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The World Health Organization declared the COVID-19 outbreak a pandemic on 11 March 2020. The situation is evolving rapidly with global case counts and deaths increasing each day. 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).[1] The virus was identified as the cause of an outbreak of pneumonia of unknown cause in Wuhan City, Hubei Province, China, in December 2019.[2] The clinical presentation is that of a respiratory infection with a symptom severity ranging from a mild common cold-like illness, to a severe viral pneumonia leading to acute respiratory distress syndrome that is potentially fatal.

Epidemiology

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

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

- [Johns Hopkins University: coronavirus COVID-19 global cases]
- [WHO: coronavirus disease (COVID-19) situation dashboard]
- [WHO: coronavirus disease (COVID-2019) situation reports]
- [CDC: COVIDView]

Data from the largest case series in China found that 87% of confirmed cases were ages 30 to 79 years, 1% were ages 9 years or younger, 1% were ages 10 to 19 years, and 3% were ages 80 years or older. Approximately 51% of patients were male and 49% were female. Nearly 4% of cases were in healthcare workers.[6]

In the US, older patients (ages ≥65 years) accounted for 31% of all cases, 45% of hospitalizations, 53% of intensive care unit admissions, and 80% of deaths, with the highest incidence of severe outcomes in patients ages ≥85 years.[7]

Infection in children is reported much less commonly than among adults. A systematic review found that children account for only 1% to 5% of confirmed cases (depending on the country).[8] In the US, children accounted for only 1.7% of all cases.[9] All cases have been in family clusters or in children who have a history of close contact with an infected patient.[10][11][12] In a case series of 2143 pediatric patients in China, the median age of children was 7 years.[13]

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.[14]
Etiology

Virology

• Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is a previously unknown betacoronavirus that was discovered in bronchoalveolar lavage samples taken from clusters of patients who presented with pneumonia of unknown cause in Wuhan City, Hubei Province, China, in December 2019. [2] Coronaviruses are a large family of enveloped RNA viruses, some of which cause illness in people (e.g., common cold, severe acute respiratory syndrome [SARS], Middle East respiratory syndrome [MERS]), and others that circulate among mammals and birds. Rarely, animal coronaviruses can spread to humans and subsequently spread between people, as was the case with SARS and MERS.

• SARS-CoV-2 belongs to the Sarbecovirus subgenus of the Coronaviridae family, and is the seventh coronavirus known to infect humans. The virus has been found to be similar to SARS-like coronaviruses from bats, but it is distinct from SARS-CoV and MERS-CoV. [15] [16] 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. [17]

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. [18] [19] [20]

• 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. [15] [16] [21] [22] Pangolins have been suggested as an intermediate host as they have been found to be a natural reservoir of SARS-CoV-2-like coronaviruses. [23] [24]

Transmission dynamics

• Person-to-person spread has been confirmed in community and healthcare settings, with local transmission now occurring in many countries around the world.

• An initial assessment of the transmission dynamics in the first 425 confirmed cases found that 55% of cases before 1 January 2020 were linked to the Huanan South China Seafood Market, whereas only 8.6% of cases after this date were linked to the market. This confirms that person-to-person spread occurred among close contacts since the middle of December 2019, including infections in healthcare workers. [20]

• 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; via direct contact with infected people; or via contact with fomites. Airborne transmission has not been reported; however, it may be possible during aerosol-generating procedures performed in clinical care. [18] [20] [25] [26]
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).[27] 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.[28]

The contribution to transmission by the presence of the virus in other body fluids is unknown; however, the virus has been detected in blood, cerebrospinal fluid, saliva, tears, and conjunctival secretions. Fecal-oral transmission may be possible, although it has not been reported yet.[29] [30] [31] [32] [33] [34]

Nosocomial transmission in healthcare workers and patients has been reported in 41% of patients in one case series.[35]

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).[36] [37]

Presymptomatic transmission

A small number of studies suggest that some people can be contagious during the incubation period, the time between exposure to the virus and the onset of symptoms. The incubation period is estimated to be between 1 and 14 days, with a median of 5 to 7 days (possibly longer in children).[38] [39] [40] [41] [42]

Presymptomatic transmission has been reported in 12.6% of cases in China.[43] 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.[44]

Presymptomatic transmission still requires the virus to be spread by infectious droplets or contact with fomites.

Asymptomatic transmission

An asymptomatic case is a laboratory-confirmed case who does not develop symptoms. There is some evidence that spread from asymptomatic carriers is possible, although it is thought that transmission is greatest when people are symptomatic (especially around the time of symptom onset).[45] [46] [47] [48] [49] [50] [51]

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.[52] However, a Japanese study of citizens evacuated from Wuhan City estimates the rate to be closer to 31%.[53] Data from a long-term care facility in the US found that 30% of patients with positive test results were asymptomatic (or presymptomatic) on the day of testing.[54] Early data from an isolated village of 3000 people in Italy estimates the figure to be higher at 50% to 75%.[55] Other studies ranged from 4% to 80%.[56]

The proportion of asymptomatic cases in children is thought to be significant, and children may play a role in community spread.[57]

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.[58]
Coronavirus disease 2019 (COVID-19)

Basics

• 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.[59] [60]
• 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.[59]

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.[61] [62] [63] 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.[64] [65] [66] [67] [68]

Pathophysiology

Reproductive number

• Preliminary reports suggested that the reproductive number ($R_0$), the number of people who acquire the infection from an infected person, was estimated to be 2.2 to 3.3.[20] [69] However, the $R_0$ may actually be lower in light of social distancing measures that have been instituted.
• The secondary attack rate for SARS-CoV-2 is estimated to be 0.45% for close contacts of US patients.[26]

Angiotensin-converting enzyme-2 receptor

• While the pathophysiology is currently unknown, it has been confirmed that the virus binds to the angiotensin-converting enzyme-2 (ACE2) receptor in humans, which suggests a similar pathogenesis to SARS.[16] [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

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

#### Mild illness

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

**Pneumonia**

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

#### Severe pneumonia in adults and adolescents

- Fever or suspected respiratory infection plus one of the following:
  - Respiratory rate >30 breaths/minute
  - Severe respiratory distress
  - \( \text{SpO}_2 \leq 93\% \) on room air.

#### Severe pneumonia in children

- Cough or difficulty breathing plus at least one of the following:
  - Central cyanosis or \( \text{SpO}_2 \leq 90\% \)
  - Severe respiratory distress (e.g., grunting, very severe chest indrawing)
  - Signs of pneumonia with a general danger sign (i.e., inability to breastfeed or drink, lethargy or unconsciousness, or convulsions).
  - Other signs of pneumonia may be present in children including chest indrawing or fast breathing (i.e., ≤2 months of age: ≥60 breaths/minute; 2-11 months of age: ≥50 breaths/minute; 1-5 years years of age: ≥40 breaths/minute).
  - While the diagnosis is made on clinical grounds, chest imaging may identify or exclude some pulmonary complications.
Primary prevention

General prevention measures

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

- [BMJ Learning: Covid-19 - handwashing technique and PPE videos]
- [WHO: coronavirus disease (COVID-19) advice for the public]

Face masks

- Recommendations on the use of face masks in community settings vary between countries. It is mandatory to wear a mask in public in certain countries, and masks may be worn in some countries according to local cultural habits. Consult local guidance for more information.
- The World Health Organization (WHO) does not currently recommend wearing a mask in community settings unless the person is unwell or is caring for someone who is sick. There is no evidence available on the usefulness of masks to protect people who are not ill. Individuals with fever and/or respiratory symptoms are advised to wear a mask and seek medical care as soon as possible. The WHO is currently reviewing this advice.
- The Centers for Disease Control and Prevention recommends that homemade cloth face coverings can be worn in public settings where social distancing measures are difficult to maintain (e.g., pharmacies, grocery stores), especially in areas where there is significant community transmission.
- Use of a mask alone is insufficient to provide adequate protection, and they should be used in conjunction with other infection prevention and control measures such as frequent hand hygiene. It is important to wash your hands with soap and water (or an alcohol-based sanitizer) prior to putting on a face mask. Used masks should be disposed of properly.

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

Screening and quarantine
• People traveling from areas with a high risk of infection may be screened using questionnaires about their travel, contact with ill persons, symptoms of infection, and/or measurement of their temperature. Combined screening of airline passengers on exit from an affected area and on arrival elsewhere has been relatively ineffective when used for other infections such as Ebola virus infection, and has been modeled to miss up to 50% of cases of COVID-19, particularly those with no symptoms during the incubation period.[100] 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.[101]

• Enforced quarantine is being used to isolate easily identifiable cohorts of people at potential risk of recent exposure (e.g., groups evacuated by aeroplane from affected areas, people returning to their home countries before border closures, or groups on cruise ships with infected people on board).[102] The psychosocial effects of enforced quarantine may have long-lasting repercussions.[103] [104]

Social distancing

• Many countries have implemented mandatory social distancing measures in order to reduce and delay transmission (e.g., city lockdowns, stay-at-home orders, curfews, nonessential business closures, bans on gatherings, school and university closures, travel restrictions and bans, remote working, quarantine of exposed people/travelers).
• Although the evidence for social distancing for COVID-19 is limited, it is emerging, and the best available evidence appears to support social distancing measures to reduce the transmission and delay spread. The timing and duration of these measures appears to be critical.[105] [106]
• Researchers in Singapore found that social distancing measures (isolation of infected individuals and family quarantine, school closures, and workplace distancing) significantly decreased the number of infections in simulation models.[107]
• [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:[108]
  • Solid organ transplant recipients
  • People with specific cancers
  • People with severe respiratory conditions (e.g., cystic fibrosis, severe asthma, or COPD)
  • People with rare diseases or inborn errors of metabolism that increase the risk of infections (e.g., sickle cell anemia, severe combined immunodeficiency)
  • People on immunosuppression therapies sufficient to significantly increase the risk of infection
  • Women who are pregnant with significant heart disease (congenital or acquired).
• These groups are advised to stay at home at all times, and avoid any face-to-face contact for a period of at least 12 weeks (this time period is subject to change). Visits from people who provide essential support should continue provided these people do not have symptoms and follow hand hygiene measures.
• Consult local health authorities for more guidance as recommendations, procedures, and resources differ between countries.
• [Public Health England: guidance on shielding and protecting people defined on medical grounds as extremely vulnerable from COVID-19]

Vaccine
• There is currently no vaccine available. Vaccines are in development, but it may take at least 12 months before one is available. An mRNA vaccine (mRNA-1273) has been shipped to the National Institute of Allergy and Infectious Diseases for phase 1 clinical trials in the US.[109] 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.[110] Other vaccines are currently in clinical trials around the world.

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:[175]

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

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

Screening of travelers

Exit and entry screening may be recommended in countries where borders are still open, particularly when repatriating nationals from affected areas. Travelers returning from affected areas should self-monitor for symptoms for 14 days and follow local protocols of the receiving country. Some countries may require travelers to enter mandatory quarantine in a designated location (e.g., a hotel). Travelers who develop symptoms are advised to contact their local healthcare provider, preferably by phone.[176]

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.[177]

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.[113] COVID-19 is a notifiable disease; report all suspected and confirmed cases to your local health authorities.
Detailed guidance on infection prevention and control measures are available from the World Health Organization and the Centers for Disease Control and Prevention:

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

Case history #1

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

Case history #2

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

Step-by-step diagnostic approach

Early recognition and rapid diagnosis are essential to prevent transmission and provide supportive care in a timely manner. Have a high index of clinical suspicion for COVID-19 in all patients who present with fever and/or acute respiratory illness and who 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.[111] Most patients can be managed remotely by telephone or video consultations.[112] 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.
Coronavirus disease 2019 (COVID-19)

[BMJ: covid-19 PPE guidance]

The World Health Organization (WHO) recommends the following basic principles:[113]

- Immediately isolate all suspected cases in an area that is separate from other patients
- Implement standard precautions at all times:
  - Practice hand and respiratory hygiene
  - Offer a medical mask to patients who can tolerate one
  - Wear personal protective equipment
  - Practice safe waste management, environmental cleaning, and sterilization of patient care equipment and linen
- Implement additional contact and droplet precautions until the patient is asymptomatic:
  - Place patients in adequately ventilated single rooms; when single rooms are not available, place all suspected cases together in the same ward
  - Wear a medical mask, gloves, an appropriate gown, and eye/facial protection (e.g., goggles or a face shield)
  - Use single-use or disposable equipment
  - Consider limiting the number of healthcare workers, family members, and visitors in contact with the patient, ensuring optimal patient care and psychosocial support for the patient
  - Consider placing patients in negative pressure rooms, if available
- Implement airborne precautions when performing aerosol-generating procedures
  - All specimens collected for laboratory investigations should be regarded as potentially infectious.
Some countries and organizations recommend airborne precautions for any situation involving the care of a COVID-19 patient.

It is important to disinfect inanimate surfaces in the surgery or hospital as patients may touch and contaminate surfaces such as door handles and desktops.[114]

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.[6] Severe illness is associated with older age and the presence of underlying health conditions.[83] Older patients and/or those with comorbidities may present with mild symptoms, but have a high risk of deterioration.[3] Atypical presentations may occur, especially in older patients or patients who are immunocompromised.

Approximately 5% of patients with a mild influenza-like illness (and no risk factors for COVID-19) who presented to a Los Angeles emergency department tested positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), although this study was limited by the brief sampling period at one medical center.[115]

The most common symptoms are:[18] [19] [35] [116] [117] [118]

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

Less common symptoms include:

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

Approximately 90% of patients present with more than one symptom, and 15% of patients present with fever, cough, and dyspnea.[19] Some patients may be minimally symptomatic or asymptomatic. Mild illness is defined as patients with an uncomplicated upper respiratory tract infection with nonspecific symptoms such as fever, cough (with or without sputum production), fatigue, anorexia, malaise, myalgia, sore throat, dyspnea, nasal congestion, or headache. Patients may have gastrointestinal symptoms. The most common diagnosis in patients with severe COVID-19 is severe pneumonia.[3]

Initial impressions from cases in the US note that the clinical presentation may be broader than that observed in China and Italy, with chest pain, headaches, altered mental status, and gastrointestinal symptoms all observed on initial presentation. Severe hepatic and renal dysfunction that spares the lungs has also been observed.[119]

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.[120]

Coinfections (e.g., influenza, human metapneumovirus) have been reported. Patients with influenza coinfection showed similar characteristics to those patients with COVID-19 only.[78] [121] [122]

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).[9] [10] [11] [123] [124] [125] However, moderate to severe illness has also been reported in children.[126] Polypnea has been reported in children with severe illness.[127] There are case reports of neonates and infants presenting with predominantly gastrointestinal symptoms.[128] [129]

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.[13] However, it is important to note that children may have signs of pneumonia on chest imaging despite having minimal or no symptoms.[130]

Coinfections may be more common in children.[130] 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.[61] [65] It is important to note that symptoms such as fever, dyspnea, and fatigue may overlap with symptoms due to physiologic adaptations of pregnancy or adverse pregnancy events.[3]

Initial investigations

Order the following investigations in all patients with severe illness:

- Pulse oximetry
- ABG (as indicated to detect hypercarbia or acidosis)
- CBC
- Comprehensive metabolic panel
- Coagulation screen
- Inflammatory markers (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.[18] [19] [35] [118] [131]

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.[3]

Molecular testing

Molecular testing is required to confirm the diagnosis. Diagnostic tests should be performed according to guidance issued by local health authorities and should adhere to appropriate biosafety practices. If testing is not available nationally, specimens should be shipped to an appropriate reference laboratory. Specimens for testing should be collected under appropriate infection prevention and control procedures.

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

Perform a nucleic acid amplification test, such as real-time reverse-transcription polymerase chain reaction (RT-PCR), for SARS-CoV-2 in appropriate patients with suspected infection, with confirmation by nucleic acid sequencing when necessary.[132]

- 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.[132] 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.[133]

Collect nasopharyngeal swabs for testing to rule out infection with other respiratory pathogens (e.g., influenza, atypical pathogens) according to local guidance. It is important to note that coinfections can occur, and a positive test for a non-COVID-19 pathogen does not rule out COVID-19.[3] [134]

Serologic testing is not available as yet, but assays are in development.[135] 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.[136]

**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.[18] [19] [137]

**Computed tomography**

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

The British Society of Thoracic Imaging (BSTI) recommends CT imaging in patients with clinically suspected COVID-19 who are seriously ill if chest x-ray is uncertain or normal. Without the suspicion of COVID-19, the radiology is nonspecific and could represent many other disease processes. The BSTI in
collaboration with NHS England have produced a radiology decision support tool to help clinicians decide whether or not chest imaging should be ordered.[138]

[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.[139]

Abnormal chest CT findings have been reported in up to 97% of COVID-19 patients in one meta-analysis of 50,466 hospitalized patients.[117] Evidence of pneumonia on CT may precede a positive RT-PCR result for SARS-CoV-2 in some patients.[135] 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.[141] 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.[142]

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.[18] [120] [143]
- Other classic findings include crazy-paving pattern, air bronchograms, and a reverse halo/perilobular pattern (i.e., organizing pneumonia patterns).[138]
- 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.[144]
- Older people are more likely to have extensive lung lobe involvement, interstitial changes, and pleural thickening compared with younger patients.[145]
- Small nodular ground-glass opacities and consolidation with surrounding halo signs are typical in children.[130] [146]

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.[18] [120] [143]

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.[140]
- 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.[143]

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]

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 ages 65 years and older, those who live in a nursing home or long-term care facility, and those with a high-risk condition (e.g., chronic respiratory disease, cardiovascular disease, immunocompromised, severe obesity, diabetes, hypertension, renal or liver disease) are at higher risk for severe illness.[83] [84]
• 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.[85] In Italy, the most common comorbidity is obesity.[86]
• Initial data suggest that immunosuppressed patients are not at increased risk of severe illness from coronaviruses; however, further research is required in this patient group.[87]

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.

**smoking**

- Smoking has been associated with more severe disease and a poorer prognosis in one retrospective analysis of 78 patients in China.[89] Results from more recent studies appear to be conflicting. Preliminary results from a meta-analysis found that active smoking is not significantly associated with an increased risk of progressing to severe disease.[90] However, a systematic review found that smoking is likely associated with negative progression and adverse outcomes.[91] Further research is warranted, but the general consensus appears to be that people who smoke may be at higher risk.

**surgery**

- Surgery may accelerate and exacerbate disease progression. A retrospective study of 34 patients in China who underwent elective surgeries during the incubation period of COVID-19 found that all patients developed pneumonia after surgery. Approximately 44% of these patients required admission to the intensive care unit, and 20% died. Further study is required.[92]

### History & examination factors

#### Key diagnostic factors

**fever (common)**

- Reported in 83% to 98% of patients in case series.[18] [19] [35] [117] [118] [152] In one case series, 44% of patients had a fever on presentation, but it developed in 89% of patients after hospitalization.[116]
- Children may not present with fever, or may have a brief and rapidly resolving fever.[10] [124] [125]
- 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.[18] [19] [35] [116] [117] [118] [152]
- Less common in children.[124]
- Cough is usually dry.

**dyspnea (common)**

- Reported in 18% to 55% of patients in case series.[18] [19] [35] [116] [118] [152]
- Median time from onset of symptoms to development of dyspnea is 5 to 8 days.[18] [19] [35]
- Polypnea has been reported in children with severe illness.[127]

**anosmia/dysgeusia (common)**

- There is 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 disorder (or both), although this figure may be higher.[153]
• King’s College London has reported that loss of smell/taste has been flagged as a key symptom for COVID-19 in the UK through its symptom tracker app.[154]
• It is possible that these patients may be hidden carriers, but further research is required.[155]
• 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).[156]

Other diagnostic factors

fatigue (common)
• Reported in 29% to 69% of patients in case series.[18] [35] [116] [118] [152]
• Patients may also report malaise.

myalgia (common)
• Reported in 11% to 44% of patients in case series.[18] [19] [35] [116] [117] [152]
• Arthralgia has also been reported.

anorexia (common)
• Reported in 40% of patients in case series.[35]

sputum production/expectoration (common)
• Reported in 26% to 33% of patients in case series.[18] [35] [116] [152]

sore throat (common)
• Reported in 5% to 17% of patients in case series, and usually presents early in the clinical course.[19] [35] [116] [152]
• Children may have pharyngeal erythema.[124]

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.[157]

confusion (uncommon)
• Reported in 9% of patients in case series.[19]

dizziness (uncommon)
• Reported in 9% to 12% of patients in case series.[35] [118]

headache (uncommon)
• Reported in 6% to 14% of patients in case series.[18] [19] [35] [116] [118] [152] [158] Other case series have reported gastrointestinal symptoms in up to 46% of patients.[159] [160]
• Some patients may present with predominantly gastrointestinal symptoms, especially children.[128] [129] [161]
• Patients may present with nausea or diarrhea 1 to 2 days prior to onset of fever and breathing difficulties.[35]
• Hematochezia has been reported.[162]

hémoptysie (uncommon)
• Reported in 1% to 5% of patients in case series.[18] [116]

rhinorrhee (uncommon)
• Reported in 4% to 5% of patients in case series.[19] [116]

chest pain (uncommon)
• Reported in 2% to 5% of patients in case series.[18] [19]
• May indicate pneumonia.

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.[163] [164]

bronchial breath sounds (uncommon)
• May indicate pneumonia.

tachypnée (uncommon)
• May be present in patients with acute respiratory distress.

tachycardie (uncommon)
• May be present in patients with acute respiratory distress.

cyanose (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><strong>pulse oximetry</strong></td>
<td>• Order in patients with severe illness.</td>
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<td></td>
<td>• Recommended in patients with respiratory distress and cyanosis.</td>
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<td><strong>ABG</strong></td>
<td>• Order in patients with severe illness as indicated to detect hypercarbia or acidosis.</td>
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<td>• Recommended in patients with respiratory distress and cyanosis who have low oxygen saturation (SpO₂ &lt;90%).</td>
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<tr>
<td><strong>CBC</strong></td>
<td>• Order in patients with severe illness.</td>
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<td></td>
<td>• The most common laboratory abnormalities in patients hospitalized with pneumonia include leukopenia, lymphopenia, and leukocytosis. Other abnormalities include neutrophilia, thrombocytopenia, and decreased hemoglobin.[18] [19] [35] [131]</td>
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<tr>
<td></td>
<td>• Lymphopenia and thrombocytopenia have been associated with increased risk of severe disease and may be useful as clinical indicators for monitoring disease progression.[165] [166]</td>
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<td><strong>coagulation screen</strong></td>
<td>• Order in patients with severe illness.</td>
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<td>• The most common abnormalities are elevated D-dimer and prolonged prothrombin time.[18] [19] [35]</td>
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<td>• Nonsurvivors had significantly higher D-dimer levels and longer prothrombin time and activated partial thromboplastin time compared with survivors in one study.[167]</td>
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<tr>
<td><strong>comprehensive metabolic panel</strong></td>
<td>• Order in patients with severe illness.</td>
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<td></td>
<td>• The most common laboratory abnormalities in patients hospitalized with pneumonia include elevated liver transaminases. Other abnormalities include decreased albumin and renal impairment.[18] [19]</td>
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<td>• Liver function abnormalities may be more common in patients with COVID-19 compared with other types of pneumonia.[144]</td>
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<tr>
<td><strong>serum procalcitonin</strong></td>
<td>• Order in patients with severe illness.</td>
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<tr>
<td></td>
<td>• May be elevated in patients with secondary bacterial infection.[18] [19] May be more common in children.[130]</td>
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<tr>
<td><strong>serum C-reactive protein</strong></td>
<td>• Order in patients with severe illness.</td>
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<td></td>
<td>• May be elevated in patients with secondary bacterial infection.[18] [19]</td>
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<tr>
<td><strong>serum lactate dehydrogenase</strong></td>
<td>• Order in patients with severe illness.</td>
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<td>• Elevated lactate dehydrogenase has been reported in 73% to 76% of patients.[18] [19] May be more common in patients with COVID-19 compared with other types of pneumonia.[144]</td>
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<td>Test</td>
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<td>serum creatine kinase</td>
<td>• Order in patients with severe illness.</td>
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<td>• Elevated creatine kinase has been reported in 13% to 33% of patients.</td>
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<td>• Indicates liver injury or lysis of blood erythrocytes.</td>
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<td>may be elevated</td>
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<td>serum troponin level</td>
<td>• Order in patients with severe illness.</td>
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<td></td>
<td>• May be elevated in patients with cardiac injury.[18]</td>
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<td></td>
<td>may be elevated</td>
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<tr>
<td>blood and sputum cultures</td>
<td>• Collect blood and sputum specimens for culture in all patients to</td>
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<td></td>
<td>rule out other causes of lower respiratory tract infection and sepsis,</td>
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<td>especially patients with an atypical epidemiologic history.[3]</td>
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<td>• Specimens should be collected prior to starting empiric antimicrobials</td>
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<td>if possible.</td>
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<td>negative for bacterial infection</td>
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<td>real-time reverse transcription polymerase chain</td>
<td>• Molecular testing is required to confirm the diagnosis. Nucleic acid</td>
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<tr>
<td>reaction (RT-PCR)</td>
<td>sequencing may be required to confirm the diagnosis.[132]</td>
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<td></td>
<td>• Collect upper respiratory specimens (nasopharyngeal and oropharyngeal</td>
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<td>swab or wash) in ambulatory patients and/or lower respiratory specimens</td>
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<td>additional clinical specimens (e.g., blood, stool, urine). Specimens</td>
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<td>should be collected under appropriate infection prevention and control</td>
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<td>procedures. Consider the high risk of aerosolization when collecting</td>
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<td>lower respiratory specimens.[132]</td>
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<td>• There are little data available on the rates of false-positive and</td>
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<td>false-negative results for the various RT-PCR tests available; however,</td>
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<td>both have been reported. If a negative result is obtained from a patient</td>
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<td>with a high index of suspicion for COVID-19, additional specimens</td>
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<td>should be collected and tested, especially if only upper respiratory</td>
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<td>tract specimens were collected initially.[132]</td>
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<td>• Many tests are available under the Food and Drug Administration’s</td>
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<td>emergency-use authorization scheme.[168] A point-of-care test that</td>
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<td>provides results within hours is available in some countries.[169]</td>
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<td>Tests are available in many laboratories worldwide and testing should</td>
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<td>be done according to instructions from local health authorities and</td>
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<td>nationally, specimens should be shipped to an appropriate reference</td>
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<td>laboratory.</td>
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<td>• Sensitivity and specificity of RT-PCR for diagnostic testing are</td>
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<td>unknown.[170]</td>
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<td></td>
<td>• Collect nasopharyngeal swabs to rule out influenza and other respiratory</td>
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<td>does not rule out COVID-19.[3][134]</td>
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<td>positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)</td>
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<td></td>
<td>viral RNA; may be positive for influenza A and B viruses and other</td>
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<td>respiratory pathogens</td>
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**Test** | **Result**
---|---
computed tomography (CT) chest | typical features: multiple bilateral lobular and subsegmental areas of ground-glass opacity or consolidation (usually peripheral or posterior, mainly in the lower lobes, less frequently in right lower lobe), crazy-paving pattern, air bronchograms, reverse halo/perilobular pattern; atypical features: interlobular or septal thickening (smooth or irregular), thickening of the adjacent pleura, subpleural involvement, pleural effusion, serous effusion, bronchiectasis, cavitary lesions, pneumothorax, lymphadenopathy, round or cystic changes

- Consider a CT scan of the chest. Consult local guidance on whether to perform a CT scan.
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- Atypical features appear to be more common in the later stages of disease, or on disease progression.[18] [120] [143]
- Older people are more likely to have extensive lung lobe involvement, interstitial changes, and pleural thickening compared with younger patients.[145] Small nodular ground-glass opacities and consolidation with surrounding halo signs are typical in children.[130] [146]
- 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.[140] 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.[143]
- 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] [Fig-2]
## 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.</td>
<td></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.</td>
<td></td>
</tr>
<tr>
<td>• Rapid antibody detection kits have been approved in Europe and the US for the qualitative detection of SARS-CoV-2 IgG/IgM antibodies in serum, plasma, or whole blood, and will be available soon.</td>
<td></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.</td>
<td></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) | • Travel history to the Middle East or contact with a confirmed case of MERS.  
• Differentiating COVID-19 from MERS is not possible from signs and symptoms.  
• Initial data suggest that the clinical course of COVID-19 is less severe and the case fatality rate is lower compared with MERS. | • 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.                                                                                                                                                                            | • RT-PCR: positive for severe acute respiratory syndrome coronavirus (SARS-CoV) viral RNA.                                                                               |
| Community-acquired pneumonia  | • Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset.  
• Differentiating COVID-19 from community-acquired bacterial pneumonia is not usually possible from signs and symptoms. However, patients with bacterial pneumonia are more likely to have rapid development of symptoms and purulent sputum. They are less likely to have myalgia, anosmia, or pleuritic pain.[171] | • Blood or sputum culture or molecular testing: positive for causative organism.  
• RT-PCR: negative for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral RNA (coinfections are possible). |
| Influenza infection           | • Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset.  
• Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms. | • RT-PCR: positive for influenza A or B viral RNA; negative for SARS-CoV-2 viral RNA (coinfections are possible).                                                                 |
<p>| Common cold                   | • Lack of residence in/travel history to an area with                                                                                                                                                                              | • RT-PCR: positive for causative organism; negative                                                                                                                                                                              |</p>
<table>
<thead>
<tr>
<th>Condition</th>
<th>Differentiating signs / symptoms</th>
<th>Differentiating tests</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset.</strong>&lt;br&gt;• Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms.</td>
<td>for SARS-CoV-2 viral RNA (coinfections are possible).</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.&lt;br&gt;• 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.</td>
<td>• RT-PCR: positive for H7-specific viral RNA.</td>
</tr>
<tr>
<td><strong>Avian influenza A (H5N1) virus infection</strong></td>
<td>• Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset.&lt;br&gt;• 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.</td>
<td>• RT-PCR: positive for H5N1 viral RNA.</td>
</tr>
<tr>
<td><strong>Other viral or bacterial respiratory infections</strong></td>
<td>• Lack of residence in/travel history to an area with ongoing transmission, or lack of close contact with a suspected/confirmed case of COVID-19 in the 14 days prior to symptom onset.&lt;br&gt;• Differentiating COVID-19 from community-acquired respiratory tract infections is not possible from signs and symptoms.&lt;br&gt;• Adenovirus and <em>Mycoplasma</em> should be considered in clusters of pneumonia patients, especially in closed settings</td>
<td>• Blood or sputum culture of molecular testing: positive for causative organism.&lt;br&gt;• RT-PCR: negative for SARS-CoV-2 viral RNA (coinfections are possible).</td>
</tr>
</tbody>
</table>
## Diagnosis

### Condition

<table>
<thead>
<tr>
<th>Condition</th>
<th>Differentiating signs / symptoms</th>
<th>Differentiating tests</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>such as military camps and schools.</td>
<td></td>
</tr>
<tr>
<td>Pulmonary tuberculosis</td>
<td>• Consider diagnosis in endemic areas, especially in patients who are immunocompromised.</td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• History of symptoms is usually longer.</td>
<td>• Sputum acid-fast bacilli smear and sputum culture: positive.</td>
</tr>
<tr>
<td></td>
<td>• Presence of night sweats and weight loss may help to differentiate.</td>
<td>• Molecular testing: positive for <em>Mycoplasma tuberculosis</em>.</td>
</tr>
<tr>
<td>Febrile neutropenia</td>
<td>• 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.[172]</td>
<td>• CBC: neutropenia.</td>
</tr>
<tr>
<td></td>
<td>• Symptoms of COVID-19 and neutropenic sepsis may be difficult to differentiate at initial presentation.</td>
<td>• RT-PCR: negative for SARS-CoV-2 viral RNA.</td>
</tr>
</tbody>
</table>

### Diagnostic criteria

**World Health Organization: case definitions[82]**

#### 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[173]

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[174]**

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

**Tier 1**

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

**Tier 2**

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

**Tier 3**

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

**Tier 4**

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

[IDSA: COVID-19 prioritization of diagnostic testing]
Step-by-step treatment approach

No specific treatments are known to be effective for COVID-19 yet; therefore, the mainstay of management is early recognition and optimized supportive care to relieve symptoms and to support organ function in more severe illness. Patients should be managed in a hospital setting where possible; however, home care may be suitable for selected patients with mild illness unless there is concern about rapid deterioration or an inability to promptly return to hospital if necessary. Children are less likely to require hospitalization.[9]

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

Rationing of medical resources may be required during the pandemic if healthcare infrastructures are overwhelmed. This raises many ethical questions on how to best triage patients to save the most lives. Recommendations have been suggested, but there is no clear international guidance on this issue as yet.[187] [188] [189] [190] [191]

Infection prevention and control

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

[BMJ: covid-19 PPE guidance]

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

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

The WHO recommends that patients should remain in isolation for 2 weeks after symptoms disappear, and visitors should not be allowed until the end of this period.[192] 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.[6] The most common reasons for intensive care unit admission are hypoxemic respiratory failure leading to mechanical ventilation and hypotension.[193] The median time from onset of symptoms to hospital admission is reported to be approximately 7 days.[18] [35]

Treatment and care planning
• Discuss the risks, benefits, and potential outcomes of treatment options with patients and their families, and allow them to express preferences about their management. Take their wishes and expectations into account when considering the ceiling of treatment. Use decision support tools if available. Put treatment escalation plans in place, and discuss any existing advance care plans or advance decisions to refuse treatment with patients who have preexisting advanced comorbidities.\[194\]

Admission to critical care

• Assess all adults for frailty on admission to hospital, irrespective of age and COVID-19 status, using the Clinical Frailty Scale (CFS). [Clinical frailty scale]
• Involve critical care teams in discussions about admission to critical care for patients where:
  • The CFS score suggests the person is less frail (e.g., CFS <5), they are likely to benefit from critical care organ support, and the patient wants critical care treatment; or
  • The CFS score suggests the person is more frail (e.g., CFS ≥5), there is uncertainty regarding the benefit of critical care organ support, and critical care advice is needed to help the decision about treatment.
• Take into account the impact of underlying pathologies, comorbidities, and severity of acute illness.\[195\]

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%.\[3\] \[196\] Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation.\[3\] Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition. Once the patient is stable, the target SpO₂ is ≥90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.\[3\] Some guidelines recommend that SpO₂ should be maintained no higher than 96%\[196\]
• Fluids: manage fluids conservatively in adults and children with severe acute respiratory infection when there is no evidence of shock as aggressive fluid resuscitation may worsen oxygenation.\[3\]
• Prevention of complications: implement standard interventions to prevent complications associated with critical illness.\[3\] Complications such as acute respiratory distress syndrome (ARDS), sepsis, and septic shock should be managed according to usual protocols. See our Complications section for more information.

Antimicrobials

• Start empiric antimicrobials to cover other potential bacterial pathogens that may cause respiratory infection, according to local protocols. Give within 1 hour of initial patient assessment for patients with suspected sepsis. Choice of empiric antimicrobials should be based on the clinical diagnosis, and local epidemiology and susceptibility data. Consider treatment with a neuraminidase inhibitor until influenza is ruled out. De-escalate empiric therapy based on microbiology results and clinical judgment.\[3\]
• Some patients with severe illness may require continued antimicrobial therapy once COVID-19 has been confirmed depending on the clinical circumstances.

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

• Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports. 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, caution is advised, and the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.

Managing cough

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

Managing breathlessness

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

Managing anxiety, delirium, and agitation

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

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.

Advanced oxygen/ventilatory support

• Follow local infection prevention and control procedures to prevent transmission to healthcare workers, especially when performing aerosol-generating procedures. Novel methods to protect clinicians without access to standard personal protective equipment during aerosol-generating procedures have been suggested (e.g., aerosol box, plastic drapes, helmet devices).

• Provide advanced oxygen/ventilatory support in patients who are deteriorating and failing to respond to standard oxygen therapy. 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. Monitor patients closely for clinical deterioration that could result in the
need for urgent intubation.[3] These procedures may avoid the need for intubation and mechanical ventilation; however, they have a higher risk of aerosol generation and you should check your local guidelines for preferred options.[205] 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.[206]

- 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.[207] 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.[3] [196]

- Consider prone ventilation in patients with persistent severe hypoxic failure.[3] [196] [208] Pregnant women may benefit from being placed in the lateral decubitus position.[3] A small cohort study of 12 patients in Wuhan City, China, with COVID-19-related acute respiratory distress syndrome suggests that spending periods of time in the prone position may improve lung recruitability.[209]

- 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.[196]

- Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise if the above methods fail.[3] [196] [208] [210]

- 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.[3] 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.[18] [211]

- The WHO (as well as other international pneumonia guidelines) does not routinely recommend systemic corticosteroids for the treatment of viral pneumonia or acute respiratory distress syndrome unless they are indicated for another reason.[3] 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.[196]
• A randomized controlled trial investigating the use of corticosteroids in patients with COVID-19 is in progress.[212]

Palliative care

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

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.[175] 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.[175]

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.[175]

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

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

Recommend symptomatic therapies (as per the recommendations above) and advise patients to keep hydrated but not to take too much fluid as this can worsen oxygenation. Advise patients to improve air circulation by opening a window or door (fans can spread infection and should not be used).[194]

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.[175] 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.[3] [213]
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.[214]
- Isolate and monitor asymptomatic pregnant women with confirmed infection at home, if appropriate, with ultrasound fetal surveillance every 2 weeks.[214]
- The American College of Obstetricians and Gynecologists has published an algorithm to help decide whether hospital admission or home care is more appropriate. [ACOG: outpatient assessment and management for pregnant women with suspected or confirmed novel coronavirus (COVID-19)]

Delivery

- Choice of delivery and timing should be individualized based on gestational age, as well as maternal, fetal, and delivery conditions. Induction of labor and vaginal delivery is preferred in pregnant women with confirmed COVID-19 infection to avoid unnecessary surgical complications; however, an emergency cesarean delivery may be required if medically justified (e.g., in patients with complications such as sepsis or if there is fetal distress).[3] [214]
- Corticosteroid therapy may be considered in women who are at risk of preterm birth from 24 to 37 weeks’ gestation for fetal lung maturation.[3] [214] [215]

Newborns and breastfeeding

- Babies born to mothers with suspected or confirmed infection should be considered a person under investigation and tested at 24 hours and 48 hours after birth.[216]
- The WHO recommends that mothers and infants should remain together when possible, and breastfeeding should be encouraged while applying appropriate infection prevention and control measures (e.g., performing hand hygiene before and after contact with the baby, wearing a mask while breastfeeding).[3] However, the CDC recommends that temporary separation of the mother and baby should be considered on a case-by-case basis, 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.[217] Consult local guidelines for specific recommendations.
- After discharge, advise mothers with COVID-19 to practice prevention measures (e.g., distance, hand hygiene, respiratory hygiene/mask) for newborn care until they are afebrile for 72 hours without use of antipyretics and at least 7 days have passed since symptoms first appeared. A newborn with documented infection requires close outpatient follow-up after discharge.[216]

Management of comorbidities

Data on the management of comorbidities in patients with COVID-19 is limited.[218] Tailor the management of critical illness to the patient’s comorbidities (e.g., decide which chronic therapies should be continued and which therapies should be temporarily stopped, monitor for drug-drug interactions).[3]

Cardiovascular disease
Coronavirus disease 2019 (COVID-19) Treatment

- 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. However, professional societies from all over the world recommend continuing these drugs unless clinically indicated. Individualized treatment decisions should be made according to the hemodynamic status and clinical presentation of each patient. 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.

- [BMJ: drugs and the renin-angiotensin system in covid-19]
- [Centre for Evidence-Based Medicine: angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers in COVID-19]

Asthma

- Advise patients to continue taking their regular prescribed medications in line with their asthma action plan to ensure their condition is as stable as possible. Advise patients to follow their asthma action plan in the event of an exacerbation. There is currently no evidence that inhaled/oral corticosteroids or biologic agents for asthma increase the risk of getting COVID-19. 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.

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. Radiation therapy should be avoided if the evidence suggests there is little to no benefit or if alternative treatment is available, or should be deferred if clinically appropriate. Clinicians should consider the severity of disease and post-transplant risks of COVID-19 when deciding on treatment plans for hematopoietic stem cell transplantation.

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.

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. It has been suggested that patients should be screened for SARS-CoV-2 infection before starting therapy with corticosteroids (for flares) or biologics.
Guidelines for the management of rheumatologic, autoimmune, inflammatory, and metabolic bone disorders are available.[237]

### Treatment details overview

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

<table>
<thead>
<tr>
<th>Initial</th>
<th>(summary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>suspected COVID-19</td>
<td></td>
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<tr>
<td>1st</td>
<td>isolation and infection prevention and control procedures</td>
</tr>
<tr>
<td>plus</td>
<td>empiric antimicrobials</td>
</tr>
<tr>
<td>plus</td>
<td>monitoring</td>
</tr>
<tr>
<td>adjunct</td>
<td>supportive care</td>
</tr>
<tr>
<td>adjunct</td>
<td>antipyretic</td>
</tr>
<tr>
<td>adjunct</td>
<td>antitussive</td>
</tr>
</tbody>
</table>
### Acute

<table>
<thead>
<tr>
<th>confirmed COVID-19</th>
<th>1st</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>severe illness; mild illness with risk factors</td>
<td>hospital admission</td>
<td>infection prevention and control procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>treatment and care planning</td>
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<tr>
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<td></td>
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<td></td>
<td>adjunct</td>
<td>antitussive</td>
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<tr>
<td></td>
<td>adjunct</td>
<td>advanced oxygen/ventilatory support</td>
</tr>
<tr>
<td></td>
<td>adjunct</td>
<td>tailor management to comorbidities</td>
</tr>
<tr>
<td></td>
<td>adjunct</td>
<td>experimental therapies</td>
</tr>
<tr>
<td>mild illness with no risk factors</td>
<td>isolation in nontraditional facility or at home</td>
<td>monitoring</td>
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<td></td>
<td></td>
<td>supportive care</td>
</tr>
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</tr>
<tr>
<td></td>
<td>adjunct</td>
<td>antitussive</td>
</tr>
</tbody>
</table>
Treatment options

Please note that formulations/routes and doses may differ between drug names and brands, drug formularies, or locations. Treatment recommendations are specific to patient groups: see disclaimer.
Coronavirus disease 2019 (COVID-19)  
Treatment

### Initial suspected COVID-19

**1st isolation and infection prevention and control procedures**

» Immediately isolate all suspected cases in an area separate from other patients, and implement appropriate infection prevention and control procedures. Suspected cases should be given a mask and kept at least 3 feet (1 meter) from other suspected cases. It is important to note that recommended distances differ between countries and you should consult local guidance.

» [BMJ: covid-19 PPE guidance]

» Detailed guidance is available from the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC):

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

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

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

» Pregnant women should be managed by a multidisciplinary team, including obstetric, perinatal, neonatal, and intensive care specialists, as well as mental health and psychosocial support.[3] [214]

**plus empiric antimicrobials**

Treatment recommended for ALL patients in selected patient group

» Start empiric antimicrobials to cover other potential bacterial pathogens that may cause respiratory infection according to local protocols. Give within 1 hour of initial patient assessment for patients with suspected sepsis. Choice of empiric antimicrobials should be based on the clinical diagnosis, and local epidemiology and susceptibility data.[3]

» Consider treatment with a neuraminidase inhibitor until influenza is ruled out.[3]

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

**plus monitoring**
### Initial

Treatment recommended for ALL patients in selected patient group

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

### adjunct supportive care

Treatment recommended for SOME patients in selected patient group

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

- Oxygen 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%.\[3\] \[196\] Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation. Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition. Once the patient is stable, the target SpO₂ is >90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.\[3\] Some guidelines recommend that SpO₂ should be maintained no higher than 96%.\[196\]

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

### adjunct antipyretic

Treatment recommended for SOME patients in selected patient group

#### Primary options

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

OR

- **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
### Initial Treatment

| mg orally every 4-6 hours when required, maximum 2400 mg/day |

» Guidelines recommend an antipyretic for the relief of fever.[3] [196] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[197] If used, these drugs should only be taken when necessary while symptoms are present.

» Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[198] 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, caution is advised, and the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.[194] [199] [200] [201]

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

| adjunct antitussive |

Treatment recommended for SOME patients in selected patient group

**Primary options**

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

**Secondary options**

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

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

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

» Consider short-term use of an oral opioid in adults if the cough is distressing to the patient. Codeine (linctus or tablet) is the preferred first-line option, with oral morphine solution reserved as a second-line option.[194]
### Acute confirmed COVID-19

<table>
<thead>
<tr>
<th>Severe illness; mild illness with risk factors</th>
<th>1st hospital admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Promptly admit patients with pneumonia or acute respiratory distress to an appropriate healthcare facility. Patients with impending or established respiratory failure should be admitted to an intensive care unit.[3]</td>
<td></td>
</tr>
<tr>
<td>» Patients with mild illness who have risk factors for poor outcomes (i.e., age &gt;60 years, presence of comorbidities) should also be prioritized for hospital admission when possible.[175]</td>
<td></td>
</tr>
<tr>
<td>» Symptomatic pregnant women with confirmed infection should be managed in a hospital setting with appropriate maternal and fetal monitoring; women with severe illness or complications may require admission to an intensive care unit.[214] Pregnant women should be managed by a multidisciplinary team, including obstetric, perinatal, neonatal, and intensive care specialists, as well as mental health and psychosocial support.[3] [214]</td>
<td></td>
</tr>
</tbody>
</table>

**Plus** infection prevention and control procedures

Treatment recommended for ALL patients in selected patient group

» Immediately isolate all confirmed cases in an area separate from other patients, and implement appropriate infection prevention and control procedures.

» [BMJ: covid-19 PPE guidance]

» Detailed guidance is available from the WHO and the CDC:

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

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

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

» The WHO recommends that patients should remain in isolation for 2 weeks after symptoms disappear, and visitors should not be allowed until the end of this period.[192] Guidance on when to stop isolation depends on local
Acute circumstances and may differ between countries; consult local guidelines.

**plus treatment and care planning**

Treatment recommended for ALL patients in selected patient group

» Assess all adults for frailty on admission to hospital, irrespective of age and COVID-19 status, using the Clinical Frailty Scale.[195] [Clinical frailty scale]

» Discuss the risks, benefits, and potential outcomes of treatment options with patients and their families, and allow them to express preferences about their management. Take their wishes and expectations into account when considering the ceiling of treatment. Use decision support tools if available. Put treatment escalation plans in place, and discuss any existing advance care plans or advance decisions to refuse treatment with patients who have preexisting advanced comorbidities.[194]

» Involve critical care teams in discussions about admission to critical care.[195]

**plus monitoring**

Treatment recommended for ALL patients in selected patient group

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

**adjunct supportive care**

Treatment recommended for SOME patients in selected patient group

» Immediately start supportive care, if necessary.

» Oxygen 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%.[3] [196] Titrate flow rates to reach a target SpO₂ ≥94% during resuscitation. Use a face mask with a reservoir bag (at 10-15 L/minute) if the patient is in critical condition. Once the patient is stable, the target SpO₂ is >90% in children and nonpregnant adults, and ≥92% to 95% in pregnant women. Nasal prongs or a nasal cannula are preferred in young children.[3] Some guidelines recommend that SpO₂ should be maintained no higher than 96%.[196]
### Acute

| |  
|---|---|
| **» Fluids:** manage fluids conservatively in adults and children with severe acute respiratory infection when there is no evidence of shock as aggressive fluid resuscitation may worsen oxygenation.[3] |
| **» Managing breathlessness:** keep the room cool, and encourage relaxation, breathing techniques, and changing body positions. Identify and treat any reversible causes of breathlessness (e.g., pulmonary edema). Consider a trial of oxygen, if available. Consider an opioid and benzodiazepine combination in patients with moderate to severe breathlessness or patients who are distressed.[194] |
| **» Managing anxiety, delirium, and agitation:** identify and treat any reversible causes (e.g., offer reassurance, treat hypoxia). Consider a benzodiazepine for the management of anxiety or agitation. Consider haloperidol or a phenothiazine for the management of delirium.[194] |
| **» Implement standard interventions to prevent complications associated with critical illness.[3]** |
| **adjunct** | **empiric antimicrobials** |
| Treatment recommended for SOME patients in selected patient group |
| **» Patients with severe illness may require continued antimicrobial therapy once COVID-19 has been confirmed depending on the clinical circumstances.** |
| **adjunct** | **antipyretic** |
| Treatment recommended for SOME patients in selected patient group |
| **Primary options** |
| **» acetaminophen:** children: 10-15 mg/kg orally every 4-6 hours when required, maximum 75 mg/kg/day; adults: 325-1000 mg orally (immediate-release) every 4-6 hours when required, maximum 4000 mg/day |
| **OR** |
| **» 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 |
**Acute**

- Guidelines recommend an antipyretic for the relief of fever.[3] [196] However, current evidence does not support routine antipyretic administration to treat fever in acute respiratory infections.[197] If used, these drugs should be taken only when necessary while symptoms are present.

- Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[198] 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, caution is advised, and the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.[194] [199] [200] [201]

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

**adjunct antitussive**

Treatment recommended for SOME patients in selected patient group

**Primary options**

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

**Secondary options**

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

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

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

- Consider short-term use of an oral opioid in adults if the cough is distressing to the patient. Codeine (linctus or tablet) is the preferred first-line option, with oral morphine solution reserved as a second-line option.[194]

**adjunct advanced oxygen/ventilatory support**
Coronavirus disease 2019 (COVID-19) Treatment

Acute

Treatment recommended for SOME patients in selected patient group

» Provide advanced oxygen/ventilatory support in patients who are deteriorating and failing to respond to standard oxygen therapy.[3] Follow local infection prevention and control procedures to prevent transmission to healthcare workers, especially when performing aerosol-generating procedures. Novel methods to protect clinicians without access to standard personal protective equipment during aerosol-generating procedures have been suggested (e.g., aerosol box, plastic drapes, helmet devices).[202] [203] [204]

» 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.[3] [196] Monitor patients closely for clinical deterioration that could result in the need for urgent intubation.[3] These procedures may avoid the need for intubation and mechanical ventilation; however, they have a higher risk of aerosol generation and you should check your local guidelines for preferred options.[205] 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.[206]

» Consider intubation and mechanical ventilation in patients who are acutely deteriorating.[3] Endotracheal intubation should be performed by an experienced provider using airborne precautions. Young children, or adults who are obese or pregnant, may desaturate quickly during intubation and therefore require preoxygenation with 100% FiO₂ for 5 minutes.[3] 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.[3] [196]

» Consider prone ventilation in patients with persistent severe hypoxic failure.[3] [196] [208] Pregnant women may benefit from being placed in the lateral decubitus position.[3] A small cohort study of 12 patients in Wuhan, China, with COVID-19-related acute respiratory distress syndrome suggests that spending periods of time in the prone position may improve lung recruitability.[209]
Coronavirus disease 2019 (COVID-19)  

Treatment

<table>
<thead>
<tr>
<th>Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.[196]</td>
</tr>
<tr>
<td>Some patients may require extracorporeal membrane oxygenation (ECMO) according to availability and expertise if the above methods fail.[3] [196] [208]</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>
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| adjunct  
tailor management to comorbidities |
<table>
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</thead>
<tbody>
<tr>
<td>Treatment recommended for SOME patients in selected patient group</td>
</tr>
<tr>
<td>Tailor the management of critical illness to the patient’s comorbidities (e.g., decide which chronic therapies should be continued and which therapies should be temporarily stopped, monitor for drug-drug interactions).[3]</td>
</tr>
<tr>
<td>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.[219] [220] However, professional societies from all over the world recommend continuing these drugs unless clinically indicated.[221] Individualized treatment decisions should be made according to the hemodynamic status and clinical presentation of each patient.</td>
</tr>
</tbody>
</table>

[BMJ: drugs and the renin-angiotensin system in covid-19]
**Acute**

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

» Asthma: advise patients to continue taking their regular prescribed medications in line with their asthma action plan to ensure their condition is as stable as possible. Advise patients to follow their asthma action plan in the event of an exacerbation. There is currently no evidence that inhaled/oral corticosteroids or biologic agents for asthma increase the risk of getting COVID-19.[223] 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.[224]

» 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.[172] Radiation therapy should be avoided if the evidence suggests there is little to no benefit or if alternative treatment is available, or should be deferred if clinically appropriate.[225] Clinicians should consider the severity of disease and post-transplant risks of COVID-19 when deciding on treatment plans for hematopoietic stem cell transplantation.[226]

» 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.[227][228][229][230][231]

» 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.[232][233][234] It has been suggested that patients should be screened for SARS-CoV-2 infection before starting therapy with corticosteroids (for flares) or biologics.[235][236]
### 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>Treatment recommended for SOME patients in selected patient group</td>
<td></td>
</tr>
<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. [3] See the Emerging section for more information about these treatments.</td>
<td></td>
</tr>
<tr>
<td>Patients with mild illness and no risk factors (i.e., age &gt;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. [175] Forced quarantine orders are being used in some countries.</td>
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</tr>
<tr>
<td>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. [175]</td>
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<tr>
<td>Asymptomatic pregnant women with confirmed infection can be managed at home, if appropriate. [214]</td>
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</tr>
<tr>
<td>Patients and household members should follow appropriate infection prevention and control measures. Detailed guidance is available from the WHO and the CDC:</td>
<td></td>
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<tr>
<td>[WHO: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts]</td>
<td></td>
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<tr>
<td>[CDC: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19)]</td>
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<tr>
<td>Two negative test results (on samples collected at least 24 hours apart) are required before the patient can be released from home isolation. If testing is not possible, the patient should remain in isolation for an additional 2 weeks after</td>
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</tbody>
</table>
## Acute

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Acute symptoms resolve.[175] Guidance on when to stop isolation depends on local circumstances and may differ between countries; consult local guidelines.</th>
<th>plus monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Treatment recommended for ALL patients in selected patient group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Monitor patients closely and advise them to seek medical care if symptoms worsen as mild illness can rapidly progress to lower respiratory tract disease.</td>
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<tr>
<td></td>
<td></td>
<td>» Ultrasound fetal surveillance is recommended every 2 weeks in pregnant women.[214]</td>
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<tr>
<td></td>
<td>plus supportive care</td>
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<tr>
<td></td>
<td>Treatment recommended for ALL patients in selected patient group</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Advise patients to keep hydrated but not to take too much fluid as this can worsen oxygenation.[175]</td>
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<tr>
<td></td>
<td>» Advise patients to improve air circulation by opening a window or door (fans can spread infection and should not be used).[194]</td>
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<tr>
<td></td>
<td>adjunct antipyretic</td>
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<tr>
<td></td>
<td>Treatment recommended for SOME patients in selected patient group</td>
<td></td>
</tr>
<tr>
<td>Primary options</td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td>» Some clinicians have suggested that nonsteroidal anti-inflammatory drugs (NSAIDs)</td>
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</table>
## Treatment

### Acute

such as ibuprofen could worsen COVID-19 or have a negative impact on disease outcome based on anecdotal reports.[198] 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, caution is advised, and the National Institute for Health and Care Excellence in the UK recommends acetaminophen as the drug of choice until there is more information available.[194] [199] [200] [201]

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

### Adjunct antitussive

Treatment recommended for SOME patients in selected patient group

#### Primary options

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

#### Secondary options

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

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

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

» Consider short-term use of an oral opioid in adults if the cough is distressing to the patient. Codeine (linctus or tablet) is the preferred first-line option, with oral morphine solution reserved as a second-line option.[194]
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.[238] 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.[239] 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.[240] [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.[241] [242] They are being trialed in patients for the treatment of mild to severe COVID-19.[243] [244] [245] They are also being trialed for prevention and post-exposure prophylaxis in the healthcare setting.[246] [247] 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.[248] However, this trial has been criticized for its limitations, and results from a similar trial could not replicate these findings.[249] [250] 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.[251] Guidelines in China and Italy recommend these drugs for the treatment of COVID-19; however, this is based on weak evidence.[252] Caution is recommended with the dosing regimen used for chloroquine due to the risk of chloroquine poisoning.[253] Hydroxychloroquine has similar therapeutic effects to chloroquine, but fewer adverse effects, is considered safe in pregnancy, and is more readily available in some countries.[254] The European Medicines Agency (EMA) has stressed that these drugs have not been shown to be effective in treating COVID-19 as yet, and should only be used in the context of clinical trials or emergency-use programs.[255] 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.[256] The American Thoracic Society recommends that either drug may be used on a case-by-case basis provided the patient’s condition is severe enough to warrant investigational therapy, the benefits and risks of treatment are discussed with the patient, data is collected on outcomes, and the drug is not in short supply.[208] [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.[241] [257] [258] [259] [260] [261] [262] 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.[263] It appears to be safe to use in pregnancy.[213] The EMA has published recommendations on compassionate use of remdesivir for COVID-19.[264]

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.[265] 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.[266] It is considered safe in pregnancy.[213]

**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.[267] 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.[268] A small preliminary case series of five critically ill patients reported clinical improvement after treatment with convalescent plasma; however, this study had many limitations.[269] 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.[270]

**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.[271]

**Intravenous immune globulin**

Intravenous immune globulin is being trialed in some patients with COVID-19; however, there are no data to support this.[19] [272]

**Treatments for cytokine release syndrome**

Interleukin-6 receptor antagonist monoclonal antibodies (e.g., tocilizumab, sarilumab, siltuximab) are being trialed in COVID-19 patients for the treatment of virus-induced cytokine release syndrome.[273] [274] [275] [276] [277] [278] [279] [280] Tocilizumab and sarilumab are already approved in some countries for the treatment of rheumatologic conditions, siltuximab is approved in some countries for Castleman disease, and tocilizumab is approved in some countries for the treatment of chimeric antigen receptor (CAR) T-cell-induced severe or life-threatening cytokine release syndrome. However, the decision to suppress the immune system of a critically unwell patient with COVID-19 is a difficult one; the beneficial anti-inflammatory effects of anti-inflammatory drugs must be weighed against the possibly detrimental effects of impairment of immunity.[281] Other drugs currently in clinical trials for the treatment of COVID-19-associated cytokine release syndrome include the Janus kinase inhibitor fedratinib and the C-C chemokine receptor type 5 (CCR5) antagonist leronlimab.[282] [283]

**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.[284] [285] [286] However, some experts believe that these drugs may worsen COVID-19 due to overexpression of ACE2 in people taking these drugs. See Management Approach for a discussion of the controversy.

**Other antivirals**

Various other antiviral drugs (monotherapy and combination therapy) are being trialed in patients with COVID-19 (e.g., oseltamivir, darunavir, ganciclovir, favipiravir, baloxavir marboxil, umifenovir, ribavirin, interferon alfa, nebulized interferon beta).[287] [288] [289] [290] [291] [292] [293] [294] [295]

**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.[296]
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.[370]

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.[214]

Perform molecular testing regularly during admission. Two consecutive negative tests (at least 24 hours apart) are required in a clinically recovered patient before discharge.[370]

Patient instructions

General prevention measures

- Wash hands often with soap and water for at least 20 seconds or an alcohol-based hand sanitizer (that contains at least 60% alcohol), especially after being in a public place, blowing your nose, or coughing/sneezing. Avoid touching the eyes, nose, and mouth with unwashed hands.

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

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

- Stay at home if you are sick, even with mild symptoms, until you recover (except to get medical care)

- Clean and disinfect frequently touched surfaces daily (e.g., light switches, door knobs, countertops, handles, phones).[93][94]

  - [BMJ Learning: Covid-19 - handwashing technique and PPE videos]

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

Face masks

- The World Health Organization does not currently recommend wearing a mask in community settings unless the person is unwell or is caring for someone who is sick.[96][97]

- The Centers for Disease Control and Prevention recommends that homemade cloth face coverings can be worn in public settings where social distancing measures are difficult to maintain (e.g., pharmacies, grocery stores), especially in areas where there is significant community transmission.[98]

  - [CDC: how to make your own face covering]

Travel advice

- Many countries have implemented international travel bans/closed their borders, have issued advice for domestic travel, and are requesting that citizens traveling abroad should come home immediately if they are able to. Some countries are restricting entry to foreign nationals who have
been to affected areas in the preceding 14 days, or are enforcing 14-day quarantine periods where the person’s health should be closely monitored (e.g., twice-daily temperature readings).

- Consult local guidance for specific travel restriction recommendations in your country:
  - [WHO: coronavirus disease (COVID-19) travel advice]
  - [CDC: coronavirus disease 2019 (COVID-19) – travel]
  - [NaTHNac: travel health pro]
  - [Public Health England: travel advice - coronavirus (COVID-19)]
  - [Smartraveller Australia: coronavirus (COVID-19)]
  - [Government of Canada: coronavirus disease (COVID-19) - travel advice]
  - [Ministry of Manpower Singapore: advisories on COVID-19]

Pets

- 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.[371] [372]
  - [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>
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<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.[18] [19] [35] [117] [152]</td>
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<tr>
<td>Children can quickly progress to ARDS.[13]</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.</td>
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<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.[342]</td>
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<tr>
<td>acute respiratory failure</td>
<td>short term</td>
<td>medium</td>
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<tr>
<td>Reported in 8% of patients in case series.[19]</td>
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<tr>
<td>Leading cause of mortality in patients with COVID-19.[334]</td>
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<tr>
<td>Children can quickly progress to respiratory failure.[13]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cardiovascular complications</td>
<td>short term</td>
<td>medium</td>
</tr>
<tr>
<td>COVID-19 is associated with a high inflammatory burden that can cause vascular inflammation, cardiac arrhythmias, and myocarditis.[343]</td>
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<tr>
<td>Acute cardiac injury has been reported in 7% to 20% of patients in case series, and indicated by elevated cardiac biomarkers.[18] [35] [152] [344] 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.[344] [345] [346] Patients with underlying cardiovascular disease but without myocardial injury have a relatively favorable prognosis.[347]</td>
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<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.[346]</td>
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<tr>
<td>Fulminant myocarditis has been reported.[334] Early corticosteroid therapy and immune globulin may be beneficial in these patients.[348]</td>
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<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.[332]</td>
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<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.[349]</td>
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<tr>
<td>A case of cardiac tamponade has been reported in a patient with a previous history of myopericarditis.[350]</td>
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<tr>
<td>Infection may have longer-term implications for overall cardiovascular health; however, further research is required.[351]</td>
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<tr>
<td>acute liver injury</td>
<td>short term</td>
<td>medium</td>
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</table>
Coronavirus disease 2019 (COVID-19) Follow up Complications Timeframe Likelihood

Reported in 14% to 53% of patients in case series. Occurs more commonly in patients with severe disease.[352] Although data support a higher prevalence of abnormal aminotransferase levels in patients with severe illness, evidence suggests that clinically significant liver injury is uncommon.[353]

cytokine release syndrome short term low

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.[18] [335] [354] [355]

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.[356]

Anti-inflammatory/immunosuppressive treatments (e.g., tocilizumab, hydroxychloroquine/chloroquine, Janus kinase inhibitors) are being trialed in COVID-19 patients.[357] See our Emerging section for more information.

septic shock short term low

Reported in 4% to 8% of patients in case series.[18] [19] [35] [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.[196]

disseminated intravascular coagulation short term low

Reported in 71% of nonsurvivors.[167]

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.[358]

secondary infection short term low

Reported in 6% to 10% of patients in case series.[18] [152]

acute kidney injury short term low

Reported in 3% to 8% of patients in case series.[18] [19] [152] A large prospective cohort study of over 700 patients in China found that over 40% of patients with COVID-19 had proteinuria on admission, and 26% had hematuria. Approximately 13% to 14% of patients had elevated creatinine, elevated blood urea nitrogen, and an estimated glomerular filtration rate <60 mL/minute/1.73 m². During the study, acute kidney injury developed in 5% of patients, and these patients had an increased risk of in-hospital mortality.[359] 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.[360]

pancreatic injury short term low
### Complications

<table>
<thead>
<tr>
<th>Complications</th>
<th>Timeframe</th>
<th>Likelihood</th>
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<tbody>
<tr>
<td>Mild pancreatic injury (defined as elevated serum amylase or lipase levels) has been reported in 17% of patients in one case series. It is unknown whether this is a direct viral effect or due to the harmful immune response that occurs in some patients. Further research is required.[361]</td>
<td></td>
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<tr>
<td>neurologic complications</td>
<td>short term</td>
<td>low</td>
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<tr>
<td>Patients with severe illness commonly have neurologic complications, likely due to viral invasion of the central nervous system (severe acute respiratory syndrome coronavirus 2 [SARS-CoV-2] has been detected in the brain and cerebrospinal fluid). Complications include acute cerebrovascular disease, impairment of consciousness, ataxia, seizures, neuralgia, skeletal muscle injury, and encephalopathy. Patients may present with these signs/symptoms, or they may develop them during the course of the disease. These patients have a poor prognosis.[362] [363] [364] [365] [366]</td>
<td></td>
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</tr>
<tr>
<td>rhabdomyolysis</td>
<td>short term</td>
<td>low</td>
</tr>
<tr>
<td>Reported as a late complication in one case report.[367]</td>
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<tr>
<td>pregnancy-related complications</td>
<td>short term</td>
<td>low</td>
</tr>
<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 to COVID-19.[61] [62] [65] [213] [368] There is one published case of stillbirth in a woman with severe COVID-19 at 34 weeks’ gestation.[369]</td>
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### Prognosis

#### Case fatality rate

The overall global case fatality rate is currently approximately 5% based on World Health Organization data as of 6 April 2020. The case fatality rate varies between countries; for example, it is currently higher in countries such as Italy and Spain, and lower in countries such as Germany and Australia.[323]

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).[6] 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).[324]

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.[325] 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. Patients who die "with" COVID-19 and patients who die "from" COVID-19 are both counted towards the death toll.[326] [327]

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).[326] 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.[328]

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%).[18] Despite the lower case fatality rate, COVID-19 has so far resulted in more deaths than both SARS and MERS combined.[329]

### Case fatality rate according to age and presence of comorbidities

The case fatality rate increases with age.[324] 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.[330]

The majority of deaths in China have been in patients ages 60 years and older and/or those who have preexisting underlying health conditions (e.g., hypertension, diabetes, cardiovascular disease). The case fatality rate was highest among critical cases (49%). It was also higher in patients ages 80 years and older (15%), males (2.8% versus 1.7% for females), and patients with comorbidities (10.5% for cardiovascular disease, 7.3% for diabetes, 6.3% for chronic respiratory disease, 6% for hypertension, and 5.6% for cancer).[6] Another study found the case fatality rate in China to be 6.4% in patients ages ≥60 years versus 0.32% in patients ages <60 years, and 13.4% in patients ages ≥80 years.[324]

In Italy, the case fatality rate was 8.5% in patients ages 60 to 69 years, 35.5% in patients ages 70 to 79 years, and 52.5% in patients ages ≥80 years.[86] In a case series of 1591 critically ill patients in Lombardy, the majority of patients were older men, a large proportion required mechanical ventilation and high levels of positive end-expiratory pressure, and the mortality rate in the intensive care unit was 26%.[331]

In the US, the case fatality rate was highest among patients ages ≥85 years (10% to 27%), followed by those ages 65 to 84 years (3% to 11%), 55 to 64 years (1% to 3%), 20 to 54 years (<1%), and ≤19 years (no deaths). Patients ages ≥65 years accounted for 80% of deaths.[7] 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.[332] The case fatality rate in residents in a long-term care facility in Washington was reported to be 34%.[333]

Children have a better prognosis than adults, and deaths have been extremely rare.[8] Three deaths have been reported in children in the US.[9]

### Causes of death

The leading cause of death in patients with COVID-19 is respiratory failure from acute respiratory distress syndrome.[334]

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.[335] Other characteristics found to be more frequent in deceased patients include leukocytosis, lymphopenia, and elevated C-reactive protein level, and presence of complications.[336]

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.[337]
**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.[89]

Thrombocytopenia has been associated with increased risk of severe disease and mortality and may be useful as a clinical indicator for monitoring disease progression.[165]

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.[338]

**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.[339] [340]

**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. It is unclear whether these were true reinfections, or if the test result was a false-negative at the time of discharge. Further research is required.[341]
# Diagnostic guidelines

## International

### Information for laboratories [178]

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

### Interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings [179]

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

### COVID-19: resource center [180]

**Published by:** Infectious Diseases Society of America  
**Last published:** 2020

### Country & technical guidance - coronavirus disease (COVID-19) [181]

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

### Laboratory testing strategy recommendations for COVID-19 [182]

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

### Laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases [132]

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

### Global surveillance for COVID-19 caused by human infection with COVID-19 virus [82]

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

### Infection prevention and control during health care when COVID-19 is suspected [113]

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

### COVID-19: guidance for health professionals [183]

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

### COVID-19 [184]

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

### A rapid advice guideline for the diagnosis and treatment of 2019 novel coronavirus (2019-nCoV) infected pneumonia [185]

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

## International

**Coronavirus disease 2019 (COVID-19): for healthcare professionals [297]**

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

**Interim clinical guidance for management of patients with confirmed coronavirus disease (COVID-19) [298]**

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

**Information for clinicians on therapeutic options for COVID-19 patients [299]**

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

**Interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19) [300]**

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

**Discontinuation of in-home isolation for immunocompromised persons with COVID-19 (interim guidance) [301]**

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

**Discontinuation of isolation for persons with COVID-19 not in healthcare settings (interim guidance) [302]**

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

**Interim U.S. guidance for risk assessment and public health management of healthcare personnel with potential exposure in a healthcare setting to patients with coronavirus disease (COVID-19) [303]**

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

**Interim considerations for infection prevention and control of coronavirus disease 2019 (COVID-19) in inpatient obstetric healthcare settings [217]**

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

**COVID#19: interim guidance on management pending empirical evidence [208]**

Published by: American Thoracic Society  
Last published: 2020

**COVID-19: resource center [180]**

Published by: Infectious Diseases Society of America  
Last published: 2020

**Management of infants born to mothers with COVID-19 [216]**

Published by: American Academy of Pediatrics  
Last published: 2020
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<tr>
<td><strong>Novel coronavirus 2019 (COVID-19)</strong> [304]</td>
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<tr>
<td><strong>Published by:</strong> American College of Obstetricians and Gynecologists</td>
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<tr>
<td><strong>Coronavirus disease (COVID-19): outbreak update</strong> [305]</td>
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<tr>
<td><strong>Published by:</strong> Government of Canada</td>
</tr>
<tr>
<td><strong>Country &amp; technical guidance - coronavirus disease (COVID-19)</strong> [181]</td>
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<tr>
<td><strong>Published by:</strong> World Health Organization</td>
</tr>
<tr>
<td><strong>Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected</strong> [3]</td>
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<tr>
<td><strong>Published by:</strong> World Health Organization</td>
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<tr>
<td><strong>Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts</strong> [175]</td>
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<tr>
<td><strong>Published by:</strong> World Health Organization</td>
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<td><strong>Advice on the use of masks in the community, during home care, and in health care settings in the context of COVID-19</strong> [96]</td>
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<td><strong>COVID-19 guidance and the latest research in the Americas</strong> [306]</td>
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<td><strong>Published by:</strong> Pan American Health Organization</td>
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<tr>
<td><strong>Surviving Sepsis Campaign: guidelines on the management of critically ill adults with coronavirus disease 2019 (COVID-19)</strong> [196]</td>
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<tr>
<td><strong>Published by:</strong> Surviving Sepsis Campaign</td>
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<tr>
<td><strong>Global interim guidance on coronavirus disease 2019 (COVID-19) during pregnancy and puerperium from FIGO and allied partners: information for healthcare professionals</strong> [307]</td>
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<td><strong>Published by:</strong> International Federation of Gynecology and Obstetrics</td>
</tr>
<tr>
<td><strong>ISUOG interim guidance on 2019 novel coronavirus infection during pregnancy and puerperium: information for healthcare professionals</strong> [308]</td>
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<tr>
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<tr>
<td><strong>COVID-19 rapid guideline: critical care in adults</strong> [195]</td>
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<tr>
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<td><strong>Coronavirus (COVID-19): rapid guidelines and evidence reviews</strong> [309]</td>
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<tr>
<td><strong>Published by:</strong> National Institute for Health and Care Excellence (UK)</td>
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<td>International</td>
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<tr>
<td><strong>COVID-19: guidance for health professionals</strong> [183]</td>
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<td><strong>Guideline for the treatment of people with COVID-19 disease</strong> [312]</td>
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<tr>
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<td><strong>Recommendations on the clinical management of the COVID-19 infection by the new coronavirus SARS-CoV2</strong> [314]</td>
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<tr>
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<tr>
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<td><strong>A rapid advice guideline for the diagnosis and treatment of 2019 novel coronavirus (2019-nCoV) infected pneumonia</strong> [185]</td>
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<tr>
<td>Published by: Zhongnan Hospital of Wuhan University Novel Coronavirus Management and Research Team; Evidence-Based Medicine Chapter of China International Exchange and Promotive Association for Medical and Health Care</td>
</tr>
<tr>
<td><strong>Diagnosis and treatment protocol for novel coronavirus pneumonia (trial version 7)</strong> [317]</td>
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<tr>
<td>Published by: National Health Commission of the People’s Republic of China; National Administration of Traditional Chinese Medicine of the People’s Republic of China</td>
</tr>
<tr>
<td><strong>Diagnosis and clinical management of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection</strong> [186]</td>
</tr>
<tr>
<td>Published by: Peking Union Medical College Hospital</td>
</tr>
</tbody>
</table>
### International

**Updates on COVID-19 (coronavirus disease 2019) local situation** [318]

**Published by:** Ministry of Health Singapore  
**Last published:** 2020

**New coronavirus (COVID-19)** [319]

**Published by:** National Institute of Infectious Diseases Japan  
**Last published:** 2020

**New coronavirus infection** [320]

**Published by:** Japanese Association for Infectious Diseases  
**Last published:** 2020

**Perinatal and neonatal management plan for prevention and control of SARS-CoV-2 infection (2nd edition)** [321]

**Published by:** Working Group for the Prevention and Control of Neonatal SARS-CoV-2 Infection in the Perinatal Period of the Editorial Committee of Chinese Journal of Contemporary Pediatrics  
**Last published:** 2020

**Coronavirus disease 2019 (COVID-19)** [322]

**Published by:** Department of Health Australia  
**Last published:** 2020
## Online resources

1. Johns Hopkins University: coronavirus COVID-19 global cases ([external link](https://coronavirus.jhu.edu/))
5. CDC: COVIDView ([external link](https://www.cdc.gov/coronavirus/2019-ncov/))
9. BMJ: facemasks for the prevention of infection in healthcare and community settings ([external link](https://www.bmj.com/content/372/bmj.j5155))
13. BMJ: covid-19 in primary care (UK) ([external link](https://www.bmj.com/content/370/bmj.k945))
15. BMJ: covid-19 PPE guidance ([external link](https://www.bmj.com/content/374/bmj.k1418))
19. BSTI: radiology decision support tool for suspected COVID-19 ([external link](https://www.bsmrc.org.uk/decision-support-tool-for-suspected-covid-19))
22. CDC: priorities for testing patients with suspected COVID-19 infection ([external link](https://www.cdc.gov/coronavirus/2019-ncov/priorities-for-testing-patients.html))
<p>| 23. | IDSA: COVID-19 prioritization of diagnostic testing | (external link) |
| 24. | BMJ talk medicine podcast: coping with Covid-19 - advice from a New York City intensivist | (external link) |
| 25. | Clinical frailty scale | (external link) |
| 26. | Surviving Sepsis Campaign: summary of recommendations on the management of patients with COVID-19 and ARDS | (external link) |
| 27. | Surviving Sepsis Campaign: summary of recommendations on the initial management of hypoxic COVID-19 patients | (external link) |
| 28. | WHO: home care for patients with COVID-19 presenting with mild symptoms and management of their contacts | (external link) |
| 29. | CDC: interim guidance for implementing home care of people not requiring hospitalization for coronavirus disease 2019 (COVID-19) | (external link) |
| 30. | ACOG: outpatient assessment and management for pregnant women with suspected or confirmed novel coronavirus (COVID-19) | (external link) |
| 31. | BMJ: drugs and the renin-angiotensin system in covid-19 | (external link) |
| 32. | Centre for Evidence-Based Medicine: angiotensin converting enzyme (ACE) inhibitors and angiotensin receptor blockers in COVID-19 | (external link) |
| 33. | WHO: off-label use of medicines for COVID-19 | (external link) |
| 34. | Centre for Evidence-Based Medicine: chloroquine and hydroxychloroquine - current evidence for their effectiveness in treating COVID-19 | (external link) |
| 35. | CDC: how to make your own face covering | (external link) |
| 36. | WHO: coronavirus disease (COVID-19) travel advice | (external link) |
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| 38. | NaTHNac: travel health pro | (external link) |
| 40. | Smartraveller Australia: coronavirus (COVID-19) | (external link) |
| 41. | Government of Canada: coronavirus disease (COVID-19) - travel advice | (external link) |
| 42. | Ministry of Manpower Singapore: advisories on COVID-19 | (external link) |</p>
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<td>CDC: coronavirus (COVID-19) (external link)</td>
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<tr>
<td>47.</td>
<td>NHS UK: advice for everyone - coronavirus (COVID-19) (external link)</td>
</tr>
</tbody>
</table>
Key articles

References


3. World Health Organization. Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected. 2020 [internet publication]. Full text


Coronavirus disease 2019 (COVID-19)


33. Centre for Evidence-Based Medicine; Ferner RE, Murray PI, Aronson JK. Spreading SARS-CoV-2 through ocular fluids. 2020 [internet publication]. Full text


46. Kupferschmidt K. Study claiming new coronavirus can be transmitted by people without symptoms was flawed. 2020 [internet publication]. Full text


<table>
<thead>
<tr>
<th>Reference</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>60.</td>
<td>Hui DS. Super-spreadering events of MERS-CoV infection. Lancet. 2016 Sep 3;388(10048):942-3. [Full text] [Abstract]</td>
</tr>
<tr>
<td>Reference</td>
<td>Title</td>
</tr>
<tr>
<td>-----------</td>
<td>-------</td>
</tr>
</tbody>
</table>


97. 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? 2020 [internet publication]. Full text
98. Centers for Disease Control and Prevention. Recommendation regarding the use of cloth face coverings, especially in areas of significant community-based transmission. 2020 [internet publication]. Full text


105. Centre for Evidence-Based Medicine; Mahtani KR, Heneghan C, Aronson JK. What is the evidence for social distancing during global pandemics? 2020 [internet publication]. Full text


113. World Health Organization. Infection prevention and control during health care when COVID-19 is suspected. 2020 [internet publication]. Full text


REFERENCES


139. American College of Radiology. ACR recommendations for the use of chest radiography and computed tomography (CT) for suspected COVID-19 infection. 2020 [internet publication]. Full text


154. King’s College London. Loss of smell and taste a key symptom for COVID-19 cases. 2020 [internet publication].  

155. ENT UK. Loss of sense of smell as marker of COVID-19 infection. 2020 [internet publication].  


171. National Institute for Health and Care Excellence. COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community. 2020 [internet publication]. Full text


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


186. 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


197. Centre for Evidence-Based Medicine; Park S, Brassey J, Heneghan C, et al. Managing fever in adults with possible or confirmed COVID-19 in primary care. 2020 [internet publication]. Full text

198. 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


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


Coronavirus disease 2019 (COVID-19)


<table>
<thead>
<tr>
<th>Reference</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>224.</td>
<td>Centre for Evidence-Based Medicine; Hartmann-Boyce J, Hobbs R. Inhaled steroids in asthma during the COVID-19 outbreak. 2020 [internet publication].</td>
</tr>
<tr>
<td>229.</td>
<td>Centers for Disease Control and Prevention. Interim additional guidance for infection prevention and control recommendations for patients with suspected or confirmed COVID-19 in outpatient hemodialysis facilities. 2020 [internet publication].</td>
</tr>
</tbody>
</table>


244. Chinese Clinical Trial Registry. Therapeutic effect of hydroxychloroquine on novel coronavirus pneumonia (COVID-19). 2020 [internet publication]. Full text


255. European Medicines Agency. COVID-19: chloroquine and hydroxychloroquine only to be used in clinical trials or emergency use programmes. 2020 [internet publication]. Full text


262. ClinicalTrials.gov. Study to evaluate the safety and antiviral activity of remdesivir (GS-5734™) in participants with moderate coronavirus disease (COVID-19) compared to standard of care treatment. 2020 [internet publication]. Full text
263. Gilead Sciences. Remdesivir. 2020 [internet publication]. Full text


276. ClinicalTrials.gov. Tocilizumab for SARS-CoV2 severe pneumonitis. 2020 [internet publication]. Full text


283. 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. 2020 [internet publication]. Full text


<table>
<thead>
<tr>
<th>Reference</th>
<th>Title and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>299.</td>
<td>Centers for Disease Control and Prevention. Information for clinicians on therapeutic options for COVID-19 patients. 2020 [internet publication]. <a href="#">Full text</a></td>
</tr>
</tbody>
</table>
REFERENCES


316. First Affiliated Hospital, Zhejiang University School of Medicine. Handbook of COVID-19 prevention and treatment. 2020 [internet publication]. Full text


320. Japanese Association for Infectious Diseases. New coronavirus infection. 2020 [internet publication]. Full text


<table>
<thead>
<tr>
<th>Reference</th>
<th>Title and Abstract</th>
</tr>
</thead>
<tbody>
<tr>
<td>326.</td>
<td>Centre for Evidence-Based Medicine; Oke J, Heneghan C. Global COVID-19 case fatality rates. 2020 [internet publication]. Full text</td>
</tr>
<tr>
<td>329.</td>
<td>Mahase E. Coronavirus covid-19 has killed more people than SARS and MERS combined, despite lower case fatality rate. BMJ. 2020 Feb 18;368:m641. Full text Abstract</td>
</tr>
</tbody>
</table>


371. Centers for Disease Control and Prevention. Interim guidance for public health professionals managing people with COVID-19 in home care and isolation who have pets or other animals. 2020 [internet publication]. Full text

372. IDEXX Laboratories. Leading veterinary diagnostic company sees no COVID-19 cases in pets. 2020 [internet publication]. Full text
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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DISCLOSURES: NJB is partially supported by the National Institute of Health Research Health Protection Unit (NIHR HPRU) in Emerging and Zoonotic Infections at University of Liverpool in partnership with Public Health England (PHE), in collaboration with Liverpool School of Tropical Medicine. He is affiliated with Liverpool School of Tropical Medicine. The views expressed are those of the author and not necessarily those of the NHS, the NIHR, the Department of Health, or PHE.

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DISCLOSURES: TEF is a consultant/expert panel member to the World Health Organization, and is funded by the UK Surgeon General, the NHS, and Liverpool School of Tropical Medicine. TEF is partially supported by the National Institute of Health Research Health Protection Unit (NIHR HPRU) in Emerging and Zoonotic Infections at University of Liverpool in partnership with Public Health England (PHE), in collaboration with Liverpool School of Tropical Medicine. He is affiliated with Liverpool School of Tropical Medicine. He has received research grants from the Wellcome Trust, Medical Research Council, and the UK Public Health Rapid Support Team (UK-PHRST). The views expressed are those of the author and not necessarily those of the NHS, the NIHR, the Department of Health, or PHE.

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