

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.

Please also refer to the NICE Rapid Guideline for the community-based care of patients with chronic obstructive pulmonary disease (COPD): <https://www.nice.org.uk/guidance/ng168>

This reiterates the importance of smoking cessation. Strongly encourage patients with COPD who are still smoking to stop, to reduce the risk of poor outcomes from COVID-19 and their risk of acute exacerbations. This could involve telephone, video or email consultation support (see [NHS Stop smoking services help you quit](#)). Ensure evidence-based interventions are available (see the [NICE guideline on stop smoking interventions and services](#)).

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

Where a patient develops a new/increased productive 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.

Do not offer patients with COPD a short course of oral corticosteroids and/or antibiotics to keep at home unless clinically indicated, as set out in the [NICE guideline on chronic obstructive pulmonary disease in over 16s](#).

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 should have been contacted directly.

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:
 - o 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.