Understanding COVID-19 new diagnostic guidelines – a message of reassurance from an internal medicine doctor in Shanghai

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The change in diagnostic criteria for COVID-19 diagnosis in Hubei province, released on 12 February 2020 by the National Health Commission of Hubei Province, caused a shift in the numbers of total cases from ≈43,000 to ≈60,000 overnight.

Understandably, this has caused significant turmoil in the lay public, especially in western countries, as well as some confusion amongst specialists. The aim of this article is to explain the rationale for the choice of the new criteria and the meaning of the new data, from the perspective of the authors (EB, GC) based in Shanghai, China, both struck by the level of panic and emotional distress in many people that has been generated by the new data.

The COVID-19 virus causes a pneumonia syndrome, with specific and already well-described symptoms [1–3]. As in Middle East respiratory syndrome (MERS) and severe acute respiratory syndrome (SARS), because of the high infection rate, the new virus poses a risk of a global pandemic, and all measures must be taken to ensure control of infection spread [4]. In this context, timely diagnosis is a crucial element.

Initially, the diagnosis was based on real-time fluorescent RT-PCR or genetic sequencing of respiratory specimens or blood specimens, which required 1–2 days for completion (currently as rapid as 6 hours). The case numbers released up to 12 February referred to patients tested positive for the virus based on such techniques.

Based on the knowledge that accumulated over the weeks, though, the guidelines for COVID-19 diagnosis have been constantly updated; in addition, the diagnostic criteria and algorithm for patients in and outside of Hubei differ slightly. The changes introduced for Hubei province in the last version (the fifth, released on 12 February), added typical pneumonia findings on pulmonary computed tomography (CT) as one of the clinical diagnostic criteria, next to clinical symptoms (fever, cough) and history of travel in the Hubei region. With the new criteria, therefore, patients previously labelled as “suspected cases” shifted to “clinically diagnosed cases” (table 1).

Clinical diagnosis is the best option for identifying patients as it allows for quick and efficient case management. A similar, standard procedure was applied in the case of SARS and MERS too. A recent publication has supported the notion that bilateral ground-glass opacities in the posterior and peripheral lungs seen on a CT scan are associated with confirmed infection [5]. Clinically diagnosed patients have been receiving standardised treatment as soon as possible, without waiting for the genetic test to be completed. Thus, their official inclusion in the new criteria was a formal step rather than any change in the standard of care. Immediate treatment of each patient increases the success outcome rate, decreasing fatality, which is still difficult to estimate [6].

It is the responsibility of media and science communicators to ensure that a proper explanation of the new statistics is provided; one option might be to clearly separate in statistics the number of clinically vs genetically confirmed cases.

Disclosure statement
No financial support and no other potential conflict of interest relevant to this article was reported.

References
Table 1: Diagnostic criteria for COVID-19 infection – development of version 4 to version 6. Version 5 implemented clinically diagnosed cases for Hubei province.

<table>
<thead>
<tr>
<th>Suspected cases</th>
<th>Epidemiological anamnesis</th>
<th>Clinical manifestations</th>
<th>Confirmed cases</th>
<th>Clinically diagnosed cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationwide</td>
<td>Travel history or residence in Wuhan and its surrounding areas within 14 days before the onset of patient’s symptoms</td>
<td>Fever</td>
<td>Real-time fluorescent RT-PCR detected a nucleic acid of novel coronavirus in respiratory (sputum, pharyngeal swabs, and lower respiratory tract secretions) or blood samples</td>
<td>Suspected cases with typical radiographic features</td>
</tr>
<tr>
<td>Wuhan</td>
<td>Travel history or residence in Wuhan and its surrounding areas within 14 days before the onset of the disease, or in other communities where cases have been reported</td>
<td>Fever and/or respiratory symptoms</td>
<td>Real-time fluorescent RT-PCR detected a nucleic acid of novel coronavirus in respiratory (sputum, pharyngeal swabs, and lower respiratory tract secretions) or blood samples</td>
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<tr>
<td>Outside of Wuhan</td>
<td>Travel history or residence in Wuhan and its surrounding areas within 14 days before the onset of the disease, or in other communities where cases have been reported</td>
<td>Fever and/or respiratory symptoms</td>
<td>Real-time fluorescent RT-PCR detected a nucleic acid of novel coronavirus in respiratory (sputum, pharyngeal swabs, and lower respiratory tract secretions) or blood samples</td>
<td></td>
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<tr>
<td>Nationwide</td>
<td>Travel history or residence in Wuhan and its surrounding areas within 14 days before the onset of patient’s symptoms</td>
<td>Chest CT features of multiple small patchy shadows and interstitial changes, obvious extrapulmonary bands (early stage). Multiple ground-glass infiltration and infiltrates in both lungs (later stages).</td>
<td>Sequencing of virus genes in respiratory or blood samples, highly homologous to SARS-CoV-2</td>
<td></td>
</tr>
</tbody>
</table>

1. Travel history or residence in Wuhan and its surrounding areas within 14 days before the onset of patient’s symptoms
2. Exposure (14 days prior to the onset of the disease) to individuals with fever or respiratory symptoms from Wuhan or other areas with persistent local case transmission
3. Family clusters or epidemiological associations with novel coronavirus infections