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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

COVID-19: Updates on Best Practices to Improve Outcomes

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Dr. Vega:
Therapeutic advances provide opportunities for improved care. But do you know how to put newer COVID-19 treatment strategies into practice for your patients?

This is CME on ReachMD, and I'm Dr. Chuck Vega.

Dr. Auwaerter:
And I'm Dr. Paul Auwaerter. Welcome to this program. Now to start things off, Chuck, when you're working in your ambulatory setting, how do you assess patients that might be at risk for severe COVID-19?

Dr. Vega:
Great question, Paul. You know, I think we've entered the DIY, or do-it-yourself, stage of the pandemic. We’ve been in it for quite a while now. We see a lot of different approaches, but you want to make sure that you get the right diagnosis first. And so most folks are doing home antigen testing now. And I think that's fine. It makes care much more efficient. You know, there's some question about the sensitivity of these tests. Recent Cochrane review published in July 2022 showed that sensitivity overall was 73%. And this is during omicron, with symptoms, but 55% without symptoms. But specificity is quite good.

So therefore, home antigen testing, I find, is reliable, particularly when it's done serially. If folks are symptomatic, and they follow up a negative test with another test the following day, many times they will turn positive. Because with omicron particularly, we aren't seeing the more severe symptomatology that we have with previous variants. We're seeing more sore throat but less severe illness overall. And in a longitudinal study that's looking at seropositivity among residents here in Southern California, 56% who seroconverted to positive antibodies during the omicron wave were unaware that they were sick, so they were just unaware that they were infected at all.

So once we have the diagnosis set, I don't think there's a ton of movement with regards to who's at high risk for complications. It has a lot to do with age, particularly over 65, but even folks over 50, if they're not vaccinated. And then all kinds of comorbid illnesses, you know, chronic dysfunction of the heart, the lung, the brain, any kind of immunodeficiency, obesity. It's a long list that really is – most of the patients in my primary care practice would be considered at elevated risk, not just with one single risk factor, but with multiple risk factors overall for complications of COVID-19.

Dr. Auwaerter:
Well, Chuck, I really think one of the breakthroughs has been the diagnostic methods that are now extended to the home environment that really affords people to be diagnosed earlier, perhaps isolate and protect oneself from others, and also call their physicians. I'd have

to say, I've been educating patients that are in older age groups that might have significant health problems that could include diabetes and so on to really call their doctor at first notice and then have a discussion about potential treatments and also make sure they're not running into trouble in terms of developing shortness of breath, which is still happening. And many people are still landing in the hospital daily, unfortunately, and we're still seeing a fair number of deaths due to COVID-19 on a daily basis.

Dr. Vega:
Well, that's a great point. And of course, it's something we really want to work to prevent.

So can you tell me about the fairly complex decision-making process that goes into deciding which outpatients get treated for COVID-19?

Dr. Auwaerter:
Yeah, Chuck, I have to say this is a little more complicated now than a traditional sort of prescribe an antibiotic. But we're lucky that we have a number of treatments available. And I think each of us that are considering treatment have to be a bit of an epidemiologist, have to know what's circulating in your community. As time moves on, is SARS-CoV-2 really there quite a bit? Is it at low levels? Is influenza or other viruses predominating? But let's say that you have someone that at the moment you know has COVID-19, and they may be at risk for severe disease. I think it's important to entertain treatment. I think many people have heard that the virus may not be as pathogenic and not causing as much severe disease. But certainly, our patients in the oldest age groups, people with significant health problems, can still easily develop severe disease and land in the hospital.

The 2 major guidelines that I usually reference are the National Institutes of Health guideline and also the Infectious Disease Society of America. And I'm an ID [infectious diseases] consultant, but I also do some primary care. So I've been sort of working both sides of the fence here. There are probably 4 main options to consider. In terms of efficacy, nirmatrelvir/ritonavir is an oral 5-day medicine that, at least when it was studied in the EPIC trial for unimmunized patients earlier in the epidemic, had a substantial benefit in terms of preventing hospitalization or death, which was the primary endpoint in most of these studies. And that was in the upper 80% range. But how well it's doing now in the omicron and highly vaccinated era is a little more difficult to say, but we still want to prescribe it for people at risk.

The trouble with this drug is it has numerous drug interactions due to ritonavir, the suicide cytochrome inhibitor. So there are certain patients we do not want to prescribe it at all or do so very cautiously. And I urge everyone to get a drug interaction profile before considering prescribing.

There's also bebtelovimab. That's a monoclonal antibody. That's the only one available. It too had the same level of efficacy in preventing hospitalization or death. Unfortunately, it's a bit of a status where we're not certain if we'll have it available, as federal funding has run out. And there's still some supply, but what will happen through the fall and winter is uncertain. We have been reserving this for people who are highly immunodeficient, have B cell deficiencies, can't mount antibody responses, such as solid organ transplants, vaccine failures. And that's what we've been using there.

Remdesivir is what we've been using in the hospital for severe COVID. It's an intravenous therapy that the PINETREE trial for 3 days of serial administration showed great efficacy. But, you know, it's 3 days. People don't like coming back 3 days in a row. But it may be an alternative for those patients that cannot be on oral medications.

And then there's molnupiravir. This drug was not as effective, with about a 30% benefit in terms of preventing hospitalization or death, which was less, but a recent secondary analysis did show that it lessened need for increased ventilatory needs, such as supplemental oxygen, and reduced length of stay. I do feel it has a role. It doesn't have any drug interactions, which is an upside. It is oral and very well tolerated. And main concern is genotoxicity because it has the potential to interfere that way. So you have to check to make sure someone's not pregnant. And for men, counsel them that they shouldn't participate in any potential child-rearing issues in terms of up to 3 months.

Dr. Vega:
For those just tuning in, you're listening to CME on ReachMD. I'm Dr. Chuck Vega, and here with me today is Dr. Paul Auwaerter. We're discussing best practices to improve outcomes for our patients at high risk for severe COVID-19.

Dr. Auwaerter:
In terms of safety and efficacy, actually all are fairly well tolerated. Again, the drug interactions with nirmatrelvir are perhaps most concerning. Otherwise, generally well-tolerated medications, including the intravenous remdesivir and the monoclonal antibody, the latter of which really rare anaphylaxis. So we've been very happy with how these drugs have performed. You just have to tailor them to your patient.

Dr. Vega:
Yeah, absolutely. That's a great review. Thank you very much.

I found a preprint study that actually looked at the rebound phenomenon because that's been in the news a lot, particularly for nirmatrelvir plus ritonavir, that folks get better initially, then they do worse again. And they found in a retrospective review that the rates of that rebound phenomenon were about 5% or so. 3% at 7 days after treatment. And within 3 days, it rose to 5%. So not very common.

And the other interesting thing that I didn't see coming was that the rates of rebound were actually pretty similar with molnupiravir. So both of them had that same phenomenon. So I don't think it's a reason not to prescribe nirmatrelvir plus ritonavir. You're right, the drug interactions are the biggest drawback to that combination treatment. But in terms of rebound, I've been using it and have not, you know, seen a case of rebounding in my practice, because it does seem to be fairly rare overall. But certainly something you want to warn patients about and be aware of as a possibility.

Dr. Auwaerter:
Yeah, I think that's a great point. Certainly, it is something I've prescribed. I've seen some rebound cases. It's never been severe. It's more of an annoyance that you might have to re-isolate. So it's not a reason not to prescribe for patients that might be at highest risk.

Dr. Vega:
Great. So this has been a really helpful conversation, I think. Do you have any other thoughts about how to implement some of these therapeutics in clinical practice?

Dr. Auwaerter:
I think for people that may be less familiar, or especially heading into the respiratory season, it'd be important to see if any of the guidances have changed. The Infectious Disease Society of America has a very helpful step-by-step algorithm that may be helpful to try to decide which patients might most benefit from 1 of the 4 drug therapies we found.

And also, there is a COVID-19 locator webpage, which will help you find treatments that are available. Oral therapies, as well as intravenous bebtelovimab, the monoclonal antibody.

So those are sort of the extra tricks that you might need to find the right treatments for people that have to still fit under eWay rules, because these are drugs, except for remdesivir, that are not FDA-approved.

In terms of monitoring patients, I have to say this is something that telemedicine has been great at. Just a quick phone call to make sure they're doing okay. I found these drugs have been really great. People generally feel better within a day or 2 after starting them. I haven't had anyone starting on the drug land in the hospital. Of course, that can still happen.

And the rebound does come up, which you had mentioned, Chuck, and that happens even on people without treatment. We do know there has been some viral and symptom rebound even without any drug therapy. So these are all things just to keep in mind.

Dr. Vega:
Yeah, from my end, I would just briefly still want to recommend vaccination for folks who do get infected. At most, I want them to wait 3 months after infection, but we can do it sooner if that's their preference. But hopefully, they're motivated. And hopefully they're motivated by our new formulations of vaccine, which have been modified to contain those omicron variants. So this is coming very soon at the timing of this recording. So it's an exciting time for vaccination.

Paul, do you have any other take-home messages before we go?

Dr. Auwaerter:
Yeah, I would just amplify, with the new boosters, getting a booster is the most important thing you can do. And you might even lay in a couple of the home antigen kits and make sure you have them on hand, especially for your patients that might be in the highest risk groups. And to make sure that they contact their doctor if they do have any respiratory symptoms.

Dr. Vega:
And for my final take today, I'm going to harken back to what you said about epidemiology. And we can't forget preventing those other common infections. So make sure that we are getting our flu vaccine on board this fall for everyone. We have some new options in terms of pneumococcal vaccines. That's exciting as well.

Unfortunately, that's all the time we have today. I want to thank our audience for listening and thank you, Dr. Paul Auwaerter, for joining me and for sharing your valuable insights. It was great speaking with you today.

Dr. Auwaerter:

Yeah, thanks so much, and I wish everyone well.

Announcer:
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