Chapter 1

COVID-19

Canadian Pharmacists Association

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CPhA acknowledges the contribution of the following authors, whose previous work was, in part, used in the creation of this chapter: Benoit Bailey, Susan K. Bowles, Timothy P. Lynch, R. Alan Purdy, Yvonne Shevchuk, Robert Strang, Daniel J.G. Thirion, Irene Worthington.

Information on the rapidly evolving understanding of the epidemiology and pathophysiology of coronavirus disease 2019 (COVID-19), caused by the novel coronavirus SARS-CoV-2, can be found at:

- Public Health Agency of Canada (PHAC)
- World Health Organization (WHO)
- Centers for Disease Control and Prevention (CDC)
- National Institute for Health and Care Excellence (NICE)

Symptoms and clinical characteristics

In the community setting, advise all patients with symptoms or questions about testing and isolation to contact their local public health unit for up-to-date recommendations regarding actions to take based on the symptoms they are experiencing. Remind patients to call ahead to any health-care provider they intend to see regarding any other health-related concern to receive instructions regarding changes in office procedures during the pandemic.

Available data indicates that symptoms and clinical characteristics of COVID-19 may include:[1][2][3]

- Asymptomatic carriage
- Acute mild/moderate illness (80%) – any of the following symptoms alone or in combination:
  - fever (>37.8°C)
  - chills, repeated shaking with chills
  - cough (with or without sputum production)
  - shortness of breath
  - anorexia, headache, malaise, myalgia
  - sore throat
  - new loss of smell and/or taste[4][5]
  - less commonly: conjunctivitis,[6][7] diarrhea, other GI symptoms, rhinorrhea, skin rashes,[8][9] neurological abnormalities
- Acute severe (15%)/critical (5%):
  - two lung phenotypes, probably occurring sequentially
    - atypical viral pneumonitis (hypoxemia with relatively compliant lungs)
    - classic acute respiratory distress syndrome (ARDS) (stiff lungs)
  - nonrespiratory organ dysfunction: renal failure, liver dysfunction, cardiac dysrhythmia, neurological abnormalities[10][11]
– hyperinflammation syndromes ("cytokine storm")

Risk factors for symptomatic disease and progression to critical illness:
■ age >50 y, substantial risk >70 y
■ male
■ obesity (BMI ≥30)
■ comorbidities: cardiovascular disease, diabetes, chronic respiratory disease, hypertension, cancer, chronic kidney disease

This chapter provides information/links to guidance for primary care practitioners regarding:
■ Prevention measures for COVID-19
■ Management of select common symptoms of COVID-19: fever, cough, headache/myalgia
■ Experimental treatments being used for COVID-19 in acute-care settings
■ Management of special populations and/or patients with comorbidities in the context of the COVID-19 pandemic

Goals of Therapy
■ Prevent spread
■ Alleviate symptoms
■ Prevent complications where possible

Prevention
There is currently no evidence that any pharmacological agent, vitamin or herbal supplement is effective in the prevention of COVID-19. Several prevention trials are ongoing (see Government of Canada, Vaccines and treatments for COVID-19: List of all COVID-19 clinical trials authorized by Health Canada). Use of any medications for the prevention of COVID-19 outside of a clinical trial or the advice of an infectious disease specialist in an acute-care setting is inappropriate.[12]

Information on various nonpharmacologic measures related to the prevention of COVID-19 is available as indicated below:
■ Handwashing, hygiene, cleaning, physical distancing: Health Canada: Coronavirus disease (COVID-19): prevention and risks
■ Homemade or cloth masks: Health Canada: Considerations in the use of homemade masks to protect against COVID-19; JAMA Patient Page: Masks and coronavirus disease 2019 (COVID-19); Pan-Canadian Public Health Network: Use of non-medical cloth masks or face coverings in community settings
■ Personal protective equipment (PPE) for pharmacies: Canadian Pharmacists Association: Suggested best practices for pharmacies during the COVID-19 pandemic
■ Personal protective equipment (PPE) for health professionals: Health Canada: Coronavirus disease (COVID-19): for health professionals
■ Skin care while using PPE: Nurses Specialized in Wound, Ostomy and Continence Canada: Prevention and management of skin damage related to personal protective equipment: update 2020

Therapeutic Choices
Guidance on the treatment of patients with known or suspected COVID-19 can be found through:
Fever

There is no evidence regarding the management of fever due to COVID-19 specifically, but the following information regarding management of patients experiencing fever in general may be helpful. See also the Compendium of Therapeutic Choices for Minor Ailments (CTMA), Fever.

■ Children <6 months of age with a fever should be assessed by an appropriate health-care practitioner.[13]

■ In a pregnant patient who is in her first trimester, the goal of antipyresis is protection of the fetus.[14][15]

■ There are many arguments against treating a fever:[16][17][18][19][20]
  – Fever is an important defence mechanism; it enhances the immune response.
  – Fever is usually self-limiting and, though sometimes distressing, the associated symptoms of fever (mild dehydration, discomfort, febrile delirium, febrile seizures) are usually not harmful.
  – Use of antipyretics may impair the use of temperature as an important clinical tool for monitoring the progress of an infection or response to antibiotics.

Nonpharmacologic Choices

General interventions for reduction of fever and associated discomfort include:[13]

■ Removal of excess clothing and bedding

■ Increased fluid intake to replace insensible water loss during fever

■ Maintenance of ambient temperatures around 20–21°C (68–70°F)

■ Avoidance of physical exertion

Physical methods for heat reduction use convection, evaporation or conduction to counteract the body's attempt to maintain a higher temperature set-point (fever). Pharmacologic methods are preferred because they lower the hypothalamic set-point.[21] In the rare instance where core temperatures exceed 41–42°C, physical methods may be used in addition to pharmacologic methods.

■ Sponging with tepid or cold water uses evaporation to dissipate body heat. Sponging with alcohol is not recommended as it may be absorbed through the skin, inhaled or accidentally ingested by the patient; it has also been associated with hypoglycemia, intoxication and coma.[22][23]
Ice packs (wrapped in cloth, i.e., not touching the skin directly) or cooling (hypothermia) blankets may be applied to the skin to lower body temperature by conduction.

Circulating fans, sometimes directed over ice before reaching the patient, use convection to transfer heat away from the skin surface.

**Pharmacologic Choices**

The decision to use antipyretics must be individualized. The goal should be reduction of fever rather than “normal” body temperature. Assessment of the patient should not depend solely on the elevation of temperature.

- **Acetaminophen** is safe and effective in children and adults.[24]
- **ASA, ibuprofen and naproxen** are also effective antipyretics and may be used in the treatment of fever due to COVID-19, keeping the following in mind:
  - Evidence to date suggests that older people (>60 y) and those with underlying medical conditions are at higher risk of severe COVID-19. As NSAIDs should be used with caution in these populations, it is reasonable to avoid NSAIDs in the elderly and in those with comorbid conditions (e.g., cardiovascular disease, renal disease, chronic respiratory disease). If the use of an NSAID is unavoidable in these patients, it should be at the lowest effective dose and for the shortest duration.[24]
  - ASA is not recommended in children or adolescents because of the potentially increased risk of Reye syndrome.[25]
  - Naproxen is not approved/recommended in children <12 years of age.
  - For more information on the use of NSAIDs, see the *Compendium of Therapeutic Choices (CTC)*, Osteoarthritis and the *Compendium of Pharmaceuticals and Specialties (CPS)*, Nonsteroidal Anti-inflammatory Drugs (NSAIDs).
- Some clinicians recommend **alternating** acetaminophen and ibuprofen administration to reduce fever; however, there is insufficient evidence to support this as a routine practice and it is not recommended.[14][26][27] No difference was found in patient discomfort in 2 trials that assessed it.[27] Potential risks of prescribing 2 antipyretics may include confusion and dosing errors with associated toxicity.

For more detailed information on medications used in the management of fever, see Table 3.

**Cough**

There is no evidence regarding the management of cough due to COVID-19 specifically, but the following general information regarding management of patients experiencing acute cough may be helpful. See also the *Compendium of Therapeutic Choices for Minor Ailments (CTMA)*, Acute Cough.

**Nonpharmacologic Choices**

- Avoid exposure to inhaled irritants such as smoke, dust, pollutants and allergens, which can further exacerbate any cough.
- Although evidence is lacking, hydration with oral liquids and humidification of room air may be beneficial. Room humidifiers should be well cleaned to avoid aerosolizing mould.

**Pharmacologic Choices**

Overall, there is little evidence for or against the effectiveness of nonprescription cough medicines.[28]
Nonprescription antitussives act centrally to suppress cough. Antitussives are not recommended when a cough performs a useful function. If used by a patient with a productive cough, more mucus is retained.[29]

- Dextromethorphan and codeine are commonly used to treat cough related to upper respiratory tract infections, although there is little evidence for efficacy.[28]

Expectorants. Cough associated with COVID-19 infection has generally been reported as dry, but sputum production may be present. Adequate hydration with oral liquids and inhalation of humidified air (e.g., warm showers, cool mist humidifiers) may be helpful in thinning and moving secretions in the respiratory tract. There is a lack of evidence to support the efficacy of products marketed as expectorants (e.g., guaifenesin[30]); they have not been found to thin sputum nor increase sputum volume, even at doses higher than recommended.[29]

Various other agents have been used for the management of cough, generally based on limited and/or poor-quality evidence.

- Honey has demulcent, antioxidant and antibacterial effects. It is proposed that the demulcent effect may act to decrease cough. It may be an effective cough suppressant in children; no studies in adults are available.[30][31]

- Zinc lozenges have been used to alleviate cough due to the common cold. However, meta-analyses have concluded there is insufficient evidence to recommend zinc preparations.[30] In addition, zinc can be associated with an unpleasant taste, mouth irritation and nausea.

- Anesthetic lozenges containing ingredients such as benzocaine, phenol and menthol may reduce the sensitivity of peripheral nociceptors. They have been used as antitussives, but evidence for efficacy is poor. Rarely observed side effects include tingling or irritation at the site of administration and hypersensitivity reactions.

- Bronchodilators such as salbutamol or formoterol are recommended only for cough due to obstructive lung disease such as asthma or COPD.[32]

For more detailed information on medications used in the management of cough, see Table 3.

Headache and myalgias

There is no evidence regarding the management of headache and/or myalgia due to COVID-19 specifically, but the following general information regarding management of patients experiencing these symptoms may be helpful. See also Headache in the Compendium of Therapeutics for Minor Ailments (CTMA) as well as Headache in Adults, Acute Pain and Influenza in the Compendium of Therapeutic Choices (CTC).

Nonpharmacologic Choices

- Simple measures such as resting in a dark, quiet room and applying a cold cloth/ice pack to the head are helpful for headache, although not evidence-based.

Pharmacologic Choices

The following medications are effective for alleviating headache and myalgia:

- Acetaminophen can be used for mild to moderate pain. Compared with full-dose NSAIDs, acetaminophen has fewer adverse effects and drug interactions but is less effective and has no anti-inflammatory action.[33]

- ASA, ibuprofen and naproxen are effective anti-inflammatory analgesics. They may be useful for the treatment of headache and myalgia in patients with COVID-19, keeping the following in mind:

  - Evidence to date suggests that older people (>60 y) and those with underlying medical conditions are at higher risk of severe COVID-19. As NSAIDs should be used with caution in
these populations, it is reasonable to avoid NSAIDs in the elderly and in those with comorbid conditions (e.g., cardiovascular disease, renal disease, chronic respiratory disease). If the use of an NSAID is unavoidable in these patients, it should be at the lowest effective dose and for the shortest duration.\[24\]

- ASA is not recommended in children or adolescents because of the potentially increased risk of Reye syndrome.\[25\]
- Naproxen is not approved/recommended in children <12 years of age.
- For more information on the use of NSAIDs, see the Compendium of Therapeutic Choices (CTC), Osteoarthritis and the Compendium of Pharmaceuticals and Specialties (CPS), Nonsteroidal Anti-inflammatory Drugs (NSAIDs).

- Headache and myalgia due to COVID-19 seem to respond adequately to acetaminophen or NSAIDs; it is unlikely that stronger analgesics such as opioids would be required.

For more detailed information on medications used in the management of headaches and myalgias, see Table 3.

**Experimental therapies for COVID-19**

Experimental therapies are being used in the acute-care setting in severely ill patients as well as earlier in the illness or in uninfected patients in attempts to prevent progression or spread of the disease. Use of any of these medications for these purposes outside of a clinical trial or the advice of an infectious disease specialist in an acute-care setting is inappropriate.\[12\]

Information about COVID-19-related clinical trials can be found at:

- Government of Canada: Vaccines and treatments for COVID-19: list of all COVID-19 clinical trials authorized by Health Canada
- Cochrane Systematic Review Database: Living mapping and living systematic review of COVID-19 studies
- Global Coronavirus COVID-19 Clinical Trial Tracker

Information about the rationale for use, dosage, adverse effects, drug interactions and safety during pregnancy or breastfeeding of select trial medications being used in Canada can be found in Table 1.

**Table 1: Select Experimental Therapies for COVID-19**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Rationale for Use</th>
<th>Dosage</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Safety in Pregnancy and Breastfeeding[38][39][40][41]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adenovirus Type 5 Vector (Ad5-nCoV)</strong>[42][43]</td>
<td>Recombinant novel coronavirus vaccine.</td>
<td>“Low” dose and “high” dose single or 2 dose regimens being tested</td>
<td>Not available.</td>
<td>Not available.</td>
<td>Not available.</td>
</tr>
<tr>
<td><strong>Azithromycin</strong></td>
<td>Antibacterial. Used in combination with hydroxychloroquine for a potential synergistic antiviral effect and to prevent concurrent infection.</td>
<td>500 mg on first day then 250 mg daily PO × 4 days</td>
<td>GI upset, rash, cholestatic hepatitis, QTc interval prolongation.[a]</td>
<td>Use cautiously with other drugs that cause QTc prolongation (e.g., hydroxychloroquine).[a] May increase warfarin effect; increased concentrations of substrates of CYP3A4</td>
<td>Pregnancy: considered safe. Breastfeeding: low levels in milk, not expected to cause adverse effects in the infant.</td>
</tr>
</tbody>
</table>

(cont’d)
### Table 1: Select Experimental Therapies for COVID-19 (cont’d)

<table>
<thead>
<tr>
<th>Drug</th>
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</thead>
<tbody>
<tr>
<td><strong>Bacterial Infections</strong>&lt;br&gt; (e.g., pneumonia).</td>
<td></td>
<td>(potent inhibitor), e.g., atorvastatin, carbamazepine, digoxin, lovastatin, simvastatin.</td>
<td></td>
<td>Pregnancy: limited data. [44][45] Animal studies have shown teratogenic effects. [46] Breastfeeding: no data available.</td>
<td></td>
</tr>
<tr>
<td><strong>Baricitinib</strong>&lt;br&gt; Janus kinase (JAK1 and JAK 2) inhibitor. Predicted to reduce the ability of the virus to infect lung cells.</td>
<td>2 mg daily PO × 10 days</td>
<td>Increased risk of serious infections, malignancy and thrombosis; increased CPK, hypercholesterolemia, pharyngitis, nausea, UTI, hypertension, URTI, headache.</td>
<td>Enhanced immunosuppression with other immunosuppressants.</td>
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<tr>
<td><strong>Chloroquine</strong>&lt;br&gt; Antimalarial. Unpublished Chinese trials suggest benefit in reducing exacerbations of pneumonia, shortening disease course and decreasing viral load.</td>
<td>Various regimens being tested, including:&lt;br&gt; Adults ≥50 kg: 500 mg BID PO × 7 days&lt;br&gt; Adults &lt;50 kg: 500 mg BID PO × 2 days followed by 500 mg daily PO × 5 days</td>
<td>Potentially fatal in overdose.&lt;br&gt; Nonallergic pruritus in African Canadians, nausea, vomiting, headache, bitter taste, QTc interval prolongation. [a]&lt;br&gt; Rare retinal toxicity (patients with underlying macular disease at an increased risk).</td>
<td>Decreased metabolism of beta-blockers. May increase digoxin levels. Increased risk of QTc prolongation with other QTc-prolonging agents and strong CYP3A4 inhibitors. [a]</td>
<td>Pregnancy: considered safe. Breastfeeding: no information on daily use during breastfeeding but is given directly to infants for malaria prophylaxis.</td>
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<tr>
<td><strong>Colchicine</strong>&lt;br&gt; Antigout therapy. Anti-inflammatory effect may reduce complications due to hyperinflammation (cytokine storm syndrome).</td>
<td>0.5 mg BID × 3 days followed by 0.5 mg daily × 27 days</td>
<td>Abdominal pain and cramps, diarrhea, nausea and vomiting. Possible neuropathy, myopathy, bone marrow suppression.</td>
<td>May increase levels of HMG Co-A reductase inhibitors; monitor for statin myotoxicity (muscle pain, weakness). Monitor for colchicine toxicity (GI symptoms, fever, leukopenia) if also taking known inhibitors of CYP3A4 (e.g., antiretroviral drugs, clarithromycin, erythromycin, itraconazole, ketoconazole, verapamil) or Pgp (e.g., cyclosporine). Fatalities have been reported with clarithromycin, which inhibits both CYP3A4 and Pgp. Avoid grapefruit juice.</td>
<td>Pregnancy: generally recommended to avoid unless benefit outweighs risk; however, a systematic review did not show increased risk of malformations or miscarriage. [48] Breastfeeding: no adverse effects reported in infants. Highest milk levels occur 2–4 h after dosing; delay breastfeeding until 4 h postdose or take dose immediately after nursing.</td>
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<tr>
<td><strong>Corticosteroids</strong>&lt;br&gt; Immunomodulator. Studies in sepsis have shown positive effects on</td>
<td>50 mg hydrocortisone IV Q6H × 7 days (or 50 mg hydrocortisone PO × 14 days)</td>
<td>Fluid retention, hypertension, Cushing syndrome.</td>
<td>Enhanced immunosuppression with other immunosuppressants.</td>
<td>Pregnancy: not associated with increased risk of major</td>
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</tbody>
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</thead>
<tbody>
<tr>
<td><strong>Heparins:</strong></td>
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<td>low molecular weight</td>
<td>low molecular weight heparins; unfractionated</td>
<td>Various regimens being tested,</td>
<td>LMWH: Bleeding; HIT and osteoporosis (less common than with UFH).</td>
<td>LMWH: increased risk of bleeding with other anticoagulants, antplatelets, NSAIDs.</td>
<td>DMX: Pregnancy: considered safe.</td>
</tr>
<tr>
<td>LMWH, unfractionated</td>
<td>heparin). For treatment of coagulopathy associated</td>
<td>until discharge, 28 days or</td>
<td>UFH: Bleeding, HIT, osteoporosis.</td>
<td>UFH: increased risk of bleeding with other anticoagulants, antplatelets, NSAIDs.</td>
<td>Breastfeeding: considered safe.</td>
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<td>(UFH)</td>
<td>with COVID-19.</td>
<td>death with any one of the</td>
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<td>IV nitroglycerin may reduce heparin’s anticoagulant effect.</td>
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<td>following: dalteparin 200</td>
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<td>units/kg daily or 100 units/kg</td>
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<td>BID SC; or enoxaparin 1.5</td>
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<td>mg/kg daily or 1 mg/kg BID</td>
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<td>SC; or tinzaparin 175 units/kg</td>
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<td></td>
<td></td>
<td>daily SC; or UFH IV as per</td>
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<td>institution protocol</td>
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<td><strong>Hydroxychloroquine</strong></td>
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<td></td>
<td>(i.e., COVID-19).</td>
<td>400–800 mg PO daily × 1–4 days</td>
<td>Nonallergic pruritus in African-Canadians, nausea, vomiting,</td>
<td>May increase digoxin levels.</td>
<td>indicate significant risk; CDC</td>
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<td>Increased risk of QTc prolongation with other</td>
<td>considers it safe for the prevention</td>
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<td>of malaria.</td>
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(cont’d)
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</thead>
<tbody>
<tr>
<td>Lopinavir/</td>
<td>Antiretroviral. Has activity (in vitro and/or in animal models) against SARS-CoV-1;</td>
<td>Treatment: 400/100 mg BID PO × 14 days or until discharge from hospital</td>
<td>GI upset, liver enzyme elevations, hyperlipidemia, and PR and QTc interval prolongation[^a] Possible increased risk of renal dysfunction.</td>
<td>Numerous serious drug interactions; consult a reputable drug interaction checker or resource.</td>
<td>Breastfeeding: low levels in milk; no adverse effects reported.</td>
</tr>
<tr>
<td>ritonavir</td>
<td>MERS-CoV. Ritonavir is added to lopinavir to increase its half-life through inhibition of CYP450.</td>
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</tr>
<tr>
<td>Peg-interferon</td>
<td>Human recombinant interferon. Stimulates immune responses during viral infections.</td>
<td>Ambulatory cohort: single dose 180 mcg SC at baseline Hospitalized cohort: 180 mcg SC at baseline, second dose on day 7</td>
<td>Preliminary data from studies in other conditions: GI upset, elevated LFTs, flu-like symptoms, musculoskeletal symptoms.</td>
<td>Data not available.</td>
<td>Pregnancy: no data available. Breastfeeding: no data available; other peginterferons (alfa and beta) are considered low risk due to low amounts transferred into breast milk and predicted minimal GI absorption in the infant.</td>
</tr>
<tr>
<td>Lambda-1A</td>
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<tr>
<td>Remdesivir</td>
<td>Antiviral. Has activity in vitro and in animal models against SARS-CoV-1; MERS-CoV.</td>
<td>200 mg IV daily on day 1 followed by 100 mg IV daily for up to 10 days</td>
<td>Generally well-tolerated. GI effects. Aminotransferase elevations.</td>
<td>Remdesivir effect possibly decreased by CYP3A4 inducers: dexamethasone (at high doses or for prolonged duration), rifabutin, rifampicin, carbamazepine, phenobarbital, phenytoin, primidone, St. John’s Wort.</td>
<td>Pregnancy: no data available; weigh benefit vs. risk. Breastfeeding: transfer into milk is unknown; there is a single case report of direct use in an infant with Ebola without adverse effects[^51].</td>
</tr>
<tr>
<td>Ruxolitinib</td>
<td>Janus kinase (JAK1 and JAK 2) inhibitor. Theoretically, may reduce</td>
<td>10 mg BID × 14 days followed by 5 mg BID × 2 days then</td>
<td>Anemia, thrombocytopenia, neutropenia, bruising, dizziness, headache.</td>
<td>Ruxolitinib exposure may be increased by fluconazole and other strong CYP3A4 inhibitors and decreased by strong CYP3A4 inducers.</td>
<td>Pregnancy: no data, weigh benefit vs. risk. Breastfeeding: no data available. Highly protein.</td>
</tr>
</tbody>
</table>
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<th>Safety in Pregnancy and Breastfeeding[^38][^39][^40][^41]</th>
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<tbody>
<tr>
<td><strong>Sarilumab</strong></td>
<td>L-6 monoclonal antibody. Theoretically, may reduce complications due to hyperinflammation (cytokine storm syndrome).</td>
<td>Single IV dose (“low” dose vs. “high” dose being studied)</td>
<td>Increased risk of serious infections, injection-site reactions, URTIs, elevated ALT levels.</td>
<td>May decrease the concentration of CYP3A4 substrates by restoring CYP3A4 activity in some patients.</td>
<td>Pregnancy: no data, weigh benefit vs. risk. Breastfeeding: no data available. Large protein molecule: milk levels predicted to be low and any ingested drug expected to be destroyed in infant’s GI tract.</td>
</tr>
<tr>
<td><strong>Tocilizumab</strong></td>
<td>IL-6 monoclonal antibody. Theoretically, may reduce complications due to hyperinflammation (cytokine storm syndrome).</td>
<td>8 mg/kg (up to max of 800 mg) × 1 dose IV, repeated once prn if symptoms worsen or show no improvement</td>
<td>Infusion reactions (very severe reactions resulting in death have been reported rarely), serious infections, GI perforation, increased neutrophils, decreased platelets, neutropenia, elevated ALT, increased lipids.</td>
<td>May increase CYP450 enzyme activity—monitor concurrent therapy with drugs metabolized by CYP450.</td>
<td>Pregnancy: limited data have not shown increased risk of major defects. Breastfeeding: limited data show small amounts in milk. Case reports have not reported adverse effects in infants.</td>
</tr>
<tr>
<td><strong>Vitamin C</strong></td>
<td>Vitamin. Has been studied with respect to lessening organ dysfunction secondary to sepsis based on experimental evidence of anti-inflammatory and antioxidant properties.</td>
<td>50 mg/kg Q6H IV × 4 days</td>
<td>Diarrhea, increased risk of renal stones in predisposed individuals.</td>
<td>Urinary acidifier in large doses, the excretion of drugs that are weak acids or bases may be decreased or increased respectively. May reduce the effect of warfarin, cyclosporine, amphetamines, bortezomib.</td>
<td>Pregnancy: data limited, crosses the placenta, possibly resulting in above-normal levels in fetus. Upper tolerable limit 2000 mg/day during pregnancy[^52] Breastfeeding: no data on high-dose IV use. Milk levels predicted to be high and predispose infant to kidney stones. If used, avoid breastfeeding for 12–24 h after dose.</td>
</tr>
</tbody>
</table>

[^38]: See Canadian Heart Rhythm Society guideline on antimicrobial drug-induced ventricular arrhythmia with COVID-19.[^47]

**Abbreviations:**  
ACE2 = angiotensin-converting enzyme 2; ALT = alanine transaminase; ARB = angiotensin receptor blocker; ARDS = acute respiratory distress syndrome; CDC = Centers for Disease Control and Prevention; CPK = creatine phosphokinase; CYP = cytochrome P; GI = gastrointestinal; HIT = heparin-induced thrombocytopenia; IL = interleukin; LFT = liver function test; MERS-CoV = Middle East respiratory syndrome coronavirus; NSAID = nonsteroidal anti-inflammatory drug; Pgp = p-glycoprotein; SARS-CoV = severe acute respiratory syndrome coronavirus; URTI = upper respiratory tract infection; UTI = urinary tract infection
Choices during Pregnancy and Breastfeeding

Management of COVID-19 during pregnancy

See Table 2 for suggested resources providing general information with respect to COVID-19 and pregnancy.

For the treatment of fever, headache, myalgia:
- Acetaminophen is considered the drug of choice during pregnancy.
- ASA and NSAIDs may be considered as alternatives during the first or second trimester, but are not recommended in the third trimester.[38]

For the treatment of cough:
- Codeine has the most evidence of safety during pregnancy.[38]
- Dextromethorphan can be considered as an alternative.[38]
- Available data do not support an association between guaifenesin use during pregnancy and congenital defects. Liquid products containing guaifenesin may contain high alcohol content. Products with high alcohol content should be avoided during pregnancy.[53]
- Honey is safe to consume during pregnancy.
- Zinc is considered safe in pregnancy, provided the recommended daily maximum zinc intake (40 mg)[54] is not exceeded. The safety of other ingredients in any zinc-based lozenges must also be assessed.

For information on the safety of experimental therapies: see Table 1.

Management of COVID-19 during breastfeeding

See Table 2 for suggested resources providing general information with respect to COVID-19 and breastfeeding. Continuation of breastfeeding is recommended, as breast milk is considered an insignificant route of transmission for other respiratory viruses. If the mother is infected, wearing a mask and practicing respiratory etiquette and hand hygiene are recommended.[55]

For the treatment of fever, headache, myalgia:
- Acetaminophen is considered the drug of choice during breastfeeding.
- Anti-inflammatory doses of ASA are not recommended due to possible excretion of salicylic acid into breast milk and risk of Reye syndrome.
- NSAIDs have been shown to be present in breast milk in small amounts and are considered safe to use. The use of short-acting drugs, such as ibuprofen, may be preferred over those with a longer half-life, such as naproxen.[56]

For the treatment of cough:
- The transfer of dextromethorphan and guaifenesin into breast milk is unknown. It is unlikely that usual maternal doses would harm a nursing infant, especially in those >2 months of age; however, liquid products containing dextromethorphan or guaifenesin may contain high alcohol content. Products with high alcohol content should be avoided while breastfeeding.[40][53]
- Use codeine with caution at the lowest effective dose for a maximum of 2–3 days in a breastfeeding mother. If codeine is used, monitor the infant for increased sleepiness, difficulty breastfeeding, breathing difficulties and limpness.[39]
- Honey is safe to consume during breastfeeding.
Zinc is considered safe in breastfeeding, provided the recommended daily maximum zinc intake (40 mg) is not exceeded. The safety of other ingredients in any zinc-based lozenges must also be assessed. For information on the safety of experimental therapies, see Table 1.

A discussion of general principles on the use of medications in these special populations can be found in CPS Clin Info, Drug use During Pregnancy and Drug use During Breastfeeding. Other specialized reference sources are also provided in these appendices.

**Resources for the Management of Special Populations/Comorbidities**

Guidance/information is available to address the concerns of health-care practitioners managing patients in special population groups and/or with various disease states with respect to prevention and treatment of COVID-19:

| Table 2: Resources for the Management of Special Populations/Comorbidities |
|---------------------------------|--------------------------|
| **Special population/comorbidity** | **Resources** |
| Anticoagulation/thrombosis | Canadian Medical Association Journal: Coagulopathy associated with COVID-19  
International Collaboration: COVID-19 and thrombotic or thromboembolic disease: implications for prevention, antithrombotic therapy, and follow-up  
Thrombosis Canada: Managing anticoagulation during the COVID-19 pandemic |
| Asthma | Canadian Thoracic Society: Inhaled salbutamol shortage - mitigation strategy for asthma  
Canadian Thoracic Society: Position statement: addressing therapeutic questions to help Canadian physicians optimize asthma management for their patients during the COVID-19 pandemic  
Global Initiative for Asthma (GINA): COVID-19: GINA answers to frequently asked questions on asthma management |
| Breastfeeding | B.C. Centre for Disease Control/B.C. Ministry of Health: Guideline for lactation for women/individuals who are confirmed or suspect cases of COVID-19  
Canadian Paediatric Society: Breastfeeding when mothers have suspected or proven COVID-19  
Centers for Disease Control and Prevention (CDC): Care for breastfeeding women, interim guidance on breastfeeding and breast milk feeds in the context of COVID-19  
Health Canada: Pregnancy, childbirth and caring for newborns: advice for mothers during COVID-19  
The Provincial Council for Maternal and Child Health: Maternal-neonatal COVID-19 general guideline  
Public Health Agency of Canada (PHAC): Updated: public health management of cases and contacts associated with coronavirus disease 2019 (COVID-19)  
Safety Fed Canada: COVID-19 infant feeding resources  
World Health Organization (WHO): Breastfeeding advice during the COVID-19 outbreak |
| Cardiovascular conditions | American College of Cardiology: COVID-19 clinical guidance for the cardiovascular care team  
Canadian Cardiovascular Society: COVID-19 and concerns regarding use of ACEi/ARB/ARNi medications for heart failure or hypertension |
| Chronic obstructive pulmonary disease | Canadian Thoracic Society: Position statement: addressing therapeutic questions to help Canadian health care professionals optimize COPD management for their patients during the COVID-19 pandemic  
Canadian Thoracic Society: Inhaled salbutamol shortage - mitigation strategy for COPD  
Global Initiative for Chronic Obstructive Lung Disease (GOLD): GOLD COVID-19 guidance |
| Contact lens care | British Contact Lens Association: The COVID-19 pandemic: important considerations for contact lens practitioners |
| Dermatological conditions | Canadian Dermatology Association: Patient information: COVID & systemic |

(cont'd)
### Table 2: Resources for the Management of Special Populations/Comorbidities (cont'd)

<table>
<thead>
<tr>
<th>Special population/comorbidity</th>
<th>Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Diabetes Canada: COVID-19 (coronavirus) and diabetes</td>
</tr>
<tr>
<td>Drug adverse effects and interactions specific to COVID-19</td>
<td>Canadian Heart Rhythm Society: Guidance on minimizing the risk of antimicrobial drug-induced ventricular arrhythmia during treatment of COVID-19</td>
</tr>
<tr>
<td>Endocrine conditions</td>
<td>European Society of Endocrinology: COVID-19 and endocrine diseases. A statement from the European Society of Endocrinology</td>
</tr>
<tr>
<td>Exercise/return to sports</td>
<td>American College of Cardiology, Sports and Exercise Cardiology Council: A game plan for the resumption of sport and exercise after coronavirus disease 2019 (COVID-19) infection</td>
</tr>
<tr>
<td>Feeding infants and young children</td>
<td>Safely Fed Canada: COVID-19 infant feeding resources</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>GeriMedRisk: COVID-19 resources for clinicians</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>Canadian Cardiovascular Society: COVID-19 and concerns regarding use of ACEI/ARB/ARNi medications for heart failure or hypertension</td>
</tr>
<tr>
<td>Human immunodeficiency virus</td>
<td>U.S. Department of Health and Human Services, AIDSinfo: Interim guidance for COVID-19 and persons with HIV</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Canadian Cardiovascular Society: COVID-19 and concerns regarding use of ACEI/ARB/ARNi medications for heart failure or hypertension</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>American Gastroenterological Association (AGA): AGA clinical practice update on management of inflammatory bowel disease during the COVID-19 pandemic</td>
</tr>
<tr>
<td>Medications requiring regular monitoring (e.g., lithium, warfarin)</td>
<td>National Health Service (NHS), Specialist Pharmacy Service: Guidance on the management of drugs requiring monitoring during COVID-19</td>
</tr>
<tr>
<td>Mental health</td>
<td>Canadian Psychological Association: Psychology works for COVID-19. Psychologists giving back to front line service providers</td>
</tr>
<tr>
<td>Multiple sclerosis</td>
<td>MS Society of Canada: Disease-modifying treatment (DMT) guidelines for coronavirus (COVID-19)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Canadian Paediatric Society: COVID-19 information and resources for paediatricians</td>
</tr>
<tr>
<td>Special population/comorbidity</td>
<td>Resources</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Rheumatic diseases</td>
<td>The Society of Obstetricians and Gynecologists of Canada: <em>Updated SOGC committee opinion – COVID-19 in pregnancy</em></td>
</tr>
<tr>
<td></td>
<td>American College of Rheumatology: <em>Guidance for the management of adult patients with rheumatic disease during the COVID-19 pandemic</em></td>
</tr>
<tr>
<td>Substance Use</td>
<td>Canadian Centre on Substance Use and Addiction: <em>Impacts of COVID-19 on substance use</em></td>
</tr>
<tr>
<td>Vaccine scheduling</td>
<td>Canadian Pharmacists Association: <em>COVID-19: Disruption of immunization schedules during the pandemic. Is a delay a problem?</em></td>
</tr>
<tr>
<td></td>
<td>PHAC: <em>Canadian immunization guide</em></td>
</tr>
<tr>
<td>Class</td>
<td>Drug</td>
</tr>
<tr>
<td>--------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Antipyretic/Analgesic</td>
<td>acetaminophen</td>
</tr>
<tr>
<td>ASA</td>
<td>Aspirin, Coated</td>
</tr>
<tr>
<td>Class</td>
<td>Drug</td>
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<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td></td>
<td>ibuprofen</td>
</tr>
</tbody>
</table>

(cont’d)
Table 3: Treatment of symptoms associated with COVID-19 (cont’d)

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Dosage</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Comments</th>
<th>Cost(e)</th>
</tr>
</thead>
</table>
|       | naproxen sodium  
Aleve, Anaprox,  
Naproxen Sodium,  
other generics | Children <12 y: not recommended  
Adults: 220 mg  
Q8–12H PO PRN;  
maximum 440 mg/day | See ibuprofen. | See ibuprofen. | See ibuprofen. | $ |

comorbid conditions (e.g., cardiovascular disease, renal disease, chronic respiratory disease). If the use of an NSAID is unavoidable in these patients, it should be at the lowest effective dose and for the shortest duration.
<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Dosage</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Comments</th>
<th>Cost[^1]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antitussives</td>
<td>codeine[^2]</td>
<td>Adults: 10–20 mg Q4–6H PO; maximum 120 mg/day Health Canada recommends against the use of codeine and other opioids in children &lt;18 y[^37] For combination products, consult label for additional ingredients; follow directions on label</td>
<td>Drowsiness, sedation, nausea, vomiting, constipation.</td>
<td>CNS depressants, including alcohol, enhance CNS side effects. MAOIs: risk of serotonin syndrome. CYP2D6 inhibitors (e.g., fluoxetine, paroxetine) may inhibit conversion of codeine to its active metabolite and reduce clinical effect.</td>
<td>Causes less sedation than hydrocodone. Metabolized to morphine. Potential for dependence/addiction. Nonprescription codeine products always contain other ingredients.</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>dextromethorphan[^4]</td>
<td>Adults and children ≥12 y: 10–20 mg Q4H PO or 30 mg Q6–8H PO; maximum 120 mg/day Children 6–11 y: 5–10 mg Q4H PO or 15 mg Q6–8H PO; maximum 60 mg/day For combination products, consult label for additional ingredients; follow directions on label</td>
<td>Generally well-tolerated. Occasional dizziness, drowsiness, nausea.</td>
<td>Modulators of serotonin: risk of serotonin syndrome, e.g., SSRI, linezolid, MAOIs (including moclobemide). CYP2D6 inhibitors (e.g., fluoxetine, paroxetine) may inhibit DM metabolism, resulting in increased DM levels and potential for adverse effects.</td>
<td>Causes less sedation than codeine and other opioids. DM has been abused for its euphoric effects.</td>
<td>$</td>
</tr>
<tr>
<td></td>
<td>honey</td>
<td>Adults: 15 mL daily to TID Children 1–18 y: 2.5–10 mL HS</td>
<td>Side effects are rare; nervousness, insomnia, hyperactivity.</td>
<td>No known interactions.</td>
<td>Only use pasteurized honey due to the risk of botulism. Due to this risk, avoid in children &lt;1 y, patients who are immunocompromised or those who have structural abnormalities of the GI tract. Avoid in patients allergic to pollen. Do not use honey made from <em>Rhododendron</em> (e.g.,</td>
<td>$</td>
</tr>
</tbody>
</table>

(continued)
### Table 3: Treatment of symptoms associated with COVID-19 (cont’d)

<table>
<thead>
<tr>
<th>Class</th>
<th>Drug</th>
<th>Dosage</th>
<th>Adverse Effects</th>
<th>Drug Interactions</th>
<th>Comments</th>
<th>Cost[^a]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectorants</td>
<td>guaifenesin</td>
<td>Adults and children ≥12 y: 200–400 mg Q4H PO; maximum 2.4 g/day Children ≥6 y: 12 mg/kg/day in divided doses Q4H PO; maximum 1.2 g/day</td>
<td>Side effects are rare; dizziness, drowsiness, headache, nausea and vomiting have been reported at high doses.</td>
<td>No known interactions.</td>
<td>$</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Robitussin Mucus &amp; Phlegm, generics</td>
<td>For combination products, consult label for additional ingredients; follow directions on label</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

[^a]: Cost per day; includes drug cost only.

[^b]: More likely to occur with antineoplastic doses of methotrexate.

[^i]: Dosage adjustment may be required in renal impairment; see Appendix I.

**Abbreviations**

ACE = angiotensin-converting enzyme; ClCr = creatinine clearance; CNS = central nervous system; DM = dextromethorphan; GI = gastrointestinal; HCP = health-care provider; INR = international normalized ratio; MAOI = monoamine oxidase inhibitor; NSAID = nonsteroidal anti-inflammatory drug; SSRI = selective serotonin-reuptake inhibitor

Legend: $ < $1
Suggested Readings


References


