

MANAGEMENT OF ADULTS WITH MILD COVID-19



NATIONAL
COVID-19
CLINICAL
EVIDENCE
TASKFORCE

FORMS OF GUIDANCE

Evidence-Based Recommendation (**EBR**)
Consensus Recommendation (**CBR**)
Practice Point (**PP**)

Types
of
EBRs

RECOMMENDATION FOR USE

RECOMMENDATION AGAINST USE

CONDITIONAL RECOMMENDATION
FOR USE

CONDITIONAL RECOMMENDATION
AGAINST USE

VERSION 42.1

PUBLISHED
9 MAY 2022

General

MANAGING RISK OF INFECTION

- Follow national advice for [use of PPE in non-inpatient healthcare settings during the COVID-19 outbreak](#). **PP** [ICEG; NHMRC]
- Manage probable cases of COVID-19 detected by rapid antigen testing (RAT) as if they are a confirmed case until 7 days has passed since the first positive test and acute respiratory symptoms have resolved, as per [CDNA advice](#). **PP** [Taskforce]

DETERMINING SETTING OF CARE

The most appropriate setting will depend on:

- Local public health policy
- Clinical evaluation of the person with COVID-19
- Evaluation of the home setting including ability to isolate
- Ability to monitor for clinical deterioration and the availability of rapid transfer to higher level of care
- Patient preference. **PP** [Taskforce/WHO]

BASELINE ASSESSMENT

Check for signs of moderate/severe disease (refer to [Pathways to Care for adults with COVID-19](#) Flowchart)

Check vaccination status and recency of vaccination.

No baseline investigations are required for mild COVID-19.

PP [Taskforce/CDNA]

Definition of disease severity

Mild illness

An individual with no clinical features suggestive of moderate or more severe disease:

- no OR mild symptoms and signs (fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhoea, loss of taste and smell)
- no new shortness of breath or difficulty breathing on exertion
- no evidence of lower respiratory tract disease during clinical assessment or on imaging (if performed)

Access to care

This flowchart should be applied after considering the clinical presentation of the patient and risk factors that might increase their overall risk of deterioration. Refer to [Pathways to Care for Adults flowchart](#).

Clinicians are encouraged to exercise greater clinical vigilance and consider appropriateness of O₂ saturation monitoring, more frequent review or referral for patients with disability who also have risk factors for disease progression.

COVID-19 THERAPIES

SUPPORTIVE CARE

Manage mild COVID-19 symptomatically and advise patients to rest.

PP [Taskforce]

An antipyretic is generally not required for mild COVID-19, but paracetamol or ibuprofen as appropriate can be considered for symptomatic relief.

PP [ACSQHC]

ANTIBIOTICS

Do not prescribe antibiotics for mild COVID-19 unless indicated for other reasons, such as community acquired pneumonia. **PP** [Taskforce]

DISEASE-MODIFYING TREATMENTS

Consider DMTs if symptom onset was within 7 days and the person is immunocompromised or at risk of disease progression. Refer to the current summary of [DMTs for adults with COVID-19](#) for treatment options and risk factors for disease progression.

Refer to the [decision support tool](#) for specific guidance on drug treatments for at risk adults with COVID-19 who do not require oxygen.

For treatment options in pregnant or breastfeeding women with COVID-19, refer to [DMTs for pregnant or breastfeeding women](#).

Treatments

THERAPIES FOR PRE-EXISTING CONDITIONS

GENERAL

Ensure that people with confirmed or probable COVID-19 continue to receive their usual care for pre-existing conditions. **PP** [Taskforce]

People taking routine NSAIDs for a chronic condition should continue with treatment. **PP** [ACSQHC]

ASTHMA AND COPD

Inhaled or oral steroids

Use inhaled or oral steroids for the management of people with co-existing asthma or COPD and COVID-19 as you normally would for viral exacerbation of asthma or COPD. Do not use a nebuliser.

CBR [Taskforce]

CONSENSUS RECOMMENDATION

DIABETES AND CARDIOVASCULAR DISEASE

ACEIs/ARBs

RECOMMENDED

In patients with COVID-19 who are receiving ACEIs/ARBs, there is currently no evidence to deviate from usual care and these medications should be continued unless contraindicated. **EBR** [Taskforce]
Stopping these medications abruptly can lead to acute heart failure or unstable blood pressure. **PP** [Taskforce]

In people with suspected or confirmed COVID-19, the use of other treatments such as insulin, other diabetes medications, or statins should continue as usual. **PP** [Taskforce]

CONDITIONS MANAGED WITH IMMUNOSUPPRESSANTS

In people with suspected or confirmed COVID-19, only cease or change the dose of long-term immunosuppressants such as high-dose corticosteroids, chemotherapy, biologics, or disease-modifying anti-rheumatic drugs (DMARDs) on the advice of the treating specialist. **PP** [Taskforce]

OESTROGEN CONTAINING THERAPIES

CONSENSUS RECOMMENDATION

Consider stopping oral menopausal hormone therapy (MHT), also known as hormone replacement therapy (HRT), in women with mild or **moderate** COVID-19. **CBR** [Taskforce]

Before restarting oral MHT, review the indication for this. If MHT is continued, consider using a transdermal preparation.

CONSENSUS RECOMMENDATION

Stop oral menopausal hormone therapy (MHT) in women with **severe or critical** COVID-19. **CBR** [Taskforce]

Before restarting oral MHT, review the indication for this and consider transitioning to a transdermal preparation.

CONSENSUS RECOMMENDATION

In women who have COVID-19 and who are taking oestrogen-containing contraception, manage these medications as per usual care. **CBR** [Taskforce]

In women who stop or suspend contraception when they have COVID-19, restart contraception at the time of discharge or when acute symptoms have resolved.

THINGS TO WATCH FOR

Advise the person with COVID-19 and their carer or family members to look out for the development of new or worsening symptoms, especially breathing difficulties which may indicate the development of pneumonia or hypoxaemia.

Reassure the person that 4 out of 5 people with COVID-19 will have a mild illness and will usually recover 2 to 3 weeks after the initial onset of symptoms.

If respiratory symptoms do worsen, this is most likely to occur in the 2nd or 3rd week of illness. **PP** [Taskforce]

Risk factors for deterioration (* refer right) include:

- Not up to date with vaccination against COVID-19
- Older age, e.g. over 50 years for Aboriginal and Torres Strait Islander people, or otherwise over 65 years
- Pregnant
- Comorbidities:
 - lung disease, including COPD, asthma or bronchiectasis
 - cardiovascular disease, including hypertension
 - obesity (BMI >30 kg/m²)
 - diabetes
 - renal failure
 - immunocompromising conditions (** refer right)
- Concerns about personal safety or access to care.

PULSE OXIMETERS

People with risk factors for deterioration, who are being cared for at home, could be offered monitoring of oxygen saturation with pulse oximetry. **CBR** [Taskforce]

There is no current evidence that supports the benefit of pulse oximetry compared with a home monitoring program in people with COVID-19 who are receiving care at home. **PP** [Taskforce]

Be aware that different pulse oximeters have different specifications, and that some can under or overestimate readings especially if the saturation level is borderline. Overestimation has been reported in people with darker skin. [NICE UK]

For guidance on when to escalate care, refer to the [Pathways to Care flowchart](#).

The RACGP has developed supporting materials to assist with care of people with mild COVID-19 at home. [Please refer to Home-care guidelines for patients with COVID-19](#).

For some patients, symptoms may persist for longer than 4 weeks, or new symptoms may develop. The range of potential long term symptoms of COVID-19 is as yet unknown. For patients who present with possible [long-term symptoms of COVID-19](#), supportive treatment is required. **PP** [Taskforce]

*The evidence to allow us to rank risk factors in order of priority is not yet available.

**IMMUNOCOMPROMISING CONDITIONS:

- Primary or acquired immunodeficiency:
 - haematologic neoplasms: leukaemias, lymphomas, myelodysplastic syndromes
 - post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months)
 - immunocompromised due to primary or acquired (AIDS) immunodeficiency
 - other significantly immunocompromising conditions
 - Immunosuppressive therapy (current or recent):
 - chemotherapy, whole body radiotherapy or total lymphoid irradiation
 - high-dose corticosteroids (≥20 mg of prednisone per day, or equivalent) for ≥14 days
 - selected other potent immunosuppressive therapies (refer to [ATAGI advice](#)).
- PP** [Taskforce]

ESCALATION OF CARE

Transfer the person to hospital if they develop symptoms or signs suggestive of moderate or severe COVID-19, such as:

- SpO₂ ≤92%¹
- increasing shortness of breath or difficulty breathing
- blue lips or face
- pain or pressure in the chest
- cold, clammy or pale and mottled skin
- new confusion or fainting
- becoming difficult to rouse
- little or no urine output
- coughing up blood

PP [BMJ]

Escalation of care may be required if infection control cannot be adequately ensured. **PP** [Taskforce]

RELEASE FROM ISOLATION

- Refer to relevant State and Territory public health advice for the conditions that must be met prior to release of a person from isolation.
- Review [Care at Home](#) advice and provide to patient if appropriate.

PP [Taskforce]

- Assist people to connect to a GP if they do not have one.
- When the acute phase of the illness has resolved, and the patient is mobile, undertake a comprehensive review to assess their ongoing and rehabilitation needs.
- Review medications that were stopped or started.
- Refer the patient to the RACGP resource on [Managing COVID-19 at home with assistance from your general practice](#) for advice on getting up-to-date with vaccination after recovery from COVID-19.

PP [Taskforce]

TRANSFER TO HOSPITAL

Check the person's wishes regarding transfer, and whether they have an Advanced Care Directive for proceeding with hospital management.

Clarify their SARS-CoV-2 status.

If the person wishes to stay in their place of residence or community-based care, discuss care arrangements with the patient, their carer(s) and family, and the local Public Health Unit. Involve their GP, and local palliative care services if available. Be aware that out-of-hospital care will be dependent on the capacity of carer(s) and family to manage infection risk at home and Public Health directives.

If the person wishes to be admitted to hospital, advise the carer or family member to call an ambulance and to **notify** the paramedics that the person has suspected or confirmed COVID-19.

PP [Taskforce]

1 – Specified O₂ levels apply only to patients who do not have underlying lung diseases associated with resting hypoxaemia. Note: in adults with darker skin, pulse oximetry may underestimate severity of hypoxaemia.

Sources

ACSQHC – Australian Commission on Safety and Quality in Health Care. [COVID-19 Position Statement - Managing fever associated with COVID-19](#) (Revised 29 April 2020).

BMJ – Covid-19: a remote assessment in primary care. *BMJ* 2020;368:m1182 doi 10.1136/bmj.m1182 (25 March 2020)

National COVID-19 Clinical Evidence Taskforce – Australian guidelines for the clinical care of people with COVID-19.

ICEG – Australian guidelines for SARS-CoV-2 infection prevention and control of COVID-19 in healthcare workers V1.0.

NHMRC – Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019).

WHO – World Health Organization. Home care for patients with suspected or confirmed COVID-19 and management of their contacts: Interim guidance. 13 Aug 2020.