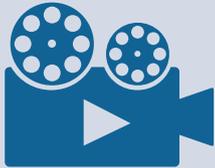




Prof Guy Richards



Click here – you need to watch the video in order to complete the CPD questionnaire.

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COVID-19 and Asthma

Professor Guy Richards, Charlotte Maxeke Academic Hospital, Johannesburg, answers your questions

LEARNING OBJECTIVES

You will learn:

- To understand the potential risk to asthma patients of COVID-19
- To have an expert opinion on what to advise your patients with asthma to do in the time of COVID-19
- To ensure that your patients have sufficient medication and a management plan in the event of an acute exacerbation during this pandemic

With regard to an asthmatic patient who has tested positive for COVID-19, does nebulising the patient in an ambulance cause aerosolisation and the possibility of transmission to the paramedic?

Yes, that certainly would be the case if you are nebulising the patient. It would be far preferable to administer the beta-stimulant using a spacer and a metered dose inhaler. The beta-stimulant can be delivered quite effectively in this manner. Furthermore, the patient and the paramedic ought to be wearing PPE in this circumstance, particularly the N95 mask.

When an asthmatic patient develops a respiratory infection, related or unrelated to COVID-19, does the use of azithromycin lower their resistance? Is azithromycin contraindicated for use with COVID-19 related infections?

There is no contraindication to the use of azithromycin as it does not lower resistance. It is a macrolide antibiotic that has immunomodulatory effects and is effective against many of the gram-negative and gram-positive respiratory pathogens that cause community-acquired infections. So, if you feel that the patient has a co-existent bacterial infection, then an antibiotic would be warranted in that setting.

Azithromycin does have some benefit in specific conditions, such as bronchiectasis and in patients with COPD that have current exacerbations not responding adequately to standard therapies. In this setting, there is no increased risk for contracting COVID-19 if you happen to be on azithromycin.

As it happens, in the ICU or in the wards, we have found that in the majority of COVID-19 patients so far, not many co-existent infections have been identified unless the patient has been ventilated for some time, in which case they may have an acquired nosocomial infection.

Does the mode of transmission of COVID-19 matter, or just the viral load? If the virus is inhaled, will infection manifest as a viral pneumonia or, if infection arises from the fingers, will symptoms mainly be gastrointestinal and, possibly, mild disease?

In terms of disease manifestation, there doesn't appear to be any difference between mode of transmission. Some people do present with gastrointestinal symptoms, some people present with respiratory symptoms, others present just with anosmia, or even with Guillain-Barré or any strange, abnormal or atypical symptoms that might actually occur.

An important factor affecting mortality rates in different countries is that some countries are testing only those patients that are symptomatic, whereas some countries are testing all populations, which means that a significant number confirmed COVID-19 infections are actually asymptomatic or have minimal symptoms. As such, the overall mortality therefore would go down relative to the number of people that are actually infected.

Severe respiratory complications increase in the winter months in patients with, for example, COPD and influenza infection. How is this different to COVID-19?

Influenza is potentially a lethal disease, particularly in patients that have comorbidities. However, COVID-19 infection manifests in an extremely different manner; although the vast majority present with upper respiratory tract infections, some will progress to pneumonia and hypoxaemia and some will then progress to develop the hyperinflammatory phase requiring ventilation and with significant increase in mortality.

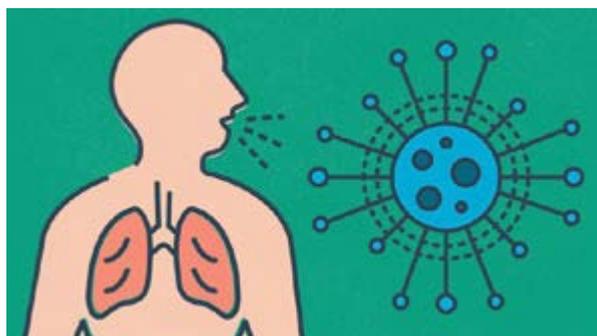
It is true that one ought to take the influenza vaccine, this applies to everybody over the age of six months. This would certainly assist with differential diagnosis when a patient happens to present with respiratory tract symptoms.

What are the indications for antibiotics in phase 1 upper respiratory tract infection?

There are no indications for antibiotics in phase 1. Phase 1 is an upper respiratory tract infection caused by viruses, and antibiotics offer no benefit whatsoever.

What are the similarities in the management of COVID-19 and high-altitude pulmonary oedema, can we use HAPE management?

There is no evidence at all that COVID-19 is similar to HAPE. COVID-19 is associated with fibrinous exudates in the alveoli and intravascular thrombosis, both venous and arterial, that requires very specific management not resembling that of HAPE.



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