

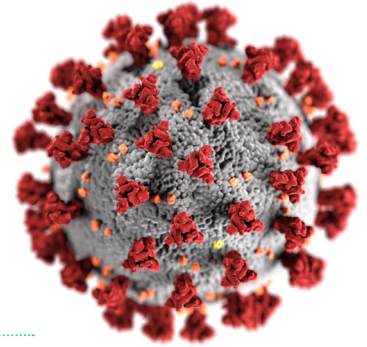
# Ten Clinical Tips on COVID-19 for Healthcare Providers Involved in Patient Care

Accessible link: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-tips-for-healthcare-providers.html>

## Treatment and Prophylaxis



1. The National Institutes of Health has developed **guidance on treatment** (<https://covid19treatmentguidelines.nih.gov/>), which will be regularly updated as new evidence on the safety and efficacy of drugs and therapeutics emerges from clinical trials and research publications.
2. There is currently **no FDA-approved post-exposure prophylaxis** for people who may have been exposed to COVID-19 (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html>).



## Symptoms and Diagnosis



3. **Non-respiratory symptoms** (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>) of COVID-19 – such as gastrointestinal (e.g., nausea, diarrhea) or neurologic symptoms (e.g., anosmia, ageusia, headache) – might appear before fever and lower respiratory tract symptoms (e.g., cough and shortness of breath).
4. **Children** (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/pediatric-hcp.html>) with COVID-19 may have fever and cough at symptom onset as often as adult patients. Although most children with COVID-19 have not had severe illness, clinicians should maintain a high index of suspicion for SARS-CoV-2 infection in children, particularly infants and children with underlying conditions.
5. **CT scans** (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html>) **should not be used** to screen for COVID-19 or as a first-line test to diagnose COVID-19. CT should be used sparingly, reserved for hospitalized, symptomatic patients with specific clinical indications for CT (<https://www.acr.org/Advocacy-and-Economics/ACR-Position-Statements/Recommendations-for-Chest-Radiography-and-CT-for-Suspected-COVID19-Infection>).

## Coinfections



6. Patients can be infected with more than one virus at the same time. **Coinfections with other respiratory viruses** (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html>) in people with COVID-19 have been reported. Therefore, identifying infection with one respiratory virus does not exclude SARS-CoV-2 virus infection.
7. Several patients with COVID-19 have been reported presenting with **concurrent community-acquired bacterial pneumonia** (<https://www.atsjournals.org/doi/pdf/10.1164/rccm.201908-1581ST>). Decisions to administer antibiotics to COVID-19 patients should be based on the likelihood of bacterial infection (community-acquired or hospital-acquired), illness severity, and antimicrobial stewardship issues (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html>).

## Severe Illness



8. Clinicians should be aware of the potential for some patients to **rapidly deteriorate** (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>) one week after illness onset.
9. The median **time to acute respiratory distress syndrome (ARDS)** ranges from 8 to 12 days (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>).
10. Lymphopenia, neutrophilia, elevated serum alanine aminotransferase and aspartate aminotransferase levels, elevated lactate dehydrogenase, high CRP, and high ferritin levels may be associated with **greater illness severity** (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>).