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EXPERT Q&A WITH PUBLIC HEALTH, EPIDEMIOLOGY, AND LAB SPECIALISTS

Webinar recording: **July 16, 2020**

URL: https://ubccpd.ca/what-covid-19-epidemic-bc-teaching-us

Slides: https://ubccpd.ca/sites/ubccpd.ca/files/COVID-19-Webinar-Slides-July-16.pdf

Disclaimer: Information on COVID-19 is changing rapidly and much of the research is preliminary. Assessment and management protocols are suggestions only; they do not take the place of clinical judgement. Please check with your own health authorities and local medical health officers as policies and support for the suggested approaches to patient care may vary between regions.

This summary was prepared by Dr. Simon Moore and not by the speakers.

Webinar Summary of Clinical Pearls

1. British Columbia has low rates, but these are increasing close to the threshold for epidemic control.

- **Current case count is low, and BC is faring well.** Even compared to countries who have had the most success in controlling COVID, BC continues to report a relatively low case rate. As well, the number of cases in hospital and intensive care remains low. Most cases are related to local acquisition (known case or cluster) but importation from outside BC remains a risk.
- **If social contacts increase past the threshold, a second wave can be expected.** Social distancing and maintaining small social bubbles are still important to stopping the spread. A contact tracing app is not currently being planned for widespread release in BC.
- **Health care workers in BC are not at high risk of contracting COVID-19.** This is due in large part to the workplace safety plans that are in place. As was the case in Wuhan once the epidemic was identified, in BC, clinicians were at higher risk when PPE is not being used, such as while in

the community. Current COVID-19 safety plans are now in place in public places and businesses to reduce this community risk.

- **Testing capacity is good in BC,** as suggested by most test turnaround happening within 24 hours.
- **Steps have been taken to help protect the most vulnerable.** Most COVID deaths in BC are from long term care facilities. As is the case in these facilities, detailed plans have been created to reduce transmission in vulnerable populations including homeless, remote, and First Nations communities.

2. We now know things about the virus we did not know a few months ago

- **Most common transmission is through close & prolonged contact.** A small amount of contact in passing is unimportant compared to household contact or sharing a meal with an infected person.
- **Children are less likely to be infected, less likely to transmit, and have less severe illness.** BC Children's Hospital has had only 1 or 2 admissions for COVID-19 so far. As a result, schools are expected to reopen return 5 days per week this fall in BC.
- **Long-term sequelae of COVID-19, including potential for reinfection, are being studied in Vancouver.** Several hundred patients are being followed up however long-term data is not yet available. Despite recovering, some patients can continue to shed virus for many months as nasopharyngeal cells can take months to turn over. The possibility of reinfection continues to be studied in BC and beyond, and systems are in place in BC to identify patients who test positive a second time; so far, however, so far it has not been confirmed in any cases.

3. Serological testing is now underway at several BC laboratories, but is not available for routine clinical use

- **Main use of serologic testing is for epidemiology and population-based studies.** Sensitivity is improved at > 14 days onset limiting its utility as a diagnostic test for acute infection. The seroprevalence of COVID-19 in the BC population is currently 0.5%, far too low for herd immunity. There is currently limited evidence on longevity of humoral response or protection from re-infection.
- **There is currently no evidence for routine clinical use of serologic testing.** Any testing is by consultation only. Serologic testing is not useful as a 'badge of immunity' to confirm that an individual can return to work, or to confirm that a patient's previous respiratory infection was due to COVID-19.
- **Home testing is less sensitive and unreliable.** Quality assurance is difficult due to wide variability in testing techniques and tests, and false-negative tests can occur commonly and can provide false reassurance to infected individuals.

4. Beyond simply expecting a "second wave," clinicians should remain up to date on the risk of COVID-19 in their community

- **Though peaks and troughs can be expected, COVID-19 is now an established human pathogen.** We are going to be living with this virus for a long time and a vaccine will not be coming anytime soon. Knowing the local epidemiology rates allows clinicians to know what the likelihood of COVID-19 as a diagnosis is in patients with compatible symptoms.
- **The upcoming influenza season will be complicated this year, but preparation is underway.** The surge of cold and flu season will make testing more challenging. In Australia there is less flu than usual, though it is still unclear if this will be the case in BC or if a surge of COVID-19 will occur in BC in the fall. Influenza vaccine has been ordered for the usual fall release timeline in large numbers and, as in previous years, will be recommended for everyone. Preparation has been made for sufficiently large COVID-19 testing capacity and personal protective equipment for the fall.

5. Though telehealth is likely to continue for the foreseeable future, clinicians can see patients in clinic if an effective COVID-19 safety plan is followed

- **All employers, including clinicians, are required to have a COVID-19 safety plan according to a current Public Health order.** These plans include multiple aspects such as pre-screening questions and diverting high-risk patients appropriately, hand hygiene, and physical barriers. Together, these interventions are much more effective at reducing risk than wearing personal protective equipment alone. Ventilation systems should be taken into account in these plans when aerosol-generating medical procedures are being done. Purchasing expensive air filtration equipment is not recommended for primary care clinics at this time.
- **PPE does not have to be worn for all patients seen in primary care.** PPE should be worn when droplet precautions are required, such as for patients with respiratory symptoms, who are being swabbed for COVID-19, and for patients being swabbed for other respiratory illnesses. If the measures listed above are in place, surgical masks are not required for clinicians to see patients who do not have respiratory symptoms. If a clinician feels a mask is necessary in a clinical setting, they should wear a medical mask. Clinicians may choose to wear non-medical (e.g. cloth) masks in the community at their own discretion.
- **Once an effective COVID-19 safety plan is implemented, it is currently considered safe for clinicians to see patients in person** for important visits and routine screening and preventive care, especially pap tests and vaccinations.

  *Detailed and specific guidance regarding **steps to limit transmission**, what **types of visits should be limited** and **how to provide in-person care** during COVID-19 are available via the links in the **Resource List** below*

- **Staying home when sick is one of the most important ways to control this pathogen.** This can be easier if clinicians have established backup coverage plans as part of their COVID-19 safety plan

6. Testing of all symptomatic patients continues to be recommended.

- Testing is available in BC; testing of symptomatic patients and contact tracing are vital to preventing the spread of this disease.
- If the COVID-19 test is negative, then investigate to determine the cause of the patient's symptoms. Because COVID-19 rates are currently low in BC, other conditions should be considered as well.
- If a patient has a lower respiratory tract infection, a lower respiratory tract sample should be submitted for COVID-19. Later in the course of infection, the virus may no longer be present in the nasopharynx.
- Testing of asymptomatic patients is not recommended in BC. The ability to accurately identify asymptomatic patients in BC via PCR testing is very low because the prevalence is so low; the chance of false positives is much higher. As well, a negative test from an asymptomatic patient is not reliable. It also sends a confusing message to patients because the test could be negative early on in an infected patient who is about to begin shedding virus.

7. Vaccine trials are moving fast but it is still unclear when a vaccine will be available

- **Out of approximately 150 vaccine candidates, two are front runners.** The phase 2 trials for these two vaccines (a mRNA and an adenovirus vaccine) have shown that they are immunogenic most of the time and the antibodies are effective *in vitro*. Whether these are effective in humans, and for how long, remains to be seen. Phase 3 trials require recruitment of thousands of patients and will take longer. A potential risk seen with previous coronavirus vaccines is that they can worsen future illness and only time will tell if this is the case with these new vaccines.

8. Mandatory masking is currently not recommended in BC

- **When there is widespread community transmission, any marginal benefit that masking offers might help reduce transmission.** However, when the risk is low, such as in BC, there is less benefit. When close prolonged contact with strangers is possible, such as on transit or in salons, masks are currently recommended in BC as it is potentially another layer of protection (though the risks of wearing masks should also be considered).

9. Patient requests for time off work to avoid COVID-19 need to be considered on a case-by-case basis.

- **Family Practitioners and their patients should decide on the best plan for the patient based on their specific risks.** Not every patient with asthma, for example, has an equal amount of risk. This will depend on the patient's specific vulnerability and individual risk tolerance and the ultimate plan may appear different for each individual patient. These plans are also only helpful in the medium term, as COVID-19 is likely going to be around for a long time. Some health authorities are making accommodations for specific staff with particular conditions, based on the advice of their physicians, but there are no blanket policies at this time.

10. New evidence has emerged regarding medications for COVID-19.

- **Enoxaparin is currently recommended for critically ill patients** by the BC Therapeutics Committee due to the thrombosis potential seen in COVID-19 patients.
- **Administration of dexamethasone (or similarly-dosed steroids) is now standard of care** for breathless patients at risk of becoming critically ill based on the data from the RECOVERY trial, as it provides an incremental but significant reduction in the need for intubation.
- **NSAIDs and ACE inhibitor medications can be continued** according to observational studies, as initial concerns regarding their safety have now been negated.

Resources

See summaries and archives of the previous 21 COVID-19 webinars: https://ubccpd.ca/covid19/archive

Including

- Emergency & Critical Care Management
- WorkSafeBC Recommendations for Patient Concerns about Work Return
- WorkSafeBC recommendations for clinician concerns about Return to Practice

Thanks to the speakers on the video:

- **Panelist: Dr. Reka Gustafson**, PHSA Vice President, Public Health and Wellness and Deputy Provincial Health Officer
- **Panelist: Dr. David Patrick**, Infectious Diseases Specialist, BCCDC
- **Panelist: Dr. Inna Sekirov**, Medical Microbiologist, BCCDC
- **Panelist: Dr. Mark Lysyshyn,** Deputy Chief Medical Health Officer, Vancouver Coastal Health
- **Moderator: Dr. Simon Moore**, Family Physician, UBC CPD Medical Lead