

## Letter to the Editor

# Why do we need to report on COVID-19 suspected cases presentation in primary care?

Sir,

While research and reporting on COVID-19 disease focused on laboratory-confirmed cases, minimal to no reporting happen to suspected cases. Initially, WHO advised screen and quarantine strategy. All suspected cases who had mild symptoms were advised to have COVID-19 polymerase chain reaction test.<sup>1</sup> Patients with positive results are advised to quarantine in either home or quarantine facilities dependant on local guidance. Feasibility of testing and isolation strategy seems unlikely in many settings because of the strain on resources; guidance was updated in different countries. Centers for disease control (CDC) and many international guidelines advised home isolation with no testing for suspected cases with mild symptoms. Case definition was updated on different occasions, but suspected cases generically defined based on history and/or risk factors.

Testing for COVID-19 virus is now reserved for severe cases or high-risk population dependant on the local guidelines. CDC provided prioritisation criteria for testing. The priority-1 population included patient requiring hospitalisation. Priority-2 population include patients older than 65 years of age, with comorbid conditions, in long term facilities and first responders with symptoms.<sup>2,3</sup> Suspected and probable cases with mild symptoms and that are not deemed as a priority case for testing will be advised to home isolate for 7-14 days with remote follow up and safety-netting. The new guidance created a new cohort of patients with diagnosis based on the risk of exposure and symptoms but no laboratory confirmation.

In confirmed cases, WHO's revised case reporting form for COVID-19 specifies clinical points to report and outcomes, the tool monitors and report cases to WHO.<sup>4</sup> These data help to inform the international community on both progress of the epidemic. It also helps to stratify patients at high risk of mortality and need for intensive care. As per current guidance, confirmed cases are more likely to have a worse presentation or more comorbidities. Those cases naturally will have worse prognosis and data underestimates the recovery and augment the mortality of the infection.

To our knowledge, there is little to no reporting on outcomes in suspected cases. The scale of patients advised to home isolate as suspected COVID-19 infection

is less defined as all reported data misses out on reporting in all suspected or probable cases. No studies to date reported on their characteristics or stratified this cohort of patients based on admission or mortality outcomes.

While current guidance advises on using clinical judgment, most of the models for stratifying severity of respiratory tract infection were designed and validated for usage in accident and emergency department or hospital settings and not primary care settings.<sup>5,6</sup> Few scoring models are suitable and validated for primary health care settings including CRB65 (pneumonia severity score), Medical Research Council dyspnoea scale and national early warning score 2 tool to assess the severity of pneumonia or sepsis.<sup>7</sup> None of those was validated in patients with suspected COVID-19 infection and with many patients assess remotely simple observations like respiratory rate and blood pressure reading may not be readily available. There is a clear gap between the guidance in place and application in everyday practice.

The international community needs countries and research studies to report on the number of suspected and probable cases, their demographic and health characteristics and to describe disease outcomes. The analysis of the association between comorbidities in mild COVID-19 cases and clinical outcomes may inform clinical decisions and help risk stratification of this cohort of patients.<sup>8</sup>

Most significant limitations of such a study would have a less defined population. The suspected and probable cases by definition may include other upper respiratory tract infection and may miss out on cases who are asymptomatic. Also, it may miss out on patients presenting to secondary care and private healthcare providers. This limitation is more representative of the general practice population where most of the diagnosis based on clinical suspicion rather than investigations.

While most agree that most cases infected with COVID-19 infections will recover, there is no data to prove that or to communicate it. This data may instil optimism to the international community that receives daily updates on confirmed cases and mortality rates but very minimal on the recovery counts. It will also inform clinical decisions in primary care settings where minimal reporting is taking place. The study results should not be used to advise the patient not to stay at home but to inspire hope into higher

rates of recovery and low rates of admission in population with mild symptoms at the time of the epidemic.

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