



Information for Clinicians: Frequently Asked Questions

There is currently a global outbreak of novel coronavirus (COVID-19).

In December 2019, an outbreak of a novel coronavirus occurred in Wuhan, Hubei Province, China. The virus, now officially named SARS-CoV-2, is thought to have originated in a seafood market and is likely to have come from bats before being transmitted to humans from an intermediate animal. In January 2020, Chinese authorities confirmed apparent human to human transmission of the virus.

The virus quickly spread throughout Hubei Province and to other provinces in mainland China, before spreading internationally. Quarantine measures implemented in mainland China and border control measures including travel restrictions implemented internationally, contained the virus and delayed significant spread. However, by the end of February 2020, cases had been reported in 57 countries with rapid increases in Iran, South Korea and Italy.

SARS-CoV-2 causes coronavirus disease 2019, commonly known as COVID-19. Symptoms of COVID-19 can range from mild illness to severe pneumonia. Researchers from around the world have been working to learn more about the epidemiological and clinical characteristics of the disease. Though there is still much to learn, we now know more than ever before.

This document answers some of the most frequently asked questions from clinicians. For general information, and to keep up to date as the situation evolves, please visit the Department of Health website at www.health.gov.au

Epidemiological FAQs

What is the incubation period?

The incubation period is the duration between exposure to the virus and the onset of symptoms. The World Health Organization (WHO) currently estimates that the incubation period ranges from 1 to 14 days, with a median incubation period of 5 to 6 days. These estimates will be refined as more data becomes available.

The Department is aware of reports that suggest there have been cases with longer incubation periods, such as 24 days. The incubation period of infections often has a skewed distribution, where most patients have an incubation period that clusters around the average, but a few patients have a longer incubation period. Medical experts believe reports of cases with longer incubation periods are statistical outliers – while longer incubation periods are possible, they may have been reported in error, or had exposure to an unidentified case at a later date that has not been identified in a transmission chain.

Is there asymptomatic or presymptomatic transmission?

To date, the exact nature of transmission of SARS-CoV-2 is not well understood. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases. However, there have been documented cases of asymptomatic and presymptomatic transmission in a small number of cases.

Can reinfection occur?

There have been reports of apparent re-infection in a small number of cases. However, most of these describe patients having tested positive within 7-14 days after apparent recovery. Immunological studies indicate that patients recovering from COVID-19 mount a strong antibody response. It is likely that positive tests soon after recovery represent persisting excretion of viral

RNA, and it should be noted that PCR tests cannot distinguish between “live” virus and non-infective RNA. Australian guidelines currently require patients who have had COVID-19 to test negative on two tests 24 hours apart before being released from isolation.

What is the case fatality rate and overall severity of the disease?

A large study conducted in China on 44,672 confirmed cases has informed much of what we currently know with regards to case fatality and overall severity of the disease. However, at the moment there is not enough data on cases outside mainland China to make a meaningful comparison.

In China, the case fatality rate (CFR) is reported to be 2.3%, however this is much higher in Hubei Province (2.9%) than in all other provinces (0.4%). The CFR is likely to be much lower than reported, due to a proportion of mild cases going underreported in the community. CFR estimates for regions outside mainland China are generally low; however, the clinical outcomes for the majority of these cases is still unknown. Based on current estimates, it is estimated that approximately 1% of COVID-19 patients will die. We will be able to better estimate this proportion once serological studies are performed.

Likewise, we continue to gather information on the overall severity of the disease. Based on current data, it is estimated that approximately 80% of cases will have a mild illness, approximately 20% will require hospitalisation, and approximately 3-5% will require ICU admission. Cases classified as critical (respiratory failure, septic shock, and/or multi-organ failure) have a CFR of approximately 50%. Patients in this circumstance have tended to be elderly with comorbidities.

How infectious is this pathogen?

There are a number of ways that this can be measured. The reproductive rate of the virus, or R_0 , measures the average number of secondary infections caused by a single case. The R_0 is a context specific measurement. While the R_0 in mainland China is estimated to be 2.58, it is likely that public health measures imposed by China have led to a relatively low R_0 . The R_0 may be higher in countries which do not implement strong public health measures, such as the case isolation and contact quarantine measures used in Australia. There has been a large variation in R_0 calculated by different studies. The WHO initially estimated the R_0 to be 1.4-2.5 (average 1.95), however a recent review of 12 studies estimated the basic R_0 to be 3.28 and the median R_0 to be 2.79.

Another measure of infectiousness is household secondary attack rate, or the proportion of household members who are likely to get infected from a case. Estimates of this rate have varied significantly between studies, ranging from as low as 3-10% to as high as 100%. This suggests that there may be factors that vary considerably between different groups, such as types of activities, duration of event, ventilation of the household and viral shedding of the case. The Department has released guidance on home isolation which outlines steps household members should take if there is a suspected or confirmed case in the house.

Clinical Care FAQs

What advice should I give my patients to prepare for COVID-19?

1. Get your information from credible sources. Visit www.health.gov.au or your state or territory public health authority website.
2. Advise your patients of the importance of personal hygiene measures:
 - Avoid touching your face

- Wash your hands frequently
 - Cough and sneeze into a tissue and then dispose of tissues and wash your hands, or cough and sneeze into your elbow if a tissue is not available
 - Stay home if you are sick
3. Recommend an influenza vaccine when available. It is important we reduce the risk of co-infection. Plan ahead and ensure adequate medication supplies, and optimise other health issues including mental health.
 4. Discuss an action plan with patients for the following scenarios:
 - If they become unwell
 - If they need to care for an ill person in their household
 - If they need to be placed in isolation or quarantine

How do people self-isolate or self-quarantine?

If you or a patient needs to self-quarantine because you have recently travelled to a high risk region or had close contact with a confirmed case of COVID-19, please view information on this factsheet: <https://www.health.gov.au/resources/publications/coronavirus-covid-19-isolation-guidance>

If you or a patient are unwell with suspected or confirmed COVID-19 and you need to self-isolate at home, please view information on this factsheet: <https://www.health.gov.au/resources/publications/coronavirus-covid-19-information-about-home-isolation-when-unwell-suspected-or-confirmed-cases>

How should I advise my patients who are planning to travel?

For patients travelling overseas, you should encourage them to:

1. Check and follow the official travel advice on the smart traveller website <https://www.smartraveller.gov.au/>
2. Review their travel insurance policies, as many policies exclude medical expenses for COVID-19 infection.

You should also ensure your patients find out what to do and who to contact if they become ill while travelling. Remember, the phone number for emergency services is different in many countries. Patients should familiarise themselves and comply with instructions from local authorities, including any local restrictions on travel, movement or large gatherings.

If your patients are travelling to high risk countries, they should be aware of any requirements for quarantine and/or work exclusion, and that they will need to seek testing if they become unwell within 14 days of leaving the high risk country.

Are surgical masks or P2 respirators more effective?

This is a controversial question with international guidelines offering conflicting advice. Australia's advice on the use of PPE is evidence-based and consistent with the WHO, European Union and Canadian guidelines. Our advice is available at: <https://www.health.gov.au/resources/publications/coronavirus-covid-19-information-on-the-use-of-surgical-masks>

Systematic reviews have found conflicting evidence to support masks compared to P2 respirators. A recent review found that both were quite effective when compared to no protection, and there was no difference in efficacy when comparing masks to P2 respirators. From a practical

perspective, P2 masks require fit testing and poorly used PPE puts the user at risk. Prolonged P2 respirator use is uncomfortable and places the user at risk of facial pressure injuries.

What should I do in my practice to prepare for COVID-19?

The response to COVID-19 is currently in the initial action phase. This means that our priority is preparing for when there are more cases in Australia. Steps your practice can take include:

- Stay informed and ensure you are keeping up to date with new advice released from the Department of Health and your state or territory public health authority.
- Consider your business continuity and what you might need to do to prepare for a pandemic (e.g. how you would manage increased absenteeism of your staff). Review your practice staffing.
- Plan and prepare for open and realistic communication with the public. Consider how you can communicate with your patients – through your website, phone messages, or in your surgery. There are a variety of resources available to help you communicate with your patients. Please visit <http://www.racgp.org.au/coronavirus>
- Review your staff capabilities and conduct staff training if needed. In particular, ensure that all staff are trained to use PPE appropriately and that staff know how to respond if there is a suspected or confirmed case visiting your practice.
- Consider your resources and supplies (PPE, cleaning agents, swabs etc.).
- Ensure you have adequate pathology support.
- Begin to consider how you will manage vulnerable patients, for example the elderly and patients with chronic conditions. Review chronic care management plans.
- Encourage your patients to get their flu vaccine.

Public Health FAQs

If we know that people won't all self-quarantine, why do we bother?

The rationale for quarantine of returning people from high risk settings (such as repatriated passengers from the Diamond Princess or from Wuhan) is to minimise their contact with other people and to facilitate timely access to testing and treatment if they become unwell.

Public health authorities recognise that interventions are not absolute, and enforcement is not always possible. However, even partial adherence to quarantine and isolation helps slow the spread of the virus and reduce the overall number of cases we expect to have in Australia.

What sort of public health measures might we expect, and what do I need to plan for?

The Australian Government has activated the Emergency Response Plan for Communicable Disease Incidents of National Significance (National CD Plan) and the Emergency Response Plan for Novel Coronavirus. State and territory governments are responsible for the operational aspects of public health responses. The implementation of public health measures may vary between different states and territories, particularly with regards to timing of implementation and stand down. The Australian Government is working closely with the state and territories to ensure preparedness for a range of possible scenarios.