COVID- 19 and respiratory illness (asthma and COPD) current knowledge and advice as at 7th May 2020

The following are advice and knowledge as best as we can gather at this point in time and may change going forward so please keep checking regularly.

Asthma

1. As far as we know COVID-19 not a major trigger for asthma

2. It is essential to maintain good asthma control to minimise risk of any asthma exacerbation and admissions. Asthma therapies are safe and should be continued (ensure reasonable stock to cope with self-isolation without stockpiling). Biologics for asthma (omalizumab, mepolizumab, benralizumab) are safe to continue.

3. Asthma is a theoretical risk factor for worse COVID-19 but not absolutely clear if true or how serious this risk is. For standard, well-controlled community asthma additional risk probably low: maintain good asthma control and social distancing.

4. For severe asthma under STH care, contact hospital team if additional concerns, you may need additional advice re degrees of self-isolation and patients are likely to meet criteria for shielding.

5. Have asthma action plan if possible, watch out for people changing their regimes themselves or restarting regimes after non-compliance.

6. People with asthma who feel they may have COVID-19 should use 111 services as usual.

7. Asthma exacerbations via GP/ 111/ 999 – dependent on severity.

8. Rescue prednisolone/antibiotics for those who have not previously had them are not indicated.

COPD

1. Patients with COPD are at increased risk of severe illness from COVID-19.

2. COPD patients are also best protected by good baseline control. Patients should continue taking their regular established inhaled and oral therapies in line with their self-management plan.

3. Be alert for new or increased issues with mental health and wellbeing, particularly anxiety and depression.

4. Rescue prednisolone/antibiotics for those who have not previously had them are not indicated.

5. COPD patients with rescue packs may continue to use them, but should immediately report having used them and be aware that COVID-19 symptoms (cough, fever) may mimic 'ordinary' exacerbations. Patients should be advised not to start a short course of oral corticosteroids and/or antibiotics for symptoms of COVID-19 for example dry cough or myalgia. If there are severe symptoms or deterioration after 48 hours on treatment or concern an exacerbation is not following their established pattern, they should call 111.

6. Smoking cessation is vital to reduce the risk of poor outcomes from COVID-19 and their risk of acute exacerbations. See Smoke free Sheffield - #Quitforcovid

7. Patients receiving ICS for COPD should continue these through the pandemic. If patients are identified who might normally be considered for ICS withdrawal, this should be noted at their COPD review, and re-assessed when the pandemic is adequately controlled, according to future guidance

General information

1. For COPD, severe asthma, asthma co-existing with significant COPD/bronchiectasis, or asthma co-existing with other relevant risk such as diabetes, hypertension, increased age, etc, then more stringent distancing/isolation makes good sense. Follow government advice for shielding for many of these groups. For advice see the following pages, which are likely to receive regular updates;

Asthma UK COVID-19 advice for patients with asthma

Government guidance on shielding

BLF advice COVID-19

We have also produced some Sheffield advice for shielding for respiratory patients.

2. Everyone should practice social distancing and handwashing.

3. Info for patients also available via BLF and Asthma UK sites and are straightforward and helpful

4. As far as we know secondary bacterial infection rates seem to be low and secondary infection seems to occur mostly in the second week of symptoms.

5. NICE has published NICE COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community. This guideline has been developed to ensure the best treatment for adults with suspected or confirmed pneumonia in the community during the COVID-19 pandemic. Within the guideline there is information on differentiating COVID-19 viral pneumonia from bacterial pneumonia. *Please note that the first line antibiotic within this rapid guideline is doxycycline which differs from previous NICE guidance NG138 - Pneumonia (community acquired) - antimicrobial treatment. Follow the rapid guideline unless there are contraindications/intolerance in which case refer back to NG 138 for alternative choices/scenarios.

6. *An exception to the above advice is in COPD where we should use Acute Exacerbation COPD guidelines.

7. Prescribe enough medicines to meet clinical need for no more than 30 days. For inhalers this depends on the type of inhaler and the number of doses in the inhaler. Prescribing larger quantities of medicines puts the supply chain at risk.

8. Advise patients to clean relevant equipment regularly with washing-up liquid (or by following manufacturer's instructions) and not to share devices.

9. Nebulisers are safe to continue as the aerosol comes from fluid in the chamber and will not carry virus particles from the patient.

Additional links to available guidance and support

NICE

COVID-19 rapid guideline: community-based care of patients with chronic obstructive pulmonary disease (COPD)

COVID-19 rapid guideline: severe asthma

BTS information for the respiratory community:

https://www.brit-thoracic.org.uk/about-us/covid-19-information-for-the-respiratory-community/

PCRS

https://www.pcrs-uk.org/coronavirus

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