**COPD and COVID-19 for Healthcare Professionals**

**Community**

Please note that the vast majority of COPD management during this pandemic period is covered in "**BTS Advice for Community Respiratory Services in relation to COVID19**" https://www.brit-thoracic.org.uk/document-library/quality-improvement/covid-19/community-service-covid19/ document has areas of relevance for COPD:

- Information on pulmonary rehabilitation
- Lung Function testing
- Reviewing out-patients and oxygen reviews – including COPD assessments
- Community acute reviews, admission avoidance and early supported discharge
- Reviewing in-patients
- Self-isolation
- Need for smoking cessation
- Options for review of advance care planning where possible
- Exacerbations – "People with COPD should continue to be treated with inhaled or oral corticosteroids according to NICE guidance. Note that the standard course recommended for AECOPD is 5 days only. There is no evidence to use or not to use oral or inhaled corticosteroids outside usual guidelines in COPD patients with COVID19. Antibiotics should be issued only if suspicion of secondary bacterial infection."

Please refer to that document.

In addition, there is **NO** evidence for "just in case" antibiotics or commencing new prophylactic antibiotics.

Where a patient develops a new/increased cough or increased breathlessness, in keeping with a previous exacerbation, it should be treated as an exacerbation, irrespective of the possible organism and they should take their appropriate rescue medication. Some patients will seek further discussion with a healthcare professional. Before prescribing steroids, ensure you are advising that the control of symptoms with increased bronchodilation, breathing exercises and pacing, for example and where appropriate. These can be highly effective.

Anxiety is inevitable for many people but may manifest particularly in patients with COPD as an increase in breathlessness or tachycardia. A telephone/video consultation may have a role. A website with information is https://www.mentalhealth.org.uk/publications/looking-after-your-mental-health-during-coronavirus-outbreak

If a patient is unwell, they should seek advice from 111.nhs.uk

If a patient with COPD has **non respiratory symptoms only** of COVID 19 (fever, fatigue, myalgia), there is no routine indication to take rescue antibiotics or additional oral steroids.

There should be **NO** alteration to advanced rescue-pack prescribing or stockpiling inhalers. These seriously compromise the medicines supply chain and equitable access.

Best practice at all times is that inhalers or spacer devices should not be shared. Certainly at the moment, this is imperative. Please store your inhalers and spacer away when not in use. Standard hygienic practice should be sufficient.

Nebulisers - Advice from PHE and HPS is that nebulisation is not a VIRAL droplet generating procedure. The droplets are from the machine (liquid bronchodilator drug particles), not the patient. Nebulisation is not therefore considered a 'viral' aerosol generating procedure.

Many patients with severe COPD may well require shielding. Patients meeting the criteria will be contacted before 29th March.

More info available at: https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19 and regarding COPD: https://www.blf.org.uk/support-for-you/coronavirus/what-is-social-shielding

The Pulmonary Rehabilitation Resource pack https://www.brit-thoracic.org.uk/document-library/quality-improvement/covid-19/resource-pack-for-pulmonary-rehabilitation/ includes information on self-management, home exercise and educational material. Online resources are available during this period where face to face rehabilitation is not available.

**Hospital** treatment of COPD will likely follow more regional or Trust specifications.

Specific comments include:

- A patient with COPD presenting in type 2 respiratory failure with their exacerbation should be considered for NIV if indicated – as per current COPD treatment guidelines (even though NIV is not recommended for COVID alone as a bridge to IPPV).
- Patients with domiciliary NIV should bring in their machines if requiring hospitalisation. NB: The mask/tubing will need checking before commencing and likely altered in line with recommendations that NIV should be delivered by a non-vented mask and vented tubing with a filter. NIV is an aerosol generating procedure.
- A combination of the severity of their COPD, comorbid state and frailty may contravene consideration of IPPV.
- There is information on discharge from hospital following COVID19
- Although natural history studies on the resolution of Covid19 symptoms have not been undertaken, it is anticipated that people who have a significant pneumonia requiring supportive hospital admission are likely to follow the recovery rate seen in many with influenza and community acquired pneumonia. Suggested timeframes for recovery:
    - At 6 weeks: cough and breathlessness should have substantially reduced.
    - At 3 months: most symptoms should have resolved but fatigue might still be present.
    - At 6 months: Symptoms fully resolved
- In those who require invasive ventilation, the period of recovery is likely to be more prolonged.
- To follow PHE guidance regarding isolation after a hospital admission.

Please note, Lung Volume Reduction procedures are not currently being performed and work-up for its consideration will likely pause. Lung volume reduction is a palliative procedure.

**More information for patients available from**:

- British Lung Foundation: https://www.blf.org.uk/support-for-you/coronavirus/people-living-with-lung-condition
- NHS https://www.nhs.uk/conditions/coronavirus-covid-19/

Please contact BTS on bts@brit-thoracic.org.uk for queries.

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**Disclaimer: Advice has been based on PHE advice where available and expert opinion where not available. Variations to this advice may be required depending on clinical setting and individual patients. Please also note that PHE and NHS advice may change over time and supersede this statement.**