\] 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, extra caution is advised, and NHS UK recommends acetaminophen as the drug of choice until there is more information available.\[193\] \[194\] \[195\] \[196\]

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

**Adjunct advanced oxygen/ventilatory support**

Treatment recommended for SOME patients in selected patient group
Provide advanced oxygen/ventilatory support in patients who are deteriorating and failing to respond to standard oxygen therapy. Follow local infection prevention and control procedures to prevent transmission to healthcare workers, especially when performing aerosol-generating procedures.

Consider a trial of high-flow nasal oxygen, or noninvasive ventilation (including continuous positive airway pressure [CPAP]) if high-flow nasal oxygen is not available, in patients with hypoxemic respiratory failure. 

Monitor patients closely for clinical deterioration that could result in the need for urgent intubation. These procedures may avoid the need for intubation and mechanical ventilation; however, they have a higher risk of aerosol generation. Patients with lower PaO₂/fraction of inspired oxygen (FiO₂) were more likely to experience failure with high-flow nasal oxygen and require ventilation in one study.

Consider intubation and mechanical ventilation in patients who are acutely deteriorating. Endotracheal intubation should be performed by an experienced provider using airborne precautions. Young children, or adults who are obese or pregnant, may desaturate quickly during intubation and therefore require preoxygenation with 100% FiO₂ for 5 minutes. 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). A higher positive end-expiratory pressure (PEEP) strategy is preferred over a lower PEEP strategy.

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

A trial of an inhaled pulmonary vasodilator may be considered in adults who have severe acute respiratory distress syndrome and hypoxemia despite optimizing ventilation. Lung recruitment maneuvers are suggested, but staircase recruitment maneuvers are not recommended.
<table>
<thead>
<tr>
<th>Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>« Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise.[5] [190]</td>
</tr>
<tr>
<td>« The risk of treatment failure is high in patients with nonacutely reversible conditions, and there is also concern about nosocomial transmission with open ventilation systems and suboptimal noninvasive face mask or nasal pillow seals. More research to define the balance of benefits and risks to patients and health workers is needed.</td>
</tr>
<tr>
<td>« [Surviving Sepsis Campaign: summary of recommendations on the management of patients with COVID-19 and ARDS]</td>
</tr>
<tr>
<td>« [Surviving Sepsis Campaign: summary of recommendations on the initial management of hypoxic COVID-19 patients]</td>
</tr>
</tbody>
</table>

**adjunct**

**tailor management 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: there is insufficient clinical or scientific evidence to determine how to manage hypertension in patients with COVID-19. There have been advocates for both the use and cessation of ACE inhibitors or angiotensin-II receptor antagonists in patients with hypertension due to theoretical concerns of increased expression of ACE2 in these patients.[209] [210] However, 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 ischemic 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. In patients with cardiovascular disease who are diagnosed with COVID-19, individualized treatment decisions should be made according to the hemodynamic status and clinical presentation of each patient.[211] [212] [213] [214] The European Medicines Agency agrees with these recommendations.[215] A small retrospective study of patients with
COVID-19 and hypertension in China found that ACE inhibitors/angiotensin-II receptor antagonists may attenuate the inflammatory response in patients with severe illness and improve clinical outcomes; however, further research is required.[216] [Centre for Evidence-Based Medicine: angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers in COVID-19]

» 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.[217]

» 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.[169] Guidelines are also available for patients undergoing radiation therapy or hematopoietic stem cell transplantation.[218] [219]

» Chronic kidney disease: the impact of COVID-19 on chronic kidney disease has not been reported as yet; however, there are challenges for patients with suspected or confirmed COVID-19 infection who are on dialysis. Guidelines for patients on dialysis and for dialysis units have been developed.[220] [221] [222] [223] [224]

» Inflammatory bowel disease: there is a lack of data about COVID-19 in patients with inflammatory bowel disease; however, guidelines have been developed. Patients who are already on treatment should continue their current drug regimen if their disease is stable, and contact their healthcare provider to discuss suitable options during disease flares.[225] [226] [227] It has been suggested that patients should be screened for SARS-CoV-2 infection before starting therapy with corticosteroids (for flares) or biologics.[228] [229]

adjunct experimental therapies

Treatment recommended for SOME patients in selected patient group
Coronavirus disease 2019 (COVID-19)

Treatment

### Acute

<table>
<thead>
<tr>
<th>mild illness with no risk factors</th>
<th>1st isolation in nontraditional facility or at home</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

Patients with mild illness and no risk factors (i.e., age >60 years, presence of comorbidities) can be isolated in nontraditional facilities (e.g., repurposed hotels or stadiums) or at home when management in a healthcare facility is not possible. This will depend on guidance from local health authorities and available resources.[173] Forced quarantine orders are being used in some countries.

Home care can be considered when the patient can be cared for by family members and follow-up with a healthcare provider or public health personnel is possible. The decision requires careful clinical judgment and should be informed by an assessment of the patient’s home environment.[173]

Asymptomatic pregnant women with confirmed infection can be managed at home, if appropriate.[205]

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)]

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

**plus monitoring**

Treatment recommended for ALL patients in selected patient group
### Acute

- 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.[205]

**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.[173]

**adjunct** antipyretic/analgesic

Treatment recommended for **SOME** patients in selected patient group

**Primary options**

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

**OR**

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

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

Introduction

No treatments have been approved or shown to be safe and effective for the treatment of COVID-19. However, there are several treatments being used off-label (use of a licensed medication for an indication that has not been approved by a national drug regulatory authority), on a compassionate-use basis, or as part of a randomized controlled trial.[230] It is important to note that there may be serious adverse effects associated with these drugs, and that these adverse effects may overlap with the clinical manifestations of COVID-19. These drugs may also increase the risk of death in an older patient or a patient with an underlying health condition. For example, chloroquine/hydroxychloroquine, azithromycin, and lopinavir/ritonavir are all potentially associated with an increased risk of cardiac death.[231] The World Health Organization and its partners have launched the Solidarity trial, a large international study to compare different treatments and ensure clear evidence of which treatments are most effective. The study will have five arms: standard of care; remdesivir; lopinavir/ritonavir; lopinavir/ritonavir plus interferon beta; and chloroquine.[232] [WHO: off-label use of medicines for COVID-19]

Chloroquine and hydroxychloroquine

Chloroquine and hydroxychloroquine are oral drugs that have been used for the prophylaxis and treatment of malaria, and the treatment of certain autoimmune conditions such as rheumatoid arthritis and systemic lupus erythematosus. Both drugs have in vitro activity against SARS-CoV-2, with hydroxychloroquine having relatively higher potency.[233] [234] They are being trialed in patients for the treatment of mild to severe COVID-19.[235] [236] [237] They are also being trialed for prevention and post-exposure prophylaxis in the healthcare setting.[238] [239] Initial data is promising, but is currently limited. A small randomized controlled trial found that hydroxychloroquine (with or without azithromycin) was efficient in reducing viral nasopharyngeal carriage of SARS-CoV-2 in 3 to 6 days in most patients.[240] However, this trial has been criticized for its limitations.[241] Another trial in 62 patients in China found that hydroxychloroquine may shorten time to clinical recovery (in terms of resolution of fever and cough, and improvement of pneumonia on computed tomographic imaging); however, this study has not been peer reviewed as yet.[242] Guidelines in China and Italy recommend these drugs for the treatment of COVID-19; however, this is based on weak evidence.[243] Hydroxychloroquine has similar therapeutic effects to chloroquine, but fewer adverse effects, is considered safe in pregnancy, and is more readily available in some countries.[244] The European Medicines Agency has stressed that these drugs have not been shown to be effective in treating COVID-19 as yet, and should only be used in the context of clinical trials or emergency-use programs.[245] The Food and Drug Administration (FDA) has granted an emergency-use authorization for chloroquine and hydroxychloroquine to treat patients when a clinical trial is not available or participation is not feasible.[246] [Centre for Evidence-Based Medicine: chloroquine and hydroxychloroquine - current evidence for their effectiveness in treating COVID-19]

Remdesivir (GS-5734®)

A novel, investigational, intravenous nucleoside analog with broad antiviral activity that shows in vitro activity against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Clinical trials with remdesivir have started in patients with mild to severe COVID-19.[233] [247] [248] [249] [250] [251] [252] It has been used on a compassionate-use basis in areas where clinical trials are not available; however, the manufacturer has paused access to the drug via this route due to overwhelming demand while they transition to an expanded access program. Exceptions will be made for patients with severe illness, and pregnant women and children with confirmed infection.[253] It appears to be safe to use in pregnancy.[204]

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.[254] A randomized controlled trial of approximately 200 patients in China found that treatment with lopinavir/ritonavir was not beneficial compared with standard care alone (primary outcome was time to improvement) in hospitalized patients with severe COVID-19.[255] It is considered safe in pregnancy.[204]
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.[256] Clinical trials to determine the safety and efficacy of convalescent plasma that contains antibodies to SARS-CoV-2 in patients with COVID-19 have started.[257] A small preliminary case series of five critically ill patients reported clinical improvement after treatment with convalescent plasma; however, this study had many limitations.[258] The FDA is also facilitating access to COVID-19 convalescent plasma for use in patients with serious or immediately life-threatening COVID-19 infections through the process of single patient emergency investigational new drug applications.[259]

Stem cell therapy

Stem cell therapy is being investigated to treat patients with COVID-19 in clinical trials. It is thought that mesenchymal stem cells can reduce the pathologic changes that occur in the lungs, and inhibit the cell-mediated immune inflammatory response.[260]

Intravenous immune globulin

Intravenous immune globulin is being trialed in some patients with COVID-19; however, there are no data to support this.[22] [261]

Tocilizumab

An interleukin-6 receptor inhibiting monoclonal antibody that is currently approved for rheumatologic conditions (e.g., rheumatoid arthritis, juvenile idiopathic arthritis) and cytokine release syndrome. Tocilizumab is being trialed in patients with severe COVID-19 to see whether it is effective in reducing the virus-induced cytokine storm, thereby potentially reducing complications.[262] [263] [264] [265] However, the decision to suppress the immune system of a critically unwell patient with COVID-19 is a difficult one; the beneficial anti-inflammatory effects of tocilizumab (or any other anti-inflammatory drug) must be weighed against the possibly detrimental effects of impairment of immunity.[266]

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.[267] [268] [269]

Other treatments

Other drugs that may show promise for the treatment of COVID-19 include teicoplanin, camostat mesylate, Janus kinase inhibitors (such as fedratinib), sarilumab, gimsilumab, and leronlimab.[270] [271] [272] [273] [274] [275] 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).[276] [277] [278] [279] [280] [281] [282] [283] [284] Healthcare workers in Australia are trialing the Bacille Calmette-Guerin (BCG) vaccine.[285]

Traditional Chinese medicine

Traditional Chinese medicine is being used in patients with COVID-19 in China according to local guidelines and as part of clinical trials.[286]
**Recommendations**

**Monitoring**

Monitor vital signs (i.e., temperature, respiratory rate, heart rate, blood pressure, oxygen saturation) and perform hematology and biochemistry laboratory testing and ECG as clinically indicated during admission. Utilize medical early warning scores that facilitate early recognition and escalation of treatment of deteriorating patients (e.g., National Early Warning Score 2 [NEWS2]) where possible.[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.[205]

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 sanitizer and avoid touching the eyes, nose, and mouth with unwashed hands.

- Avoid close contact with people (i.e., maintain a distance of at least 3 feet [1 meter]), particularly those who are sick. It is important to note that recommended distances differ between countries (for example, 6 feet [2 meters] is recommended in the US and UK) and you should consult local guidance.

- 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.[90] [91]

- [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 traveling abroad should come home immediately if they are able to. Some countries are restricting entry to foreign nationals who have been to affected areas in the preceding 14 days, or are enforcing 14-day quarantine periods where the person’s health should be closely monitored (e.g., twice-daily temperature readings).

- Consult local guidance for specific travel restriction recommendations in your country:

  - [WHO: coronavirus disease (COVID-19) travel advice]
  - [CDC: coronavirus disease 2019 (COVID-19) – travel]
  - [NaTHNac: travel health pro]
  - [Public Health England: travel advice - coronavirus (COVID-19)]
  - [Smartraveller Australia: coronavirus (COVID-19) - travel advice]
  - [Government of Canada: coronavirus disease (COVID-19) - travel advice]
  - [Ministry of Manpower Singapore: advisories on COVID-19]

**Pets**

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Follow up

- 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.[353] [354]
- [CDC: coronavirus disease 2019 (COVID-19) - if you have animals]

Resources

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

<table>
<thead>
<tr>
<th>Complications</th>
<th>Timeframe</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>acute respiratory distress syndrome (ARDS)</td>
<td>short term</td>
<td>medium</td>
</tr>
<tr>
<td>Reported in 15% to 33% of patients in case series. [21] [22] [38] [118] [152]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children can quickly progress to ARDS. [16]</td>
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<tr>
<td>There is anecdotal evidence from Italy that patients may have an atypical presentation, showing a dissociation between well-preserved lung mechanics and the severity of hypoxemia. [331]</td>
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</tr>
<tr>
<td>Factors that increase the risk of developing ARDS and death include older age, neutrophilia, elevated lactate dehydrogenase levels, and elevated D-dimer levels. [332]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>acute liver injury</td>
<td>short term</td>
<td>medium</td>
</tr>
<tr>
<td>Reported in 14% to 53% of patients in case series. Occurs more commonly in patients with severe disease. [333] Although data support a higher prevalence of abnormal aminotransferase levels in patients with severe illness, evidence suggests that clinically significant liver injury is uncommon. [334]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cardiovascular complications</td>
<td>short term</td>
<td>low</td>
</tr>
<tr>
<td>COVID-19 is associated with a high inflammatory burden that can cause vascular inflammation, cardiac arrhythmias, and myocarditis. [335]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute cardiac injury has been reported in 7% to 20% of patients in case series, and indicated by elevated cardiac biomarkers. [21] [38] [152] [336] Prevalence is high among patients who are severely or critically ill, and these patients have a higher rate of in-hospital mortality. Patients with cardiac injury were more likely to require noninvasive or invasive ventilation compared with patients without cardiac injury. [336] [337] [338] Patients with underlying cardiovascular disease but without myocardial injury have a relatively favorable prognosis. [339]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generally presents in two ways: acute myocardial injury and dysfunction on presentation; and myocardial injury that develops as the severity of illness worsens. [338]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fulminant myocarditis has been reported. [322] Early corticosteroid therapy and immune globulin may be beneficial in these patients. [340]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiomyopathy has been reported in 33% of critically ill patients. It is unknown whether it is a direct cardiac complication of COVID-19 or due to overwhelming clinical illness. [320]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myopericarditis with systolic dysfunction has been reported in a patient without signs/symptoms of pneumonia 1 week after the resolution of upper respiratory tract symptoms, highlighting the need for strict monitoring of patients with a history of cardiovascular disease. [341]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A case of cardiac tamponade has been reported in a patient with a previous history of myopericarditis. [342]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection may have longer-term implications for overall cardiovascular health; however, further research is required. [343]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>secondary infection</td>
<td>short term</td>
<td>low</td>
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<tr>
<td>Reported in 6% to 10% of patients in case series. [21] [152]</td>
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<tr>
<td>acute respiratory failure</td>
<td>short term</td>
<td>low</td>
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</table>
## Complications

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<tr>
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<th>Timeframe</th>
<th>Likelihood</th>
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<tbody>
<tr>
<td><strong>FOLLOW UP</strong></td>
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<tr>
<td><strong>Complications</strong></td>
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<tr>
<td>Reported in 8% of patients in case series.[22]</td>
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<tr>
<td>Leading cause of mortality in patients with COVID-19.[322]</td>
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<tr>
<td>Children can quickly progress to respiratory failure.[16]</td>
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</tr>
<tr>
<td><strong>acute kidney injury</strong></td>
<td>short term</td>
<td>low</td>
</tr>
<tr>
<td>Reported in 3% to 8% of patients in case series.[21] [22] [152] However, a retrospective study of 116 hospitalized patients in Wuhan found that the few patients who had elevated blood urea nitrogen, serum creatinine, or albuminuria did not meet the diagnostic criteria for acute kidney injury.[344]</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.[21] [22] [38] [152] Guidelines for the management of shock in critically ill patients with COVID-19 recommend a conservative fluid strategy (crystalloids preferred over colloids) and a vasoactive agent. Norepinephrine (noradrenaline) is the preferred first-line agent, with vasopressin or epinephrine (adrenaline) considered suitable alternatives. Vasopressin can be added to norepinephrine if target mean arterial pressure cannot be achieved with norepinephrine alone.[190]</td>
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<tr>
<td><strong>cytokine release syndrome</strong></td>
<td>short term</td>
<td>low</td>
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<tr>
<td>Elevated serum proinflammatory cytokines (e.g., tumor necrosis factor alpha, interleukin-2, interleukin-6, interleukin-8, interleukin-10, granulocyte-colony stimulating factor, monocyte chemoattractant protein 1) and inflammatory markers (e.g., C-reactive protein, serum ferritin) have been commonly reported in patients with severe COVID-19. This likely represents a type of virus-induced secondary hemophagocytic lymphohistiocytosis, which may be fatal.[21] [323] [345] [346] One study found that patients who require admission to the intensive care unit have significantly higher levels of interleukin-6, interleukin-10, and tumor necrosis factor alpha, and fewer CD4+ and CD8+ T cells.[347] Anti-inflammatory/immunosuppressive treatments (e.g., tocilizumab, hydroxychloroquine/chloroquine, Janus kinase inhibitors) are being trialed in COVID-19 patients.[348] See our Emerging section for more information.</td>
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<tr>
<td><strong>disseminated intravascular coagulation</strong></td>
<td>short term</td>
<td>low</td>
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<tr>
<td>Reported in 71% of nonsurvivors.[166]</td>
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<tr>
<td>Anticoagulant therapy with a low molecular weight heparin or unfractionated heparin has been associated with a better prognosis in patients with severe COVID-19 who have a sepsis-induced coagulopathy (SIC) score of ≥4 or a markedly elevated D-dimer level.[349]</td>
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<tr>
<td><strong>pregnancy-related complications</strong></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 labor, respiratory distress, thrombocytopenia, and abnormal liver function have been reported; however, it is unclear whether these effects are related to maternal SARS-CoV-2 infection. No maternal deaths have been reported so far, but miscarriage (2%), intrauterine growth restriction (10%), and preterm birth (39%) have been reported. It is unclear whether this is related</td>
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Complications

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<tr>
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<td>COVID-19</td>
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There is one published case of stillbirth in a woman with severe COVID-19 at 34 weeks’ gestation.[351]

rhabdomyolysis

short term

low

Reported as a late complication in one case report.[352]

Prognosis

Case fatality rate

The overall global case fatality rate is approximately 5% based on World Health Organization data as of 1 April 2020. Current case fatality rates vary between countries, for example:[312]

- Italy - 11.7%
- Spain - 8.7%
- Iran - 6.5%
- UK - 7.1%
- US - 1.7%
- Germany - 1%
- Australia - 0.4%.

The overall case fatality rate in China has been estimated to be 2.3% (0.9% in patients without comorbidities) based on a large case series of 72,314 reported cases from 31 December 2019 to 11 February 2020 (mainly among hospitalized patients).[10] However, another study estimates the case fatality rate in China to be lower at 1.38% (after adjusting the crude estimate for censoring, demography, and under-ascertainment).[313]

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).[314] The case fatality rate among people on board the Diamond Princess cruise ship, a unique situation where a more accurate assessment of the case fatality rate in a quarantined population can be made, was 0.99%. However, it should be noted that the rate in a younger, healthier population could be lower.[315]

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.[316] 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. The way COVID-19 related deaths are identified and reported in Italy may have also resulted in an overestimation of cases.[314] [317]

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%).[21] Despite the lower case fatality rate, COVID-19 has so far resulted in more deaths than both SARS and MERS combined.[318]
Case fatality rate according to age and presence of comorbidities

The case fatality rate increases with age.[313] The presence of comorbidities is associated with greater disease severity and poor clinical outcomes, and the risk increases with the number of comorbidities a patient has.[319]

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).[10] Another study found the case fatality rate in China to be 6.4% in patients aged ≥60 years versus 0.32% in patients aged <60 years, and 13.4% in patients aged ≥80 years.[313]

In Italy, the case fatality rate was 8.5% in patients aged 60 to 69 years, 35.5% in patients aged 70 to 79 years, and 52.5% in patients aged ≥80 years.[85]

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.[11] The case fatality rate among critically ill patients admitted to the intensive care unit reached 67% in one hospital in Washington state. Most of these patients had underlying health conditions, with congestive heart failure and chronic kidney disease being the most common.[320] The case fatality rate in residents in a long-term care facility in Washington was reported to be 34%.[321]

Children have a better prognosis than adults, and deaths have been extremely rare (2 deaths have been identified in children up until 18 March 2020).[12]

Causes of death

The leading cause of death in patients with COVID-19 is respiratory failure from acute respiratory distress syndrome.[322]

In one retrospective study of 113 deceased patients, older age, male sex, presence of chronic hypertension or other cardiovascular comorbidities (as well as indicators of cardiac injury), symptoms related to hypoxemia, and multi-organ dysfunction were more frequent in deceased patients compared with those who recovered.[323] Other characteristics found to be more frequent in deceased patients include leukocytosis, lymphopenia, and elevated C-reactive protein level, and presence of complications.[324]

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. Nonsurvivors were more likely to develop acute respiratory distress syndrome and require mechanical ventilation. Nonsurvivors were older (>65 years of age) and more likely to have chronic medical illnesses.[325]

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.[326]

Thrombocytopenia has been associated with increased risk of severe disease and mortality and may be useful as a clinical indicator for monitoring disease progression.[164]

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 nonsurvivors.[78]
Refractory disease
Refractory disease (patients who do not reach obvious clinical and radiologic remission within 10 days after hospitalization) has been reported in nearly 50% of hospitalized patients in one retrospective single-center study of 155 patients in China. Risk factors for refractory disease include older age, male sex, and the presence of comorbidities. These patients generally require longer hospital stays as their recovery is slower.[327]

Infectivity of recovered cases
Potential infectivity of recovered cases is still unclear. There have been case reports of patients testing positive again after being discharged (i.e., after symptom resolution and two consecutive negative test results two days apart). This suggests that some patients in convalescence may still be contagious, although this is yet to be confirmed.[328][329]

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 nonreactivated patients. Further research is required on these patients.[330]
## Diagnostic guidelines

### International

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<th>COVID-19 [181]</th>
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<tr>
<td><strong>Published by:</strong> European Centre for Disease Prevention and Control</td>
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<th>A rapid advice guideline for the diagnosis and treatment of 2019 novel coronavirus (2019-nCoV) infected pneumonia [182]</th>
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International

Diagnosis and clinical management of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection [183]

Published by: Peking Union Medical College Hospital

Last published: 2020
# Treatment guidelines

## International

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<td>Information for clinicians on therapeutic options for COVID-19 patients [289]</td>
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<td>Centers for Disease Control and Prevention</td>
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<td>Discontinuation of in-home isolation for immunocompromised persons with COVID-19 (interim guidance) [291]</td>
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<td>Discontinuation of home isolation for persons with COVID-19 (interim guidance) [292]</td>
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<td>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) [293]</td>
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<tr>
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**Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected** [5]

*Published by:* World Health Organization  
*Last published:* 2020

**Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts** [173]

*Published by:* World Health Organization  
*Last published:* 2020

**Advice on the use of masks in the community, during home care, and in health care settings in the context of COVID-19** [93]

*Published by:* World Health Organization  
*Last published:* 2020

**Surviving Sepsis Campaign: guidelines on the management of critically ill adults with coronavirus disease 2019 (COVID-19)** [190]

*Published by:* Surviving Sepsis Campaign  
*Last published:* 2020

**ISUOG interim guidance on 2019 novel coronavirus infection during pregnancy and puerperium: information for healthcare professionals** [296]

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*Last published:* 2020

**COVID-19 rapid guideline: critical care in adults** [189]

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

**Coronavirus (COVID-19): rapid guidelines and evidence reviews** [297]

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

**COVID-19: guidance for health professionals** [298]

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

**Coronavirus (covid-19): latest news and resources** [299]

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

**COVID-19** [181]

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

**Coronavirus (COVID-19) infection in pregnancy** [300]

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*Last published:* 2020

**Guideline for the treatment of people with COVID-19 disease** [301]

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

**Recommendations for COVID-19 clinical management** [302]

*Published by:* National Institute for the Infectious Diseases (Italy)  
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<td>Spanish Paediatric Association</td>
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<tr>
<td>Handbook of COVID-19 prevention and treatment</td>
<td>First Affiliated Hospital, Zhejiang University School of Medicine</td>
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<tr>
<td>A rapid advice guideline for the diagnosis and treatment of 2019 novel coronavirus (2019-nCoV) infected pneumonia</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>Diagnosis and treatment protocol for novel coronavirus pneumonia (trial version 7)</td>
<td>National Health Commission of the People's Republic of China; National Administration of Traditional Chinese Medicine of the People's Republic of China</td>
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<td>Diagnosis and clinical management of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection</td>
<td>Peking Union Medical College Hospital</td>
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<td>Updates on COVID-19 (coronavirus disease 2019) local situation</td>
<td>Ministry of Health Singapore</td>
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<td>New coronavirus (COVID-19)</td>
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## Online resources

1. Johns Hopkins University: coronavirus COVID-19 global cases ([external link](https://coronavirus.jhu.edu/))
2. WHO: coronavirus disease (COVID-19) situation dashboard ([external link](https://covid19.who.int/))
3. WHO: coronavirus disease (COVID-19) situation reports ([external link](https://covid19.who.int/))
5. CDC: locations with confirmed COVID-19 cases, by WHO region ([external link](https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html))
8. BMJ: facemasks for the prevention of infection in healthcare and community settings ([external link](https://www.bmj.com/content/369/bmj.m1587))
11. BMJ: covid-19 in primary care (UK) ([external link](https://www.bmj.com/content/369/bmj.m1587))
12. BMJ: covid-19 a remote assessment in primary care ([external link](https://www.bmj.com/content/369/bmj.m1587))
15. CDC: strategies to optimize the supply of PPE and equipment ([external link](https://www.cdc.gov/coronavirus/2019-ncov/communication/strategies-to-optimize-supply-of-ppe-and-equipment.html))
16. BSTI: radiology decision support tool for suspected COVID-19 ([external link](https://www.bstm.org.uk/radiology/))
21. Clinical frailty scale ([external link](https://clinicalfrailty.org/))
22. Surviving Sepsis Campaign: summary of recommendations on the management of patients with COVID-19 and ARDS ([external link](https://survivingsepsis.org/Guidance/COVID-19/))
23. **Surviving Sepsis Campaign**: summary of recommendations on the initial management of hypoxic COVID-19 patients ([external link])

24. **WHO**: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts ([external link])

25. **CDC**: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19) ([external link])

26. **Centre for Evidence-Based Medicine**: angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers in COVID-19 ([external link])

27. **WHO**: off-label use of medicines for COVID-19 ([external link])

28. **Centre for Evidence-Based Medicine**: chloroquine and hydroxychloroquine - current evidence for their effectiveness in treating COVID-19 ([external link])

29. **WHO**: coronavirus disease (COVID-19) travel advice ([external link])

30. **CDC**: coronavirus disease 2019 (COVID-19) – travel ([external link])

31. **NaTHNac**: travel health pro ([external link])

32. **Public Health England**: travel advice - coronavirus (COVID-19) ([external link])

33. **Smartraveller Australia**: coronavirus (COVID-19) ([external link])

34. **Government of Canada**: coronavirus disease (COVID-19) - travel advice ([external link])

35. **Ministry of Manpower Singapore**: advisories on COVID-19 ([external link])

36. **CDC**: coronavirus disease 2019 (COVID-19) - if you have animals ([external link])

37. **WHO**: coronavirus disease (COVID-19) pandemic ([external link])

38. **WHO**: stay physically active during self-quarantine ([external link])

39. **CDC**: coronavirus (COVID-19) ([external link])

40. **NHS UK**: advice for everyone - coronavirus (COVID-19) ([external link])
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36. Centre for Evidence-Based Medicine; Ferner RE, Murray PI, Aronson JK. Spreading SARS-CoV-2 through ocular fluids. March 2020 [internet publication]. Full text


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94. Centre for Evidence-Based Medicine; Greenhalgh T, Chan XH, Khunti K, et al. What is the efficacy of standard face masks compared to respirator masks in preventing COVID-type respiratory illnesses in primary care staff? March 2020 [internet publication]. Full text


Coronavirus disease 2019 (COVID-19)

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<td>American College of Radiology. ACR recommendations for the use of chest radiography and computed tomography (CT) for suspected COVID-19 infection. March 2020 [internet publication].</td>
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160. ENT UK. Loss of sense of smell as marker of COVID-19 infection. March 2020 [internet publication].


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179. World Health Organization. Laboratory testing strategy recommendations for COVID-19. 2020 [internet publication]. Full text


183. Li T. Diagnosis and clinical management of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection: an operational recommendation of Peking Union Medical College Hospital (V2.0). Emerg Microbes Infect. 2020 Mar;9(1):582-5. Full text Abstract


192. 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


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211. 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]. Full text


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<td>275.</td>
<td>CytoDyn Inc. Leronlimab used in seven patients with severe COVID-19 demonstrated promise with two intubated patients in ICU, removed from ICU and extubated with reduced pulmonary inflammation. March 2020 [internet publication].</td>
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<td>297</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.

Xu XW et al. BMJ. 2020;368:m606
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