Canterbury Primary Response Group | Pegasus partners in health | The Canterbury Initiative WORKING BETTER TOGETHER · ME MAHI TAHI TĀTOU

General Practice monitoring and management of mild to moderate COVID-19 illness – learnings from Canada

Webinar 25th August - Summary of unanswered/text Q&A

Dr Dee Mangin has kindly provided the following answers in response to questions that were not able to be answered on the night. There is also information on the questions answered by text on the night from Dr Kim Burgess – CPRG and Dr Janine Close – HPW.

Question	Response
Dee please can you address the fact that primary care is well funded (and free to patient) in Canada, but not here. Therefore, we are concerned about out-stretched workforce here which is poorly funded by central govt and relies on significant part charging. This will pose a problem if we get a good number of covid community cases here	CPRG response: Advocacy is happening with MOH around this. In Canterbury Acute Demand funding may apply. DM: I agree with this need totally!
There are 'el cheapo' pulse oximeters on Trade Me at about $20 each. How do you know what's good enough?	There was a suggestion that PHARMAC might source and MoH can recommend
Is BP of value in assessment? I'm thinking of CURB score in pneumonia.	No - CURB has been trialled but doesn't work very well for COVID - similarly other scores have been tested but not accurate enough to be clinically useful to use in primary care yet. (e.g. NEWS 2 etc)
How do we check Sats in patients with dark coloured painted fingernails?	darker skin - patients with nail polish MUST remove it. See the patient information sheet on the HFAM website: https://hfam.ca/wp-content/uploads/2021/04/Pulse-Oximetry-Patient-Instructions-2020-Jan-29.pdf
assume we can use acute demand funding if we need to do this monitoring- extended out for 14/7??	Advocacy is happening with MOH around this. In Canterbury Acute Demand funding may apply.
How did you manage any patients in residential care that were not for t/f to hospital-preference or hospital unable to accept? Any particular issues w nursing cares. Residential care in NZ has not been prioritised w N95 masks nor fit testing ..	All staff were masked at all times in LTC (carers were an initial major source for transmission in this group). There were standing orders for nursing staff or IV fluids, O2 therapy and medications as needed. There was excellent backup from hospital geriatric services providing virtual consultations and advice: see pathway here to get an idea: https://hfam.ca/clinical-pathways-and-evidence/ltc/ltc-cares/ The palliative pathway may also one helpful: https://hfam.ca/clinical-pathways-and-evidence/managing-progressive-life-limiting-conditions/
I worry about keeping family members in the house safe, knowing that delta is v v infectious- how do we stop them getting sick? and doubling our workload etc	We had specific guidance (from public health) for how to care for a patient who is quarantining within the home -keeping family members safe. An MIQ arrangement was available for when the home setting did not allow for quarantining in their own room etc. in reality by the time public health or anyone connect with the patient family members have been in close contact during the max infectious period anyway. There are

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	guides for household members on this website: https://www.publichealthontario.ca/en/diseases-and-conditions/infectious-diseases/respiratory-diseases/novel-coronavirus/public-resources - scroll down to second section on website. Specifically, this one was very helpful: https://www.publichealthontario.ca/-/media/documents/ncov/factsheet-covid-19-guide-isolation-caregivers.pdf?la=en&sc_lang=en&hash=221D89706DEBA24CB42303C32512E679
Are all your patients remotely assessed, including those that you send off to ED?	Yes, all virtual - it is obvious when the patient needs to go to the Ed and exam doesn't help. If you think a patient needs in person they probably require rapid diagnostics anyway which need ED to be fast and safe for others.
What did practices do around business as usual, screening etc during high covid loads	at some points particular screening programs were paused or limited to high risk groups. You can see examples here (see cancer screening section in the section below and in the linked blog from the cancer screening lead you can see how this changed over time) https://hfam.ca/clinical-pathways-and-evidence/condition-specific-guides-for-modifying-routine-primary-care-schedules-in-person-virtual/
Can you get viral meningitis from COVID?	I have seen a few case reports, but we didn't see any in our patients cohort and my sense is it is uncommon.
Is heathpathways developing a similar system for NZ? or are there links on healthpathways to Ontario system?	There is some information on HealthPathways currently. This will be updated building on the Canadian experience. A link to the Ontario system has been put in the 'for health professionals' section on Canterbury HealthPathways.
Any data on how many doctors to patient ratio required especially in areas of High deprivation, how many of them on community monitoring required hospitalisation	We found 10-30% of positive patients would be "high risk" intensive monitoring (our family health team serves a deprived area and we had around 30%) this amounted to 3/4 patients per GP in the active monitoring 14 day period at any of time so it was not overwhelming even at the peak. Prevention and screening was suspended for the few weeks around the peak to allow for this.
How rural were some of these patients, e.g. internet access/no cell service	as remote as you can imagine - Northern Ontario. This doesn't require patients to have internet - a phone (landline or cell) is enough for the consultation and we were able to get pulse ox's to most patients within 48 hours. If a patient has no phone at all you have to look at whatever they usually use to communicate I guess.
Can you please outline the usual course of the illness	This is on the HFAM website in the patient information sheet: https://hfam.ca/wp-content/uploads/2021/02/COVID-19-Symptom-Timeline.pdf Also have a look at the notes under the risk assessment table for a detailed description of trajectory for serious illness: https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/ go to 6 Monitoring and then the "risk stratify patient" subheading.
I have well informed patients asking for Ivermectin RX ... what is your advice. is it okay to prescribe off label	My advice is: Do not use it - there is evidence for your discussion in the management section. There are reports now coming from the USA of poisoning with ivermectin in people with COVID who have used it. My view is that it's not OK to

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	use on patients when there is no reliable evidence of benefit (despite a social media campaign - similar to that we saw for HCQ earlier) and no evidence that it is not harmful in this illness. The PRINCIPLE trial platform is trialling it so we will quickly have even more solid answers in primary care (the trials to date are extremely poor quality and subject to bias). See here: https://hfam.ca/clinical-pathways-and-evidence/covid/assessment-diagnosis-and-management-of-covid/ under 7. Management / treatment subheading.
I think lab staff, GPs, district nurses and home care assistants will worry about their risk entering the infectious person's home? The access to PPE is not excellent here nor do we have easy access to fitted high level masks. What do you advise?	No need for in person assessment. No indication for blood tests etc. We did not have N95s only surgical masks and full face shields as there was no supply. I am not aware of ANY clinical or practice staff in Hamilton primary care (I was on the monitoring group so had detailed information access). In contrast hospital staff did get workplace infections. Of course, delta is more infectious but to date still no cases. Meticulous rehearsal of PPE and esp donning and doffing is really important.
Pulse oximetry has limitations in some patients who need to be in a warm environment. Many elderly have circularly issues e.g. Reynaud's etc. These give falsely low readings and can. Isles if other vital signs are not consistent with cardio respiratory failure.	You integrate these as part of vitals picture as you always would with these patients or pts with COPD etc. See instructions for use of pulse oxs where we deal with these issues - in a low reading we get the patients to retest making sure hands are warmed no fingernail polish etc. Some patients also run at a lower baseline "normal" saturation. Here change is the key - you will have a series while they are well and you can see change easily. in the end if you send a patient to ED for further assessment because you are worried this is not an issue/ failure if they are sent home after a formal ABG. in practice we found this didn't happen.
How long will you be monitoring patients for? 2 weeks?	14 days from test positive or first symptoms
How many GP staff got Covid, how did it affect General practice in Canada	There were no workplace infectious of staff in Hamilton city (a bit bigger than ChCh) so uncommon. The only GPs I know in Canada who got COVID got it from community contacts outside work. Hospital staff and rest home carers were much more commonly affected (the latter because of inadequate PPE supply)
what are recommendations for unvaccinated people that may develop covid- when (following their illness) can they then be vaccinated?	This is on HealthPathways: Defer vaccination until 4 weeks after the individual has recovered from the acute SARS-CoV-2 infection if symptomatic, or 4 weeks from the first confirmed positive PCR if asymptomatic and criteria have been met for release from isolation. As the duration of protection post-infection is unknown, vaccination is recommended regardless of history of disease. Viral or serological testing is not required before vaccination.
Is there a role for voluntary organisations here? If we look at Churches and other groups, they generally have long term relationships with patients and the members are usually around for years so training is an investment. When staff are in short supply, isn't there a role for these groups, obviously with some training?	Yes, voluntary organisations could be very helpful in backup for pulse ox delivery (with contactless training) and for delivering food etc as well as social calls to older adults living alone - the medical students here set up a social calling system.

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Did you do the initial assessment in person or by phone?	Phone (or video)
how would you advise a pt with essential thrombocytosis regarding safety of the vaccine given reported cases of blood clots after getting the vaccine	No concern with mRNA vaccines being used in NZ, only with viral vector vaccines and still extremely low risk and thrombocytosis is not a contraindication (in Australia) to the viral vector vaccines either
Did you assess all the covid patients by phone or did some need to be seen in person?	Almost all completely virtual - if they are sick enough that there's a concern / reason for in person we found they probably need to be in ED with immed access to diagnostic like ABGs etc. Chest exam adds nothing to decision making.
Aspirin? to prevent clots?	No evidence to give at present in our patents. These had been some suggestions from retrospective case control studies but these are subject to bias++ Evidence for anticoag (LMWH) in hospitalised pts with more serious illness but even in these patients there is strong evidence now for no overall benefit from a recent v sold design trial of aspirin - see recent RECOVERY trial: https://www.recoverytrial.net/news/recovery-trial-finds-aspirin-does-not-improve-survival-for-patients-hospitalised-with-covid-19
would you ever use steroids in a covid positive patient in whom the covid had exacerbated asthma or COPD?	Common sense would indicate that if they are having an exacerbation that needs steroids you should give - we actually didn't see much in the way of exacerbations triggered by COVID
Did you consider recommending proactive breathing exercises to improve oxygen saturation e.g., box breathing, blowing balloons, blowing bubbles through a straw into water etc alongside proning? Also, reduction in viral load through mouth and nasal rinsing? All these steps won't cause harm and are likely to be beneficial and help keep the patient calm and occupied at home? How about ensuring Vitamin D levels are adequate and some Vitamin C and zinc to boost immunity. Were these recommended?	See links above to patients instructions for breathing positions. It is important not to do anything that increases the mechanical work of breathing as this increases the lung damage from COVID so we don't give advice to do anything that increases respiratory exertion.
Have you seen any difference in COVID related symptoms in different ethnicities?	Anecdotally - no and I haven't seen anything convincing in the literature. Comorbidities are often different however. We did see poorer diabetes control and sometimes new diabetes in general.
How do you treat covid illness in patients with asthma/COPD (assume these get exacerbated due to covid). (esp your comment on not using steroids in community management of covid)	See above. Clinical indication. Important not to use as a rationalisation for using steroids in COVID alone.
What about patients who have asthma who often need prednisone for acute infectious exacerbations and develop COVID? Do avoid prednisone for them?	See above don't avoid if clinical indication.
Just to confirm all monitoring consults are done as VIDEO consults?	Many actually done as telephone (older adults didn't want video and acute illness not the time to teach new technology)

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Did any patients who remained well enough to avoid hospitalization i.e. didn't become hypoxic, go onto later develop thrombotic events?	Not in our experience in our cohort. Immobilisation though would increase risk as for any illness so changing positions etc still important advice. No evidence for blood thinning in primary care patinets. Recent RECOVERY trial results also suggest no positive risk benefit for aspirin even in hospitalised patients: https://www.recoverytrial.net/news/recovery-trial-finds-aspirin-does-not-improve-survival-for-patients-hospitalised-with-covid-19
Please try and get MOH on board with funding	There is a lot of work underway on this, looking positive

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