CLINICAL OVERVIEW

Coronavirus: novel coronavirus (COVID-19) infection

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Synopsis

Key Points

- COVID-19 (coronavirus disease 2019) is respiratory tract infection due to a novel coronavirus, SARS-CoV-2 (initially called 2019-nCoV); as of March 11, 2020, extent of infection was declared pandemic by the WHO.¹

- Virus is thought to be zoonotic in origin, but the animal reservoir is not yet known, and it is clear that human-to-human transmission is occurring

- Infection ranges from asymptomatic to severe; symptoms include fever, cough, and (in moderate to severe cases) dyspnea; disease may evolve over the course of a week or more from mild to severe. Upper respiratory tract symptoms (eg, rhinorrhea, sore throat) are uncommon.²

- A significant proportion of clinically evident cases are severe; the mortality rate among diagnosed cases is about 2% to 3%.¹

- Infection should be suspected based on presentation with a clinically compatible history and known or likely exposure (residence in or travel to an affected area within the past 14 days, exposure to a known or suspected case, exposure to a health care setting in which patients with severe respiratory tract infections are managed)

- Chest imaging in symptomatic patients almost always shows abnormal findings, usually including bilateral infiltrates; laboratory findings are variable but typically include lymphopenia and elevated lactate dehydrogenase and transaminase levels

Urgent Action

- Triage screening is recommended at registration for medical care to identify patients with symptoms and exposure history that suggest the possibility of COVID-19, and to promptly institute isolation measures

- Patients with respiratory distress require prompt administration of supplemental oxygen; patients with respiratory failure require intubation

- Patients in shock require urgent fluid resuscitation and administration of empiric antimicrobial therapy
- Diagnosis is confirmed by detection of viral RNA on polymerase chain reaction test of upper or lower respiratory tract specimens or serum specimens

- There is no specific antiviral therapy, although compassionate use and trial protocols for several agents are underway; treatment is largely supportive, consisting of supplemental oxygen and conservative fluid administration

- Most common complications are acute respiratory distress syndrome and septic shock; myocardial, renal, and multiorgan failure have been reported

- There is no vaccine available to prevent this infection; infection control measures are the mainstay of prevention (ie, hand and cough hygiene; standard, contact, and airborne precautions; social distancing)

Pitfalls

- It is possible (but not yet well established) that persons with prodromal or asymptomatic infection may spread infection, making effective prevention more challenging

- Knowledge of this disease is incomplete and evolving; moreover, coronaviruses are known to mutate and recombine often, presenting an ongoing challenge to our understanding and to clinical management

Terminology

Clinical Clarification

- COVID-19 (coronavirus disease 2019) is a respiratory tract infection with a newly recognized coronavirus thought to have originated as a zoonotic virus that has mutated or otherwise adapted in ways that allow human pathogenicity

- Disease was provisionally called 2019-nCoV infection at start of outbreak (2019 novel coronavirus infection)

- Outbreak began in China, where its effects to date are most widespread; it has since spread to many other countries, and it was officially declared by WHO to be a pandemic\(^1\) on March 11, 2020

- Illness ranges in severity from asymptomatic or mild to severe; a significant proportion of patients with clinically evident infection develop severe disease\(^1\)

- Mortality rate among diagnosed cases (case fatality rate) is about 2% to 3%; true overall mortality rate is uncertain, as the total number of cases (including undiagnosed persons with milder illness) is unknown

- Knowledge of this disease is incomplete and evolving; moreover, coronaviruses are known to mutate and recombine often, presenting an ongoing challenge to our understanding and to clinical management

1. https://www.clinicalkey.com/#!/content/clinical_overview/67-s2.0-0e7112a3-e94d-4136-94ba-cfdf9242ea43
Classification

- Pathogen is a betacoronavirus, similar to the agents of SARS (severe acute respiratory syndrome) and MERS (Middle East respiratory syndrome)

- Classified as a member of the species Severe acute respiratory syndrome–related coronavirus

- Designated as SARS-CoV-2 (severe acute respiratory syndrome coronavirus)

Diagnosis

Clinical Presentation

History

- In symptomatic patients, illness may evolve over the course of a week or longer, beginning with mild symptoms that progress (in some cases) to the point of dyspnea and shock

- Most common complaints are fever (almost universal) and cough, which may or may not be productive

- Myalgia and fatigue are common

- Patients with moderate to severe disease complain of dyspnea

- Hemoptysis has been reported in a small percentage of patients

- Pleuritic chest pain has been reported

- Upper respiratory tract symptoms (eg, rhinorrhea, sneezing, sore throat) are unusual

- Headache and gastrointestinal symptoms (eg, nausea, vomiting, diarrhea) are uncommon but may occur

- Patients may report close contact with an infected person; outside of an identified outbreak area, a history of recent travel (within 14 days) to an area with widespread infection is relevant, although cases with no identifiable risk factor are being reported

Physical examination

- Reported case series have not detailed physical findings, but clinicians should be particularly attuned to pulmonary and hemodynamic indicators of severe disease
Patients with severe disease may appear quite ill, with tachypnea and labored respirations.

Fever is usual, often exceeding 39 °C. Patients in the extremes of age or with immunodeficiency may not develop fever.²

Hypotension, tachycardia, and cool/clammy extremities suggest shock.

In children, hypotension plus 2 or 3 of the following criteria;²

- Altered mental status
- Tachycardia (heart rate more than 160 beats per minute in infants or 150 in older children) or bradycardia (heart rate less than 90 in infants or 70 in older children)
- Prolonged capillary refill (more than 2 seconds) or warm vasodilation and bounding pulses
- Tachypnea
- Mottled skin, petechiae, or purpura
- Oliguria
- Hyperthermia or hypothermia

Causes and Risk Factors

Causes

- Infection due to SARS-CoV-2 (2019 novel coronavirus)

- Person-to-person transmission has been documented⁶ and is presumed to occur by close contact,¹⁰ probably via respiratory droplets.¹¹

- It is not known when in the course of infection a person becomes contagious to others. Chinese authorities have reported the possibility that the virus may be transmitted before symptoms develop,¹² and a few case reports from Germany¹³ and from China¹⁴ have been published; if such transmission truly exists, its frequency is not yet known.¹¹ ¹⁴

- Additional means of transmission have not been ruled out (eg, contact with infected environmental surfaces)

Risk factors and/or associations

Age

- Most reported cases are adults of middle age and older,² ⁵ but several pediatric infections⁶ have been reported

Sex
In published case series, males have been affected more often than females overall.\(^2\) \(^3\) \(^5\) \(^6\)

Other risk factors/associations

- Early on, an association was noted between infected persons and a market in Wuhan that sold seafood, livestock, and wild game; infection was presumed to have been acquired by exposure to infected animals.\(^15\)

- However, although environmental samples from the implicated market showed evidence of the virus, no animal specimens have been positive; a zoonotic origin of the virus remains likely, but the original source and reservoir of infection are unknown.\(^16\)

Diagnostic Procedures

Primary diagnostic tools

- Infection should be suspected in persons with a compatible respiratory illness and exposure history

- A map of areas reporting cases\(^17\) is available through CDC, but it must be noted that it includes countries reporting just a single case, in which risk to general population is extremely low

- Chest imaging is essential to document presence of pneumonia and to assess severity; both plain radiography and CT have been used.\(^5\)

- In Hubei Province only, a trained medical professional can classify a suspected case of COVID-19 as clinically confirmed on the basis of chest imaging, rather than by laboratory confirmation.\(^18\)

- Oxygenation should be assessed by peripheral saturation (eg, pulse oximetry) or by arterial blood gas test.\(^9\)

- Polymerase chain reaction tests have been developed by CDC and other governmental and commercial organizations. In the United States, the FDA\(^19\) is permitting use of validated tests developed by certain qualified laboratories that have submitted a request for emergency use authorization. Attempts to culture the virus are not recommended

Chest radiographs and chest CT scans of 3 patients with 2019-nCoV infection. - Case 1: chest radiograph was obtained on January 1 (1A). The brightness of both lungs was diffusely decreased, showing a large area of patchy shadow with uneven density. Tracheal intubation was seen in the trachea, and the heart shadow outline was not clear. The catheter shadow was seen from the right axilla to the mediastinum. Bilateral diaphragmatic surface and costal diaphragmatic angle were not clear, and chest radiograph on January 2 showed worse status (1B). Case 2: chest radiograph obtained on January 6 (2A). The brightness of both lungs was decreased and multiple patchy shadows were observed; edges were blurred, and large ground-glass opacity and condensation shadows were mainly on
CDC ¹⁰ and WHO ⁹ have slightly different criteria for whom to test. These criteria apply to patients with compatible features of COVID-19 who are in the following categories (such patients would be considered PUIs—persons under investigation—by CDC):

- WHO ²⁰ ²¹
  - Acute respiratory tract illness (fever and at least 1 sign/symptom of respiratory tract disease) and a history of travel to or residence in an area reporting local transmission of COVID-19 during the 14 days preceding symptom onset
  - A patient with any acute respiratory tract illness and close contact with a person with confirmed or probable COVID-19 in the 14 days preceding illness onset
  - Severe acute respiratory tract infection requiring hospital admission without an alternative etiologic diagnosis

- CDC ¹⁰
  - Recommends that clinicians use their judgment, informed by knowledge of the patient’s travel and/or exposure history, local COVID-19 activity, and other risk factors to determine the need for testing in persons with a clinically compatible illness

Collection of specimens from upper respiratory tract, lower respiratory tract, and serum is recommended for polymerase chain reaction testing, plus a sputum specimen if productive cough is present. ¹⁰ Additional specimens (eg, stool, urine) may be collected and stored for later testing at the discretion of public health authorities. Care must be taken to minimize risks associated with aerosolization during specimen collection.

- CDC provides specific instructions for collection and handling of specimens: ²²

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the lower right lobe. Tracheal intubation could be seen in the trachea. Heart shadow roughly presents in the normal range. On the left side, the diaphragmatic surface is not clearly displayed. The right side of the diaphragmatic surface was light and smooth, and rib phrenic angle was less sharp. Chest radiograph on January 10 showed worse status (2B). Case 3: chest CT obtained on January 1 (3A) showed mass shadows of high density in both lungs. Bright bronchogram is seen in the lung tissue area of the lesion, which is also called bronchoinflation sign. Chest CT on January 15 showed improved status (3B).

Chest CT images in 2019-nCoV infection. - A, Transverse chest CT images from a 40-year-old man showing bilateral multiple lobular and subsegmental areas of consolidation on day 15 after symptom onset. B and C, Transverse chest CT images from a 53-year-old woman showing bilateral ground-glass opacity and subsegmental areas of consolidation on day 8 after symptom onset (B) and bilateral ground-glass opacity on day 12 after symptom onset (C).
• Upper respiratory tract
  - Both a nasopharyngeal and an oropharyngeal swab should be obtained; only synthetic fiber swabs with plastic shafts are acceptable. The 2 specimens should be submitted in separate containers
  - Insert swab into nostril parallel to palate. Leave swab in place for a few seconds to absorb secretions
  - Swab the posterior pharynx, avoiding the tongue and tonsils
  - Nasopharyngeal wash (or aspirate) or nasal aspirate specimens are also acceptable

• Lower respiratory tract
  - Bronchoalveolar lavage or tracheal aspirate are suitable lower respiratory tract specimens
  - A deep cough sputum specimen (collected after mouth rinse) is also acceptable
  - WHO advises against attempts to induce sputum, because the process may increase aerosolization and risk of transmission

• Serum
  - Blood should be collected in a serum separator tube and centrifuged after upright storage for 30 minutes
  - Minimum of 1 mL of whole blood is needed (eg, in pediatric patients)

Other testing should be performed concurrently, if indicated, to identify alternative pathogens (eg, influenza virus, respiratory syncytial virus, bacterial pathogens); such tests should not delay arrangements for SARS-CoV-2 polymerase chain reaction testing (Related: Community-acquired pneumonia in adults)
Routine blood work should be ordered as appropriate for clinical management based on disease severity (eg, CBC, coagulation studies, chemistry panel including tests of hepatic and renal function and—if sepsis is suspected—lactate level) (Related: Sepsis)

Clinicians should report suspected cases of COVID-19 to appropriate public health authorities, who can facilitate testing if necessary and can undertake contact tracing and monitoring. In the United States, contact local or state health department 10 23

Laboratory

Positive identification of SARS-CoV-2 (2019-nCoV) RNA by polymerase chain reaction test is considered confirmation of diagnosis.

Routine blood work is not diagnostic, but a pattern of typical abnormalities is emerging in case series of hospitalized patients:

- Leukopenia may be observed and relative lymphopenia is common, especially in patients with more severe illness 2 5 6
- Anemia was noted in about half of patients in one series 5
- Both elevated and low platelet counts have been seen 2 5 6
- A prolonged prothrombin time has been reported 24
- Levels of D-dimer and fibrinogen may be elevated 2 6
- Elevated levels of lactate dehydrogenase and liver enzymes (ALT and AST) are common 2 5
- Serum procalcitonin levels are usually within reference range; elevated levels have been seen in patients with secondary infection 2
- Serum levels of some other acute phase reactants (eg, C-reactive protein, ferritin) are elevated in most patients, as is the erythrocyte sedimentation rate 5

Lactate level of 2 mmol/L or higher suggests presence of septic shock 9

Imaging
Chest imaging (eg, plain radiography, CT) has shown abnormalities in most reported patients; it usually shows bilateral involvement, varying from consolidation in more severely ill patients to ground-glass opacities in less severe and recovering pneumonia.

CT appears to be more sensitive than plain radiographs, but normal CT appearance does not exclude COVID-19.

Differential Diagnosis

Most common

*Because COVID-19 cannot be distinguished clinically from other pneumonias, history of contacts or travel remains an important differentiator, although cases without such history are increasing in frequency.*

**Influenza**

Presentation includes fever, dry cough, and myalgias; unlike with COVID-19, upper respiratory tract symptoms are common (eg, coryza, sore throat)

Most cases are self-limited, but elderly persons or those with significant comorbidities often require hospitalization

Usually occurs in winter months in temperate climates but is less seasonal in equatorial regions

Patients with severe disease may have abnormal chest radiographic findings suggesting influenzal pneumonia or secondary bacterial pneumonia

Positive result on rapid influenza diagnostic test confirms influenza diagnosis with high specificity during typical season; negative result does not rule out influenza

**Other viral pneumonias**

(Related: )

**Community-acquired pneumonia in adults**

Presentations include fever, dry cough, and dyspnea

Physical examination may find scattered rales

Chest radiography usually shows diffuse patchy infiltrates

Diagnosis is usually clinical; testing for specific viral causes (eg, respiratory syncytial virus, adenovirus) may be done
Bacterial pneumonia
(Related: ) Presentation includes fever, cough, and dyspnea; pleuritic pain occurs in some cases

Physical examination may find signs of consolidation (eg, dullness to percussion, auscultatory rales, tubular breath sounds)

Chest radiography usually shows lobar consolidation or localized patchy infiltrate

Sputum examination may find abundant polymorphonuclear leukocytes and a predominant bacterial organism

Pneumococcal or legionella antigens may be detectable in urine; sputum culture may find those or other pathogens

Treatment

Goals

- Ensure adequate oxygenation and hemodynamic support during acute phase of illness

Disposition

Admission criteria

Nonsevere pneumonia

- Radiographic evidence of pneumonia; progressive clinical illness with indications for supplemental oxygen and hydration; inadequate care at home

- CDC provides guidance for determining whether the home is a suitable venue and patient and/or caregiver is capable of adhering to medical care recommendations and infection control measures

Criteria for ICU admission

- WHO provides criteria for severe pneumonia

  - Severe pneumonia characterized by tachypnea (respiratory rate greater than 30 breaths per minute), severe respiratory distress, inadequate oxygenation (eg, SpO₂ less than 90%)

    - Pediatric criteria include central cyanosis or SpO₂ less than 90%; signs of severe respiratory distress (eg, grunting, chest retractions); inability to drink or breastfeed; lethargy, altered level of consciousness, seizures; severe tachypnea defined by age:

      - Younger than 2 months: 60 or more breaths per minute
      - Aged 2 to 11 months: 50 or more breaths per minute
- Aged 1 to 5 years: 40 or more breaths per minute

- Presence of severe complications (e.g., septic shock, acute respiratory distress syndrome)

**Recommendations for specialist referral**

- All patients should be managed in consultation with public health authorities

- Consult infectious disease specialist to coordinate diagnosis and management with public health authorities

- Consult pulmonologist to aid in obtaining deep specimens for diagnosis and managing mechanical ventilation if necessary

- Consult critical care specialist to manage fluids, mechanical ventilation, and hemodynamic support as needed

**Treatment Options**

Standard, contact, and airborne precautions should be implemented as soon as the diagnosis is suspected

- Immediately provide the patient with a face mask and place the patient in a closed room (preferably with structural and engineering safeguards against airborne transmission, such as negative pressure and frequent air exchange) pending further evaluation and disposition decisions

At present, no specific antiviral agent is approved for treatment of this infection. Several existing antiviral agents are being used under clinical trial and compassionate use protocols based on in vitro activity (against this or related viruses) and on limited clinical experience

- Lopinavir-ritonavir is FDA-approved for treatment of HIV infection. It has been used for other coronavirus infections; it was used empirically for SARS and is being studied in the treatment of MERS

  - In China this combination is used in conjunction with interferon alfa for treatment of some patients with COVID-19

- Remdesivir is an experimental antiviral agent with significant in vitro activity against coronaviruses and some evidence of efficacy in an animal model of MERS

- Information on therapeutic trials and expanded access is available at clinicaltrials.gov

Corticosteroid therapy is not recommended for either viral pneumonia or acute respiratory distress syndrome
Until a diagnosis of COVID-19 is confirmed by polymerase chain reaction test, appropriate antiviral or antimicrobial therapy for other viral pathogens (eg, influenza virus) or bacterial pathogens should be administered in accordance with the site of acquisition (hospital or community) and epidemiologic risk factors.

Otherwise, treatment is largely supportive and includes oxygen supplementation and conservative fluid support.


Nondrug and supportive care
- WHO provides specific guidance for oxygenation, ventilation, and fluid management.

- Oxygenation and ventilation
  - Nasal cannula at 5 L/minute, titrated to target peripheral oxygen saturation: SpO₂ of 90% or higher in nonpregnant adults; 92% or higher in pregnant patients
  - In most children the target SpO₂ is 90% or greater; for those who require urgent resuscitation (eg, those with apnea or obstructed breathing, severe respiratory distress, central cyanosis, shock, seizures, or coma), a target SpO₂ of 94% or higher is recommended
  - High-flow nasal oxygen or noninvasive ventilation may be necessary to achieve adequate oxygenation in some patients, although there is concern that these techniques may result in higher risk of aerosolization of the virus.
  - Mechanical ventilation may be necessary for patients in whom oxygenation targets cannot be met with less invasive measures or who cannot maintain the work of breathing; recommended settings are tidal volume of 4 to 8 mL/kg and inspiratory pressures less than 30 cm H₂O
  - Use of PEEP may be necessary in patients with acute respiratory distress syndrome. Optimal regimen is not clearly defined, although WHO suggests higher rather than lower pressures (Related: Acute respiratory distress syndrome in adults)
  - For patients with severe acute respiratory distress syndrome, prone positioning is recommended
  - Extracorporeal membrane oxygenation has been used in severely ill patients, and it can be considered if resources and expertise are available

- Fluid management
- Overhydration should be avoided, because it may precipitate or exacerbate acute respiratory distress syndrome

- In patients with shock:
  - Administration of crystalloids (ie, saline or lactated Ringer solution) is recommended
    - Adults: total of 30 mL/kg over the first 3 hours; goal is mean arterial pressure of at least 65 mm Hg (if invasive pressure monitoring is available)
    - Children: 20 mL/kg bolus and up to 40 or even 60 mL/kg over the first hour

Comorbidities
- Severe disease due to SARS-CoV-2 (2019-nCoV) has been associated with chronic conditions such as diabetes, hypertension, and other cardiovascular conditions; existing published guidance does not address management issues specific to these comorbidities

Special populations
- Pregnant patients
  - WHO guidelines suggest that pregnant patients receive supportive care as recommended for nonpregnant adults, with accommodations as dictated by the physiologic changes of pregnancy (eg, expanded volume of distribution, elevated diaphragm)

Monitoring
- Patients who do not require admission should self-monitor temperature and symptoms, and they should return for reevaluation if symptoms worsen; deterioration may occur a week or more into the course of illness
- In hospitalized patients with proven COVID-19, repeated testing is recommended to document clearance of virus, defined as 2 consecutive negative results on polymerase chain reaction tests at least 24 hours apart

Complications and Prognosis
Complications
- Most common complication is acute respiratory distress syndrome; other reported complications include: (Related: Acute respiratory distress syndrome in adults)
  - Septic shock (Related: Sepsis)
  - Acute kidney injury
  - Myocardial injury (Related: Heart failure)
Secondary bacterial and fungal infections

Multiorgan failure

Prognosis

Patients who require hospital admission often require prolonged inpatient stay (more than 20 days), although duration of stay may be inflated by need for isolation until documentation of sustained absence of fever and serial negative results on polymerase chain reaction test.

Otherwise, short and long-term prognosis (e.g., recovery of pulmonary function) remains to be seen with time.

Mortality rate of diagnosed cases is about 2% to 3%.

Screening and Prevention

Screening

At-risk populations

Screening of travelers from affected areas is being done under the guidance of public health authorities at airports to assure that persons who are ill are referred for medical evaluation, and to educate those who are not ill but at risk for infection about self-monitoring.

Triage screening is recommended at points of medical care to identify patients with symptoms and exposure history that suggest the possibility of COVID-19, so that prompt isolation measures can be instituted.

Screening tests

Screening and triage to isolation and PCR testing are based on clinical presentation and exposure history:

- Presence of respiratory symptoms (cough, dyspnea) and fever (CDC, WHO)
- Recent (within 14 days) travel to Wuhan City, China or broader geographic areas with widespread COVID-19 (WHO, CDC)
- Close contact with a person with known or suspected COVID-19 while that person was ill (WHO, CDC)
- Work in a health care setting in which patients with severe respiratory illnesses are managed, without regard to place of residence or history of travel (WHO)
- Unusual or unexpected deterioration of an acute illness despite appropriate treatment, without regard to place of residence or history of travel, even if another cause has been identified that fully explains the clinical presentation (WHO)
Prevention

- There is no vaccine against COVID-19. Prevention depends on standard infection control measures, including isolation of infected patients. Quarantine may be imposed on asymptomatic exposed persons deemed by public health authorities to be at high risk.\(^{39}\)

- For the general public, avoidance of ill persons and diligent hand and cough hygiene are recommended. Social distancing should be used as much as possible. Advise public as follows:\(^{11}\)
  - Avoid large gatherings and unnecessary gatherings; stay home when possible
    - Telecommute if nature of job makes it possible
  - Wash hands often and thoroughly. Soap and water are best. High-alcohol hand sanitizers are acceptable until next possible handwashing
  - Greet others without touching; nod or wave instead of shaking hands or hugging. Try to maintain 1-m (3-ft) social distance
  - Cover coughs. Use tissue and throw it away; second choice is sleeve, not hand
  - Avoid touching face

- Patients managed at home\(^{40}\)
  - Patient is encouraged to stay at home except to seek medical care, to self-isolate to a single area of the house (preferably with a separate bathroom), to practice good hand and cough hygiene, and to wear a face mask during any contact with household members
    - Patients should be advised that if a need for medical care develops, they should call their health care provider in advance so that proper isolation measures can be undertaken promptly on their arrival at the healthcare setting
    - Duration of infectious potential and need for precautions has not been fully established; CDC recommends consultation with public health authorities and demonstration of negative results of molecular assays for SARS-CoV-2 RNA on 2 sets of respiratory secretions at least 24 hours apart, as well as subjective and objective evidence of clinical improvement\(^{41}\)
  - Household members/caregivers should:
    - Wear face masks, gowns, and gloves when caring for patient; remove and discard all when leaving the room (do not reuse)
    - Dispose of these items in a container lined with a trash bag that can be removed and tied off or sealed before disposal in household trash
- Wash hands for at least 20 seconds after all contact; an alcohol-based hand sanitizer is acceptable if soap and water are not available

- Not share personal items such as towels, dishes, or utensils before proper cleaning

- Wash laundry and "high-touch" surfaces frequently

  - Wear disposable gloves to handle dirty laundry and use highest possible temperatures for washing and drying, based on washing instructions on the items

  - Clean surfaces with diluted bleach solution or an EPA-approved disinfectant

  - Restrict contact to minimum number of caregivers and, in particular, ensure that persons with underlying medical conditions are not exposed to the patient

- In health care settings

  - CDC provides preparedness checklists for outpatient and inpatient health care settings

  - Provide the patient with a face mask and place the patient in a closed room (preferably with structural and engineering safeguards against airborne transmission, such as negative pressure and frequent air exchange)

  - Persons entering the room should follow standard, contact, and airborne precautions

    - Gloves, gowns, eye protection, and respirator (N95 or better) with adherence to hospital donning and doffing protocols

    - In circumstances in which supplies of N95 respirators and other protective equipment are short, their use should be prioritized for aerosol-generating procedures; standard surgical face masks should be used for other situations

    - Equipment used for patient care should be single-use (disposable) or should be disinfected between patients; WHO suggests using 70% ethyl alcohol

  - Criteria for discontinuation of isolation precautions have not been determined. CDC recommends individualized assessment in consultation with public health officials. Factors to be considered include clinical improvement in temperature and respiratory status and negative results on polymerase chain reaction from 2 consecutive sets of throat and nasopharyngeal specimens at least 24 hours apart

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