

Rotherham Long Covid Pathway – Management and Guidance

Post-COVID patient presents to GP with ongoing symptoms

Stratification of patients presenting includes:

- Acute COVID-19: signs and symptoms of COVID-19 for up to 4 weeks.
- Ongoing symptomatic COVID-19: signs and symptoms of COVID-19 from 4 to 12 weeks.
- Post-COVID-19 syndrome: signs and symptoms that develop during or after an infection consistent with COVID-19, continue for more than 12 weeks and are not explained by an alternative diagnosis

GP consultation:

History and examination using Newcastle Screening tool. Investigations in primary care, as required based on symptoms – Management of post-acute covid-19 in primary care <https://www.guidelines.co.uk/infection/nice-long-covid-guideline/455728.article> Symptom Specific Recommended Management-see Table below

GP supports self-management of common symptoms

Provides the TRFT COVID-19 patient Rehabilitation Booklet [LINK](#) and direct to the NHSE Post Covid-19 Online Support Tool: www.yourcovidrecovery.nhs.uk
If patient experiencing Anxiety, depression, OCD, PTSD make referral to IAPT Service
If patient could benefit from social prescribing support make a referral to the SP LTC service

Symptoms improve

Symptoms do not improve but are singular need:

- refer to appropriate speciality

Care remains in Primary Care

Symptoms do not improve, are multiple and are significantly impacting on life:

- At referral to the Post-Covid 19 Assessment clinic patients would usually be expected to be 12+ weeks from initial COVID infection. Earlier than this many will improve with the above measures.
- Positive PCR or Ab tests are not essential but would usually be expected to substantiate the history of COVID infection after the first wave (March-April 2020) when testing was not widely available.
- Symptom based investigations must be completed or in process at the point of onward referral (see table below).

Refer to Post Covid Hub for initial review and completion of Holistic Needs Assessment by PT/OT/Nurse

Refer to appropriate speciality as necessary

Access to Post Covid MDT Assessment Clinic & Covid community rehabilitation team (Medic, Psychologist, AHP & VAR – Cardiology & Respiratory input as needed))

Appropriate follow up as necessary

*Symptom Specific Management

Post Covid Symptom	Considerations specific to COVID-19	Initial investigations to consider as part of clinical assessment	When to deviate from the pathway: Red Flags
Fatigue	<ul style="list-style-type: none"> • Very common post COVID • Consider impact of fatigue on role – e.g. caregiving, vocation, time off work and phased return. • Self-management advice in the TRFT Health Pathway COVID-19 Patient Information and Rehabilitation booklet LINK • Direct patient to NHSE/I www.yourcovidrecovery.nhs.uk • Reassure that with time and self-management fatigue usually improves gradually • If no improvement after 3 months, worsening of symptoms or impacting significantly on life, refer to Community Based Services 	<ul style="list-style-type: none"> • Investigate modifiable contributors to fatigue, considering individual comorbidities and clinical assessment <p>Would usually include:</p> <ul style="list-style-type: none"> • FBC, Fe, B12 and Folic Acid , U&Es TFTs, vitamin D, Ca • Assess and monitor fatigue using the Modified Fatigue Impact Scale https://www.sralab.org/sites/default/files/2017-06/mfis.pdf (cognitive and physical domains should be scored separately). 	
Anxiety, depression and PTSD	<ul style="list-style-type: none"> • Common feature post COVID • Consider if fatigue/ pain/ sleep disturbance/ cognition is also contributing or co-occurring. • PTSD especially in ITU survivors – ask about intrusive thoughts, flashbacks, nightmares, avoiding reminders of the event/illness. Also excessive/ obsessional cleaning/ checking, fear of going out. • Concerns re PTSD and/ or other mental health issues not improving 	<ul style="list-style-type: none"> • Consider a screening tools PHQ9 for depression or GAD7 for anxiety • Quality of life questionnaire - Work & Social Adjustment Scale (WSAS) • PTSD more likely in context of premorbid trauma • Mood impeding recovery/ causing protracted symptoms where physical examinations are normal. • Complex presentation i.e. contribution of several factors/ lack of progress despite physical recovery/ difficulties completing 	<ul style="list-style-type: none"> • Suicidal ideation or immediate risk of harm to self or others refer to Mental Health Crisis Team • Neurocognitive problems in the presence of a new or pre-existing neurological diagnosis; refer to

	<p>refer to IAPT. In context of significant fatigue and/ or cognitive issues neuropsychological input will be required.</p> <p>Other resources: https://www.bps.org.uk/coronavirus-resources https://www.mind.org.uk/information-support/coronavirus/</p>	<p>ADLs or work. Consider referral to IAPT</p> <ul style="list-style-type: none"> • Systemic distress/ carer strain contributing to reactive distress/ relationship breakdown/ loss of support. Refer to IAPT. 	<p>Community Neurological Rehab Team</p>
Breathlessness	<ul style="list-style-type: none"> • Very common post COVID • Exertional breathlessness often persists for many weeks. Usual pattern is a gradual recovery. • Review at 3 months post Covid if not improving. • Unexplained crackles on auscultation refer for CXR. Depending on the results of this a HRCT scan may also be indicated. CXR appearances alone should not determine the need for further care. Be aware that a plain CXR may not be sufficient to rule out lung disease • Consider increased risk of VTE / PE post-COVID • BNP normal result will exclude cardiac failure as a cause 	<ul style="list-style-type: none"> • Bloods: FBC, U&E, LFT, Ca2+, TFT, BNP • Consider sputum sample if productive cough • ECG • O2 sats at rest – SpO2 – 93% • Oxygen desaturation on exercise – 1 minute sit to stand test LINK <p>Results</p> <ul style="list-style-type: none"> • If <4weeks post acute Covid-19 – and SpO2<93% of 4% drop from baseline - Acute assessment • Consider referral to Community Respiratory Service for oxygen desaturation monitoring if indicated 	<ul style="list-style-type: none"> • Acute onset (<48 hours) /severe SOB O2<93% (if new for the patient) • Resting pulse <60bpm or >120bpm RR >30 breaths/minute refer for exclusion of Acute Pathology inc. PE. • Myocardial ischaemia (chest pain) • Syncope/postural dizziness • Heart failure • Shock (hypotension)
Cough	<ul style="list-style-type: none"> • Cough is a common symptom. • Dry cough likely to be post-viral and self-limiting though can persist 	<ul style="list-style-type: none"> • Consider sputum sample if productive cough • treat with antibiotics according to current guidelines. If no improvement after 6 weeks 	<ul style="list-style-type: none"> • Haemoptysis • Unintentional weight loss night sweats

	for weeks as airways remain hyper-sensitive.	request CXR	<ul style="list-style-type: none"> and/or a strong smoking history urgent 2 week referral is appropriate
Pleuritic Chest Pain	<ul style="list-style-type: none"> Non specific chest is common post covid-19 syndrome. It does not signify in the absence of other typical features <p>Oxygen saturation normal: PLUS normal chest x-ray:</p> <ul style="list-style-type: none"> Consider non-respiratory causes (e.g. infection or inflammation elsewhere). <p>PLUS chest x-ray abnormal/showing consolidation:</p> <ul style="list-style-type: none"> Symptoms may be explained by pneumonia and assess and treat appropriately <p>Typical pericardial pain (positional, inspiratory component) can be managed with analgesia +/- colchicine. Imaging is not usually helpful for uncomplicated cases.</p> <p>Chest pain suggestive of myocardial ischaemia should be managed conventionally (RAPC for stable exertional symptoms, urgent admission for possible ACS)</p>	<ul style="list-style-type: none"> Bloods: FBC, CRP CXR ECG O2 sats 	<ul style="list-style-type: none"> Acute hypoxia, O2<93% (if new for the patient) Acute severe breathlessness, Pulse rate >120bpm
Palpitations/Tachycardia	<ul style="list-style-type: none"> Palpitations are common. Up to 30% at 3 months Positional Orthostatic Tachycardia 	<ul style="list-style-type: none"> Blood tests (including thyroid function) Erect and supine BP and HR ECG 	<ul style="list-style-type: none"> Syncope, Myocardial ischaemia Complete heart block

	<p>syndrome is seen post COVID – ensure adequate fluid and salt intake as a first line.</p>		
Anosmia	<ul style="list-style-type: none"> • Very common-up to 50% • 9 out of 10 patients significant improvement within four weeks • Reassurance, Olfactory training and safety advice Patient advice for anosmia or loss of smell caused by COVID-19 (entuk.org) • Reassess 	<ul style="list-style-type: none"> • Associated nasal symptoms • Neurological symptoms • ENT referral if anosmia >3 months. 	<ul style="list-style-type: none"> • Anosmia>6 weeks with focal neurological symptoms-Referral to ENT
Abnormal Liver Function (mild rise in liver transaminase)	<ul style="list-style-type: none"> • Mild abnormalities in ALT <3xULN will be common post Covid-19. • Approximately 25-30% of tested population have abnormal ALT. • Check any past LFTs. • Check alcohol history • Stop any NSAIDS. Do not introduce statins at this stage. • If abnormalities are mild, statins could be continued in Diabetic patients. 	<ul style="list-style-type: none"> • ALT <x3ULN and new: Monitor monthly. It should normalise. Investigate at 3 months if not • ALT >x3ULN and new: Monitor again 2-4 weeks. Investigate at 1 month if not normalised or reducing. • Address any history of excess alcohol, optimise diabetic control, introduce exercise as possible. • Isolated raised bilirubin: Request conjugated/unconjugated bilirubin split. • Isolated raised ALP: Optimise vitamin D levels, Consider Ultrasound scan (to check biliary tract) with Doppler (to check vascular supply); Check BNP as cardiac impairment may give this picture 	<ul style="list-style-type: none"> • Jaundice not attributable to Gilberts syndrome or not in isolation. • Acute liver injury ALT>10xULN • Start investigations immediately and refer for specialist opinion
Reduction in kidney function following an episode of Acute kidney	<ul style="list-style-type: none"> • Observed in small proportion of recovering patients • Assess for improvement or 	<ul style="list-style-type: none"> • BP • Dip urine for blood and protein • Urinary Protein/Creatinine ratio 	<ul style="list-style-type: none"> • Urinary Protein/Creatinine ratio > 50

injury (reduced eGFR from pre-COVID baseline)	worsening of eGFR over one year <ul style="list-style-type: none"> Consider referral if progressive fall in eGFR or increasing ACR 	<ul style="list-style-type: none"> Monitor renal function 2 monthly Review medication 	<ul style="list-style-type: none"> Haematuria Sustained fall in eGFR > 5ml/min/month eGFR<30ml/min (new for patient)
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Resources:

[Post discharge symptoms and rehabilitation needs in survivors of COVID-19 infection: A cross-sectional evaluation \(wiley.com\)](https://onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.2020.02500.x)

[Management of post-acute covid-19 in primary care | The BMJ](https://www.bmj.com/lookup/doi/10.1136/bmj.n1111)

[Managing the long term effects of covid-19: summary of NICE, SIGN, and RCGP rapid guideline \(bmj.com\)](https://www.bmj.com/lookup/doi/10.1136/bmj.n1111)

[Anosmia and loss of smell in the era of covid-19 | The BMJ](https://www.bmj.com/lookup/doi/10.1136/bmj.n1111)

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