MANAGEMENT OF ADULTS WITH MILD COVID-19

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

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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

General

MANAGING RISK OF INFECTION

- Follow national advice for use of PPE in non-inpatient healthcare settings during the COVID-19 outbreak. **PP** [Taskforce/ICEG; NHMRC]
- Manage any person clinically and epidemiologically assessed as being a suspected case of COVID-19 as if they are a confirmed case until they have a negative SARS-CoV-2 PCR test done while symptomatic, and there is an alternative diagnosis or 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 capacity for strict infection control
- 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 status of oro/nasopharyngeal swab results.

No baseline investigations are required for mild COVID-19.

Whole genome sequencing of all COVID-19 cases should be undertaken. **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, sore throat, malise, 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.

Treatments

COVID-19 THERAPIES

SUPPORTIVE CARE

Manage mild COVID-19 in a similar way to seasonal flu and advise patients to rest. **PP** [BMJ]

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

Refer to the current Summary of DMTs for Adults
(Note: a **Summary for DMTs for Pregnant women** is under development).

THERAPIES FOR PRE-EXISTING CONDITIONS

GENERAL

Ensure that people with confirmed or presumed 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 — CONSENSUS RECOMMENDATION
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]

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]

Treatments (cont.)

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 been resolved.

Monitoring

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]

PULSE OXIMETERS

Pulse oximeters

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

For guidance on when to escalate care, refer to the Pathways to Care flowchart.

We are aware that the RACGP is developing supporting materials. As soon as these are available we will provide a link to them here.

Risk factors for deterioration(* refer right) include:

- Older Age, e.g. over 50 years for Aboriginal and Torres Strait Islander people, or otherwise over 65 years
- Unvaccinated or partially vaccinated
- Pregnant

Comorbidities:

- lung disease, including COPD, asthma or bronchiectasis
- cardiovascular disease, including hypertension
- obesity (BMI >30 kg/m^2)
- diabetes
- renal failure
- immunocompromising conditions (** refer right)

- Concerns about personal safety or access to care

Use pulse oximetry with adults to assist in assessing and monitoring the severity of respiratory symptoms and detect early deterioration. Provide patients with education on how to self-monitor using pulse oximetry and when to call a GP or triple 0. **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 boderline. Overestimation has been reported in people with darker skin. [NICE UK]

*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 (HIV/AIDS) immunodeficiency
- Other significantly immunocompromising conditions:
  - immunosuppressive therapy (current or recent)
  - chemotherapy or radiotherapy
  - high-dose corticosteroids (≥ 20 mg of prednisone per day, or equivalent) for ≥ 14 days
  - all biologics and most disease-modifying anti-rheumatic drugs (DMARDs) **PP** [Taskforce]

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]

Next steps in care

ESCALATION OF CARE

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

- SpO_2 ≤ 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 patient Care at Home advice and provide to patient if appropriate.

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]

Follow up care

- 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. **PP** [Taskforce]

1 – Specified O_2 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.

National COVID-19 Clinical Evidence TasICEG – 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.