Diabolical Despot Defies Diagnosis

King COVID-19 continues its cruel cavort, consorting continuously in the scarehead. In this AEM Editor-in-Chief Pick of the Month, Carpenter et al., provide a needed resource in Diagnosing COVID-19 in the Emergency Department: A Scoping Review of Clinical Examinations, Laboratory Tests, Imaging Accuracy, and Biases, which critically appraises the clinical conundrum associated with the recovery of SARS CoV-2 RNA from the nose or throat. The meager results reflect the protean prevarications of a shifty biological particle. Fever, present in 84 percent of cases, does not distinguish from other infections; cough, present in just over half of COVID-19 patients, provides no certainty for diagnosis or exclusion; and loss of either smell or taste function appears to be an uncommon but highly specific clinical manifestation of our nasty nemesis. Findings from the complete blood count provide no solid leads, and the highest reported diagnostic sensitivity of infiltrates on plain film chest radiography is a soft 60 percent. The diagnostic indices of computed tomography of the chest are better but bereft, with sensitivities of 75-94 percent and specificities ranging from 24 to 100 percent. And these derelict diagnostics of CT evoke the milk toast mantra: “We have to shut the scanner down for two hours to ensure disinfection.” (It’s namby-pamby because we don’t shut down ED rooms for two hours after a COVID patient.) The tear-jerking “mid turbinate” swab (attention pain researchers, you got your 10/10 pain gold standard) remains the best test that might, possibly, give actionable same-day data, but itself suffers from a 20-30 percent false negative rate. Repeated swabs (five times over five days...please, no pushing in line) or anti-SARS CoV-2 IgM/IgG serology — 20 days later — are the most sensitive and specific testing options. In summary, for accurate testing of COVID-19, all you need is a time machine.

Best wishes,
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