March 27 2020

CDC COCA Call: Underlying Medical Conditions and People at Higher Risk for Coronavirus Disease 2019 (COVID-19)

Clinicians should refer patients to locan and state health departments for COVID-19 tsting and test results. Clinician should not refer patients to CDC to find out where or how to get tested for COVID-19 or to get COVID test results.

20% increase in diagnosis and deaths. Infections in all 50 states. Some states that had early cases ware now seeing control. We are seeing a major acceleration in confirmed cases .
Almost all countries in the world have reported COVID-19.

Dr. Brooks:

Who is most at risk for COVID –

- Adult > 50 and especially >65. Data clearly show older persons are at higher risk of more severe disease and death.
- Therefore, where older people are congregated needs to be especially protected.
- All persons with comorbid conditions are at increased risk e.g. Asthma, morbid obesity and diabetes – this means they cannot easily manage any respiratory infection.
- Examples of conditions that increase risk:
- Chronic lung disease – mod- severe asthma is included.
    - Heart conditions
    - Uncontrolled HIV
    - Organ transplant
    - Chronic steroid use
    - Severely obese (BMI >40)
    - Other uncontrolled condition e.g. Renal, diabetes and liver disease.
    - Immune suppression

What to advise health care providers who may have some of those above conditions

- Each medical organization needs to decide how to manage the risk. Some facilities have prioritized staff with these issues for PPE or moved staff to lower risk areas. Please share any solutions you might have implemented.

Dr. Peacock:

- Chronic lung disease e.g. COPD, emphysema, pulmonary fibrosis and cycstic fibrosis, moderate to severe asthma will increase risk of poor outcomes from COVID.
- COVID can exacerbate lung disease.
- tobacco smoking will increase risk of COVID-19. MD should encourage patient to quit smoking.
- Chronic heart disease does increase risk for COVID – but unsure what conditions exactly will increase risk. Guidance is based on experience with other reparatory infections. Conditions thought to increase risk includes. Heart failure, cardiomyopathy, pulmonary hypertension.
- Observation data indicates hypertension may be a risk factor – but unsure precisely how much increase in risk.

Dr. Brooks

- If patient is on ACE inhibitor – should we stop treatment (as association of ACEI use with COVID – harder to manage if they get COVID) we recommend that you do not change the dose, do not start new patients on it, but do not take patients off it.

Dr. Moore

- Underlying medical conditions: insufficient data to look at specific risk factors independently and translate the risk into impact on COVID outcomes. We are working on making those linkages.
- Note – any condition irrespective of age – will increase the risk of poor outcomes
- Currently – no vaccine or medication approved to treat COVID. Non-pharm interventions are the most critical treatments right now. There are ongoing studies for use of hydroxychloroquine and Chloroquine and redemsivir for both treatment and prophylaxis. But studies are ongoing.
- No evidence to link NSAID and worsening COVID-19 symptoms currently.
- Important to focus on adjunctive therapy and whatever medication is needed for pain relief. Though if you are concerned, you can avoid using NSAID.
- For patients such as those with arthritis that need NSAID and COVID +ve, should continue to use NSAID.
- Strongly encourage patients with underlying medical conditions to socially distance and closely follow care plan. But encourage physical distancing – not social isolation.
- Be aware of mental health impacts, and encourage pts to take action to reduce stress. Including eating well, exercising and do activities they enjoy and connect with family and friends by phone, text or email. If pt is very overwhelmed and to reduce viewing of news/social media.
- This is equally important in healthcare workers – advise looking out for fellow healthcare workers.

Q: who is the most at risk based on geographical location?
A: where the older and immunocompromised are gathered. E.g. in nursing homes. There is no geographic part of the US that is spared. Urban settings are more densely populated and therefore more likely to get it, but they often have higher concentrations of healthcare available. VP Pence has raised concerns about rural communities accessing health care. We are working to protect those such homeless in congregate settings like shelters or rehab facilities. We are thinking about where to send these individuals as they become symptomatic and try to isolate those symptomatic people to prevent spread. There are concerns about dialysis patients – transfer the patient to outpatient dialysis – as they already have chronic renal disease as a risk factor. Also persons in prisons or jails.

Q: is age or comorbid condition the bigger risk factor?
A: the older people are, the risk increases. Approx. 85% of deaths in patients >65. The older people are the more underlying conditions they have, the two are additive.

Q: what if I am a healthcare provider and I have an underlying condition?
A: no specific guidance. Individual hospitals need to decide on what protections are appropriate and how to prioritize access to and highest level of PPE, or reassign to duties where they will not encounter patients with COVID. Have to be careful to not inadvertently disclose the providers condition to others.

Q: how did you identify the conditions that increase risk of COVID to patient?
A: we don't know enough information, but we put at the top of the list from prior experience the conditions that make it hard to manage respiratory illness. The published literature to date does not allow

us to be specific about what cardiac conditions are particularly vulnerable for example. Will update as more information arises.

Q: can you speak to whether just hypertension increases risk?
A: unclear right now. See above.

Autoimmune conditions

- For patients that are being treated for autoimmune disease or are oncology or HIV patients, they are immunocompromised and will be at increased risk. For patients with cancer – Chinese papers suggest that there is an increased risk of getting COVID-19. Perhaps not the cancer itself, but the treatments that increase risk.
- For HIV patients – the treatment can increase the CD4 cell count. The antiretrovirals for HIV – do not seem to impact COVID 19 – unlike in SARS – but too early to tell right now.
- Chloroquine and hydroxychloroquine – we are studying their use – and we are supporting their use ONLY in the setting of a clinical trial.

Q: are you recommending that patients with comorbidities be screen for COVID-19 to have better outcomes
A: We have limited testing. We have to preserve our tests. But it will be a discussion for the patients to have their provider. Anyone with symptoms should use the app to self-screen and seek appropriate medical advice. App to self screen: www.cdc.org – tab – what to do if you sick – to walk you through symptoms and suggest next steps. Clinical staff/ state DOH can call: 770-488-7100 to access CDC guidance on whether a test should be done. The hotline is available 24/7.

Q: Rheumatology – should I be starting patients on hydroxychloroquine as normal or using alternative DMARDS now?
A: have to use clinical judgement – continue to use hydroxychloroquine if is best drug for the patient's clinical condition. No need to switch the medication unless clinically indicated. We are reminding people to not access medications online from non-licensed providers?

Q: for asthma patient who has an exacerbation – should we tell them to avoid albuterol or steroids?
A: no – should treat the asthma as usual.

Q: if a patient has a ventilator at home and has COVID like symptoms, and are concerned that the hospital they are going to may not have a ventilate, should they bring their own ventilator?
A: yes – if they have a ventilator and can bring it – by all means. But they can call the CDC hotline above to ask for guidance.