Post COVID-Pneumonia information for primary care

We thought it would be helpful to explain the pathway for patients discharged from BSUH after a COVID pneumonia illness. Note all COVID patients without a diagnosis of DVT/PE will be discharged on 2/52 of thrombo-prophylaxis. The British Thoracic Society (BTS) have issued guidelines which we plan to follow (with some local interpretation). **In brief:**

Severe COVID pneumonia (ICU/HDU stay or newly discharged on oxygen):

Telephone assessment by ICU/Respiratory team at 4-6 weeks post discharge

If recovering, for CXR at 12 weeks plus face to face assessment (Respiratory or ID OPC)

If poor progress for face to face assessment to consider further investigation (Respiratory or ID OPC)

Non-severe COVID pneumonia (radiographic changes and non-frail):

If PE/DVT diagnosed during admission follow up in VTE clinic 8-12 weeks (Dr Barden).

To have CXR (requested by respiratory/ID) at that attendance, results to requester

IF no PE/DVT diagnosed during admission for CXR 12 weeks post discharge and non-face to face assessment (Respiratory or ID). If clinical concern at this stage for further assessment.

(Many patients will also have follow up at varying frequencies due to being recruited to one of the COVID trials.

We recognised that there will be some patients with an illness consistent with COVID pneumonia managed in primary care or who have self-managed. If they have ongoing symptoms (new or worsened breathlessness or persistent cough – 3 weeks or more) we recommend that (if clinically appropriate) they are referred for CXR via the **Brighton Lung Pathway** (BLP). It is vital that the clinical history is very clear so that these CXRs can be reported appropriately. If you think the patient may have had COVID this must be stated, and also the date symptoms started. You must also be clear about what antibiotics have been given and when. If the CXR shows changes consistent with a recovering COVID pneumonia the report will suggest referral to respiratory medicine outpatients for further assessment. If the CXR is normal and there is ongoing clinical concern they should be referred to the appropriate speciality, e.g.:

Concern re thromboembolic disease to EACU via PLS

Concern re cardiomyopathy (BNP > 400 to cardiology)

If BNP 400-2000, for echo within 6 weeks and referral to RAHF clinic

If >2000 then urgent echo for review in RAHF clinic within 2 weeks

Concern re respiratory cause of new symptoms to respiratory medicine

This is still an evolving situation and we will update if the pathway changes.

There is a useful website to signpost patients to https://covidpatientsupport.lthtr.nhs.uk/#/

This is intended to be an online patient support resource for those discharged from hospital following admission with COVID-19.

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