

20TH APRIL 2020

ISSUE 03



THE COVID UPDATE

A WEEKLY NEWSLETTER
FROM CEYLON COLLEGE OF
PHYSICIANS

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PRESIDENT'S MESSAGE



Dear Fellows and Members,

Prepare for the Worst. Work for the Best.

We face the challenge of preparing ourselves to treat the non-COVID patients and a possible increase in COVID patients in the following months with the relaxing of the "lock down". The biggest problem faced by the developed countries in the West during the pandemic was the lack of PPEs.

Ctd...

PRESIDENT'S MESSAGE

CTD... FROM PAGE 01

A news article on the situation in UK read "Doctors and nurses working in the NHS are continuing to voice concerns over access to protective equipment amidst the outbreak as Public Health England changed its advice on 18th April to allow the reuse of gowns if stocks run low". US has already run out of N95 masks. We are also likely to face the same situation, especially for N95 masks as it is not manufactured in Sri Lanka. Therefore, it is extremely important that PPE is used appropriately without wasting the available ones. Taking leadership to train the staff on this is essential. Stock piling those in our hospitals is another important strategy. Fortunately, we have a limited number of patients in Sri Lanka as of yet. However, it is likely that the number of COVID cases will rise with the increase in movement of people.

We cannot be complacent. We cannot relax. We have the golden opportunity to learn from other countries such as UK, Italy and USA who are already facing the epidemic. The take home message is that we need to plan ahead and be prepared. The Ministry of Health has already identified hospitals to admit COVID patients in the event of an increase in numbers. We, my fellow physicians should take the leadership at this moment in helping with planning and organizing the identified healthcare facilities to accommodate the patients.

Training the staff to manage the situation of increase in numbers should also be a priority.

Amidst all this, we have to bear in mind that we had only a small number of patients so far. It is important to remember that the spread is limited to pockets of areas and that there is no community spread. There will be an increase in non-COVID patients coming to the hospital following the relaxation of the 'lockdown'. We have to make sure that the healthcare facilities are ready to cater to these non-COVID patients and give them the appropriate care. The challenge would be providing optimum care while maintaining social distancing and ensuring that the healthcare workers are taking appropriate protective measures (without wasting PPE). As such, we have to prepare for the worst, but let's work for the best.

**Dr Ananda Wijewickrama
President**

THE LINK CORNER

FOLLOW THESE LINKS FOR DETAILED INFORMATION
ON STATISTICS, NEW CIRCULARS AND OTHER
DOCUMENTS ON COVID-19

[A comparison with the world](#)

[Detailed updates from the
Epidemiology Unit](#)

[The CCP COVID-19 Information
portal](#)



THE EDITORIAL

Excerpts from the paper:

Coronavirus disease 2019: The harms of exaggerated information and non-evidence-based measures¹

The evolving COVID-19 pandemic is cause for concern. Optimal decision-making is an ongoing challenge, as data evolve. This challenge is compounded by exaggerated information. This can lead to inappropriate and potentially harmful actions.

Sensationalism can affect top scientific venues with papers bearing untruths being published in reputed journals and later withdrawn. Such an example was the first report documenting transmission by an asymptomatic individual, published in the New England Journal of Medicine (January 30). However, the specific patient did have symptoms, but researchers had not asked. Claiming transmission during the asymptomatic phase has major implications for what protective measures might work. Thus in such instances peer review may malfunction when there is little evidence but strong opinion.

There have been exaggerated estimates of the pandemic.

Early speculation was that 40%-70% of the global population will be infected. However, this was later revised to 20%-60% of adults. But this too is substantially exaggerated.

Reported case fatality figures also seem exaggerated. The most widely quoted case fatality rate (CFR) has been 3.4%, reported by WHO dividing the number of deaths by documented cases. This ignored undetected infections and the strong age dependence of CFR. The true CFR may be 1% in the general population, higher than seasonal flu (CFR = 0.1%), but not by much.

The extent of community spread can be ascertained by testing; however the number of tests done depends on how many test-kits are available and how many patients seek testing. Even if these barriers are removed the epidemic curve may still reflect primarily population sensitization and willingness for testing rather than true epidemic growth.

Evidence is lacking for aggressive measures such as lockdowns. Plain hygienic measures have the strongest evidence. Most evidence on protective measures comes from non randomized studies which is prone to bias.

An argument in favour of lockdowns is that postponing the epidemic wave ("flattening the curve") gains time to develop vaccines and reduces strain on the health system. However, vaccines take many months (or years) to develop and test properly.



THE EDITORIAL

CTD... FROM PAGE 03

Maintaining lockdowns for many months may have worse consequences than an epidemic wave. Focusing on protecting susceptible individuals may be preferable to maintaining countrywide lockdowns.

The economic downfall of such extreme measures is already apparent. February 22-28 was the worst week for global markets since 2008. A quote of \$2.7 trillion loss is already speculated.

Claims that Covid-19 is a once-in-a-century pandemic has to be taken in perspective. For example, other corona viruses from 1999 to 2003 showed annual infection rates ranging from 2.8% to 26% in prospective cohorts, and prevalence of 3.3%-11.1% in the hospitalized cohort. CFR of 8% has been described in outbreaks among nursing-home elderly. This pandemic is often compared to the 1918 influenza pandemic. However, this year we are dealing with thousands, not tens of millions deaths.

COVID-19 is not as grave as depicted, high evidence standards are equally relevant. Exaggeration and over reaction may seriously damage the reputation of science, public health, media and policy makers. It may foster disbelief that will jeopardize the prospects of an appropriately strong response if and when a major pandemic strikes in the future.

1. Ioannidis JPA. Coronavirus disease 2019: the harms of exaggerated information and non-evidence-based measures [published online ahead of print, 2020 Mar 23]. Eur J Clin Invest. 2020;e13223. doi:10.1111/eci.13223

EXPERTS RECOMMEND

Important Decisions and Recommendations of Expert Committee on COVID-19

The above committee was formed on invitation and facilitated by:

Dr Hasitha Tissera
Consultant Epidemiologist
Epidemiology Unit.

Members:

- **Dr Ananda Wijewickrama**, Consultant physician, IDH.
- **Prof Senaka Rajapakse**, Faculty of Medicine, Colombo.
- **Prof Chandanie Wanigatunge**, Professor in Pharmacology, Faculty of Medical Sciences, University of Sri Jayewardenepura.
- **Dr Amitha Fernando**, Consultant Respiratory Physician, NHSL.
- **Dr Neranjan Dissanayake**, Consultant Respiratory Physician, Teaching Hospital, Rathnapura.



EXPERTS RECOMMEND

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Members

- **Dr Chandimani Undugodage**, Consultant Respiratory Physician, Faculty of Medical Sciences, University of Sri Jayewardenepura.
 - **Dr Indika De Lanerole**, Consultant Emergency Physician, NHSL.
 - **Prof Asita De Silva**, Chairman, NMRA
 - **Prof Neelika Malavige**, Faculty of Medical Sciences, University of Sri Jayewardenepura.
 - **Dr Rajeewa De Silva**, Consultant Immunologist, MRI
 - **Dr Upul Dissanayake**, Consultant Physician, NHSL
 - **Dr Rohitha Muthugala**, Consultant Virologist, TH Kandy
 - **Prof Vasanthi Pinto**, Consultant Anaesthetist, Faculty of Medicine, University of Peradeniya
 - **Dr Priyankara Jayawardena**, Consultant Physician, SLCIM
 - **Dr Krishantha Jayasekara**, Consultant Physician, SLCIM
 - **Dr Harsha Sathischandra**, Consultant Physician, SLCIM
 - **Dr Nalayani Rajarathnam**, Consultant Physician, SLCIM
 - **Dr Malika Karunaratna**, Consultant Immunologist, MRI
 - **Dr Suranga Manilgama**, Consultant Physician, TH-Kandy

Decisions and recommendations made:

Testing/Diagnosis/Surveillance

- Sequencing of the virus isolates from Sri Lankan patients was performed at the Centre for Dengue Research laboratory and the results will be available in the near future.
 - Viral shedding of diagnosed COVID-19 patients reveals an average of 14 days with a shorter duration in younger patients (data from Centre for dengue research: see page 07 for further details)
 - Nasopharyngeal swabs from SLINTEC and imported from China is being validated.
 - The widespread spraying of alcohol/disinfectants on roads and public places was discussed and it was decided to request the College of Microbiologists to give a recommendation.



Testing/Diagnosis/Surveillance

- The consensus document on guidance on testing of suspected and confirmed COVID-19 patients tabulated by the subcommittee convened by CCP was presented and tabled.
- It was decided to recommend the “in-hospital COVID expert committee” to meet twice a week (Included in hospital preparedness plan)
- The following will be included in the HCW exposure protocol in the hospital preparedness plan: “PCR testing of the HCW after 7 days and on completion of 14 days of quarantine”

Treatment/Management

- HCQ is not recommended for asymptomatic COVID-19 patients due to lack of a clear benefit.
- Gazette stating cremation as compulsory for all COVID deaths has been issued under the quarantine act.

Research/ Training

- Training modules will be uploaded to the CCP website which would also include different case scenarios of quarantine of HCW.

ON VIRAL SHEDDING

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**Duration of viral
shedding in a
cohort of
COVID-19 patients**

The preliminary results as at 15th April 2020, on viral shedding of diagnosed COVID-19 patients studied by Professor Neelika Malavige , Director of Centre for Dengue Research, Faculty of Medical Sciences, University of Sri Jayewardenepura, at the Centre for Dengue Research are shown on the following page (07).



ON VIRAL SHEDDING

CTD... FROM PAGE 06

Table 1: Duration of viral shedding in COVID-19 patients

Duration of viral shedding (days)	n=45	%
<5	7	15.56
5- 10	15	33.33
11- 15	8	17.78
>15	6	13.33
>20	4	8.89
>25	2	4.44
>35	3	6.67

Table 2: Median duration of viral shedding in different age groups

Age group (years)	Median (days)
<30	6
30-44	14
45-60	11
>60	11

- The duration of viral shedding was less in those age <30 years to those above 30 years but not significant ($p=0.06$)
 - Association of duration of viral shedding with age: none (Spearmans $r=0.17$, $p=0.23$)
 - Association of duration of viral shedding with initial RT-PCR Ct value: none (Spearmans $r=-0.05$, $p=0.69$)



AN ANALYSIS

The following are graphical representations of distributions in gender, age and symptoms of a total of 58, COVID-19 patients currently discharged after full recovery from the National Institute of Infectious Diseases.

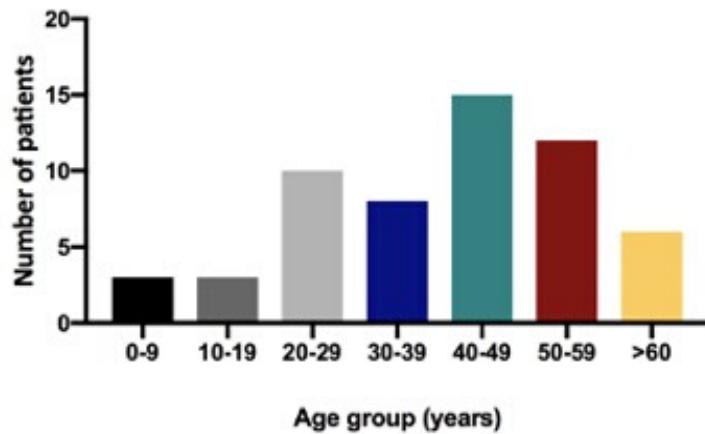


Figure 2: Age Distribution of COVID-19 patients discharged from NIID

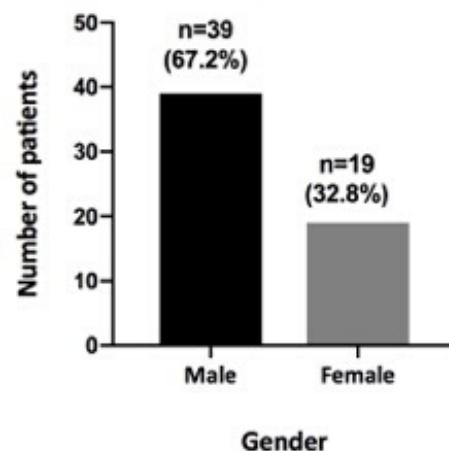


Figure 1: Gender Distribution of COVID-19 patients discharged from NIID

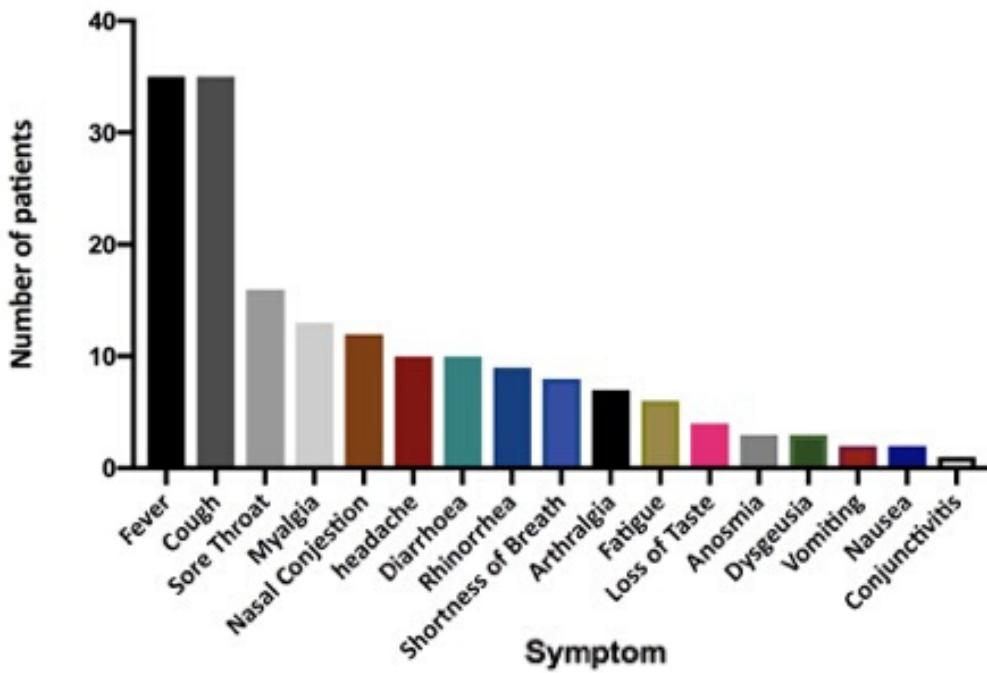
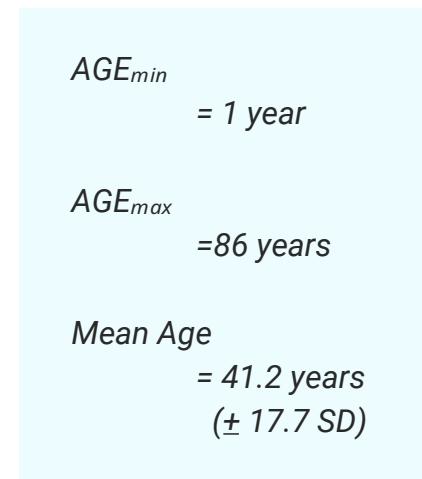


Figure 3: (Left)
Relative frequency of symptoms of COVID-19 patients discharged from NIID



KNOW THE STATS

Sri Lanka Status Summary as at 20.04.2020

Total cases	New cases	Total deaths	New deaths	Total recovered	Active cases	Critical	Total cases/ 1M population	Deaths/ 1M population
304	+33	7	0	98	199	1	14	0.3

Summary of PCR testing in the Past week (All Centers); *the latest available*

	13.04.2020	14.04.2020	15.04.2020	16.04.2020	17.04.2020	18.04.2020
Samples Received	541	342	333	548	679	502
Samples Tested	431	342	461	548	710	499
Positive Samples - First Time	10	15	5	1	7	4
Positive Samples - Repeat Sample	17	24	14	17	16	25
Inconclusive Samples	4	10	6	4	14	12
Negative Samples	400	293	436	526	673	458

