Ontario Long Term Care Clinicians

Wednesday, April 29, 2020

COVID-19 REPORT

Patients with COVID-19 present primarily with fever, cough, myalgia and fatigues. Sometimes the presenting symptoms may be predominantly gastro-intestinal. These typical symptoms may be absent in the elderly. Only 20-30% of geriatric patients with infection present with fever. Atypical COVID-19 symptoms include delirium, falls, generalized weakness, malaise, functional decline, and conjunctivitis, anorexia, increased sputum production, dizziness, headache, rhinorrhea, chest pain, hemoptysis, diarrhea, nausea/vomiting, abdominal pain, nasal congestion, and anosmia.

Presenting signs in the older adult include Tachypnea, delirium, unexplained tachycardia. The threshold for fever should be lower, 37.5°C or an increase of >1.5°C from usual temperature. Older age, frailty, multiple co-morbidities increase the probability of an atypical presentation. Older adults may present with mild symptoms that are disproportionate to the severity of their illness.

Treatment guidelines published in the Canadian Medical Association Journal today answers to overly sanguine assessments from experts, regulatory authorities and prominent politicians regarding the potential benefits of treatments, with under appreciation of potential harms. Key points are:

- Although there are several observational studies and controlled trials with COVID-19, they are limited in sample size and rigour, permitting only weak recommendations.
- Because of inevitable adverse effects of interventions, most informed patients would decline treatment because of the low quality of the evidence and the uncertainty of benefit.
- Although it is a weak recommendation, the expert panel favours the use of corticosteroids in patients with acute respiratory distress syndrome (ARDS).
- The panel recommends against the use of steroids in patients without ARDS, convalescent plasma and several antiviral drugs.
- Rigorous randomized trials are urgently needed to assess the benefit and risks of candidate interventions.

Evidence-based guideline for COVID-10, CMAJ, Apr.29

Clinicians should anticipate atypical presentation in patients over 75 years old. Frail older adults with atypical symptoms have more adverse outcomes. Delirium as a presentation is more common in LTC. Consider COVID-19 as the cause of delirium if any of the following are present:

- Symptoms are suggestive – even if only mild ILI (influenza-like illness) symptoms or low- grade temperature are present
- History of COVID exposure or exposure to others with ILI symptoms
- Hypoxia otherwise unexplained, even if mild (SaO2 <90%)
- Rapid clinical deterioration
- No other clear reason for delirium identified. Be careful not to dismiss delirium as secondary to an UTI. LTC residents show high rates of bacterial colonization, or bacteriuria
- CXR consistent with pneumonia (unilateral or bilateral)

If COVID-19 is suspected, perform a COVID-19 swab and initiate isolation precautions.

Investigations may include CBC, differential, electrolytes, creatinine, eGFR, liver enzymes, LDH, CRP and ferritin. Although not readily feasible for our resident s in LTC, a CT scan of the chest shows typical findings are focal unilateral ground glass opacities rapidly evolving to bilateral diffuse ground glass opacities.
COVID-19 in Older Adults, Toronto RGP, Apr 7

A portable chest x-ray is the most accessible imaging in LTC. Moreover, the American College of Radiology notes that CT decontamination required after scanning COVID-19 patients may disrupt radiological service availability and suggests that portable chest radiography may be considered to minimize the risk of cross-infection. Patterns of COVID-19 lung disease can be identified on conventional chest radiography as well as chest CT. Typical verbiage when reporting patients with, or suspected COVID-19 on CXR include terms such as irregular, patchy, hazy, reticular, and widespread ground glass opacities. Relevant findings on chest radiographs may include (i) ground glass densities, (ii) bilateral lower lobe consolidations, (iii) peripheral air space opacities and (iv) diffuse air space disease. The requisition should include possible, presumed or confirmed COVID-19.
Journal of Clinical Imaging, Apr 8