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CMAAO Coronavirus Facts and Myth Buster: Long COVID – NICE Guideline

NICE ISSUES RAPID GUIDELINE ON LONG COVID

- People may have ongoing symptomatic coronavirus disease 2019 (COVID-19) if they have symptoms 4-12 weeks after the onset of acute symptoms.
- People may have post-COVID syndrome if their symptoms do not resolve after 12 weeks.
- The rapid guideline on managing the long-term effects of COVID-19, or 'long COVID', has been issued by NICE in collaboration with the Scottish Intercollegiate Guidelines Network (SIGN) and the Royal College of General Practitioners (RCGP).
- The guideline was published as the NHS announced that patients with long-term symptoms of COVID-19 could access specialist help at an increasing number of clinics across England.
- One in 5 individuals with COVID-19 develop longer term symptoms. Nearly 1,86,000 individuals experience health problems for up to 12 weeks, suggests the Office for National Statistics (ONS).
- The ONS estimates that around 9.9% of people who had COVID-19 continued to be symptomatic after 12 weeks.
- The most common symptoms included fatigue, cough and headache.

- The NICE guidance covers the care of people having signs and symptoms that develop during or after an infection consistent with COVID-19, continuing for over 4 weeks, and that cannot be explained by an alternative diagnosis. The recommendations are based on current evidence and expert consensus.
- The guideline makes recommendations in several other important areas, such as assessing people with new or ongoing symptoms after acute COVID-19; investigations and referral; planning care; management, including self-management, supported self-management and rehabilitation; follow-up and monitoring; service organization.

The following clinical definitions were used for the initial illness and long COVID at different times:

- **Acute COVID-19:** Signs and symptoms of COVID-19 for up to 4 weeks.
- **Ongoing symptomatic COVID-19:** Signs and symptoms of COVID-19 from 4 to 12 weeks.
- **Post-COVID-19 syndrome:** Signs and symptoms developing during or after an infection consistent with COVID-19, continuing for over 12 weeks that cannot be explained by an alternative diagnosis.

COMMON SYMPTOMS OF ONGOING SYMPTOMATIC COVID-19 AND POST-COVID-19 SYNDROME

Symptoms after acute COVID-19 are variable. The most commonly reported symptoms include (but are not limited to) the following:

Respiratory symptoms

- Breathlessness
- Cough

Cardiovascular symptoms

- Chest tightness
- Chest pain
- Palpitations

Generalized symptoms

- Fatigue
- Fever
- Pain

Neurological symptoms

- Cognitive impairment ('brain fog', loss of concentration or memory issues)
- Headache
- Sleep disturbance
- Peripheral neuropathy symptoms (pins and needles, numbness)
- Dizziness
- Delirium (in older populations)

Gastrointestinal symptoms

- Abdominal pain
- Nausea
- Diarrhea
- Anorexia and reduced appetite (in older populations)

Musculoskeletal symptoms

- Joint pain
- Muscle pain

Psychological/Psychiatric symptoms

- Symptoms of depression
- Symptoms of anxiety

Ear, nose and throat symptoms

- Tinnitus
- Earache
- Sore throat

- Dizziness
- Loss of taste and/or smell

Dermatological

- Skin rashes

Investigations and Referral

These recommendations are aimed at healthcare professionals carrying out initial investigations in primary care or community services for people with new or ongoing symptoms 4 weeks or more after the onset of suspected or confirmed *acute COVID-19*.

3.1 People with *ongoing symptomatic COVID-19* or suspected *post-COVID-19 syndrome* to be urgently referred to the relevant acute services if there are signs or symptoms that could be caused by an acute or life-threatening complication, including (but not limited to):

- Severe hypoxemia or oxygen desaturation on exercise
- Signs of severe lung disease
- Cardiac chest pain
- Multisystem inflammatory syndrome (in children).

3.2 Tests and investigations tailored to people's signs and symptoms to be offered to exclude acute or life-threatening complications and find out if symptoms are likely caused by ongoing symptomatic COVID-19, post-COVID-19 syndrome or a new, unrelated diagnosis.

3.3 If there is suspicion of another diagnosis not related to COVID-19, investigations and referral to be offered in accordance with relevant national or local guidance.

3.4 Blood tests to be offered that may include a full blood count, kidney and liver function tests, C-reactive protein (CRP) test, ferritin, B type natriuretic peptide (BNP) and thyroid function tests.

3.5 If appropriate, an exercise tolerance test may be offered that suits the person's ability (for example the 1-minute sit-to-stand test). During the exercise test, level of breathlessness, heart rate and oxygen saturation must be recorded. An appropriate protocol must be followed to conduct the test safely.

3.6 For individuals with postural symptoms, such palpitations or dizziness on standing, lying and standing blood pressure and heart rate recordings (3-minute active stand test, or 10 minutes if postural tachycardia syndrome, or other forms of autonomic dysfunction are suspected) to be done.

3.7 A chest X-ray to be done by 12 weeks after acute COVID-19 if the individual has not had one and has continuing respiratory symptoms. Chest X-ray

appearances alone should not guide the need for referral for further care. A plain chest X-ray may not be sufficient to rule out lung disease.

3.8 People with ongoing symptomatic COVID-19 or suspected post-COVID-19 syndrome to be referred urgently for psychiatric assessment if they have severe psychiatric symptoms or have a risk of self-harm or suicide.

3.9 National or local guidelines on referral to be followed for individuals with anxiety and mood disorders or other psychiatric symptoms. Referral to be considered for the following:

- Psychological therapies if the person has common mental health symptoms, such as symptoms of mild anxiety and mild depression or

- To a liaison psychiatry service if the person has more complex needs (particularly if there is a complex physical and mental health presentation).

3.10 After acute or life-threatening complications and alternative diagnoses are excluded, referral to an integrated multidisciplinary assessment service (if available) to be considered any time from 4 weeks after the onset of acute COVID-19.

3.11 Do not exclude people from referral to a multidisciplinary assessment service or for further investigations or specialist input on the basis of absence of a positive SARS-CoV-2 test.

(Excerpts from Medscape; <https://www.nice.org.uk/guidance/NG188>)

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Second Dose of Covishield to be Administered Between 4 and 6 Weeks: DCGI

In its permission to the Serum Institute of India for manufacture for sale or distribution of Covishield, the DCGI stated that the second dose has to be administered between 4 and 6 weeks of the first dose. The regulator further stated that data is available for administration of the second dose up to 12 weeks following the first dose from the overseas studies.

According to the permission document, the firm must ensure that the factsheet for the vaccine recipient or attendant is provided before vaccine administration. It further stated that the vaccine is meant for the active immunization of the individuals above 18 years of age for the prevention of COVID-19 when administered in two doses. The order specified that the shelf-life is 6 months when stored at 2-8°C... (HT – ANI)

Diet Restricts GERD Beyond Acid Suppressants

Adhering to an anti-reflux lifestyle may prevent many symptoms of gastrointestinal reflux disorder (GERD) in women, suggest data from Nurses' Health Study II. The decreased risk was observed even in regular users of acid suppressants, including proton pump inhibitors (PPIs) and histamine-2 receptor antagonists (H2RAs).

Andrew T Chan, MD, MPH, of Massachusetts General Hospital in Boston, and colleagues noted that the possible explanations for this could be reduction in lower esophageal sphincter tone, increases in gastroesophageal pressure gradients and mechanical factors, such as hiatal hernia. The results support the significance of lifestyle modification in managing GERD, reported researchers in *JAMA Internal Medicine*. Researchers used an anti-reflux lifestyle score (range 0-5) consisting of five variables including normal weight, defined as BMI of 18.5 to <25.0; never smoking; moderate-to-vigorous physical activity for at least 30 minutes in a day; not more than two cups of coffee, tea or soda per day; eating a prudent diet. In comparison with women who did not adhere to anti-reflux lifestyle factors, the multivariable HR for GERD symptoms was 0.50 (95% CI 0.42-0.59) among those with five anti-reflux lifestyle factors... (Medpage Today)