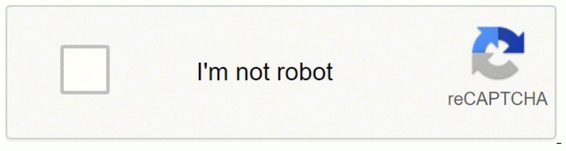

Next

Chest guidelines anticoagulation vte

INR range and treatment duration

Condition	Time of Duration
1st episode venous thrombosis and documented antiphospholipid antibodies or 2 or more thrombophilic conditions (combined factor V Leiden and prothrombin 20210A gene mutations),	at least 12 months-life long
Any one of the following: deficiencies of antithrombin, protein C, or protein S; factor V Leiden; prothrombin 20210A; hyperhomocysteinemia; or high factor VIII levels (>90th percentile) Life threatening PE	6-12 months till life long

Table 2. Guidelines for Managing VTE in Cancer Patients

Recommendation	NCCN (2014)	ASCO (2015)	ACCP (2015)
Initial therapy	LMWH preferred	LMWH recommended	LMWH recommended
Chronic therapy	LMWH preferred over warfarin for 1st 6 mo	LMWH preferred for ≥6 mo	LMWH preferred Extended therapy >3 mo recommended. In patients not treated with LMWH, VKA suggested over rivaroxaban or dabigatran
Chronic outpatient treatment	Novel oral anticoagulants not currently recommended for VTE thromboprophylaxis or treatment owing to insufficient clinical data in cancer patients	Novel oral anticoagulants not currently recommended for patients with cancer and VTE owing to limited data in cancer patients	LMHW and VKA recommended over rivaroxaban or dabigatran

ACCP, American College of Chest Physicians; ASCO, American Society of Clinical Oncology; LMWH, low-molecular-weight heparin; NCCN, National Cancer Comprehensive Network; VKA, vitamin K antagonist; VTE, venous thromboembolism.
Source: References 15, 19, 20.

	LOW- RISK COVID-19	HIGH-RISK COVID-19
HIGH-RISK VTE	**For VTE:** • Anticoagulant therapy • If recurrent symptoms or deterioration, consider systemic thrombolysis or potentially catheter-directed therapy as an alternative • Consider need and safety of hemodynamic support and monitoring	**For VTE:** • Anticoagulant therapy • Consider systemic fibrinolysis • Catheter-directed or surgical therapies in case not suitable for systemic fibrinolysis • Consider need and safety of hemodynamic support and monitoring
LOW/INTERMEDIATE RISK VTE	**For VTE:** • Anticoagulan therapy • Catheter-directed or surgical therapies only if recurrent/ persistent symptoms or decompensation	**For VTE:** • Anticoagulant therapy • Other therapies reserved for select cases such as those with significant recurrent/persistent symptoms or decompensation

Treatment of VTE
9th ACCP Guideline Recommendations

→ Anticoagulant therapy over other approaches for most acute DVT or PE (2C)
parenteral therapy using LMWH or fondaparinux (1B)
long-term therapy for at least 3 months (1B)
evaluate risk-benefit of extended therapy

→ Catheter - Directed Thrombolytic (CDT) therapy for DVT
anticoagulant therapy alone over CDT most patients (2C)
selected patients with DVT may benefit

→ Anticoagulant therapy over no anticoagulation for extensive superficial vein thrombosis (2B) (fondaparinux over LMWH, 2C)

→ Thrombolytic therapy for PE
acute PE + hypotension (2C)
acute PE, high risk of hypotension, low risk of bleeding (2C)
intracranial bleeding in 2 to 3% in contemporary studies

→ Inferior vena cava filter
anticoagulants contraindicated (1B)

Kearon et al CHEST 2012; 141: (2) Suppl: e419s - e494s

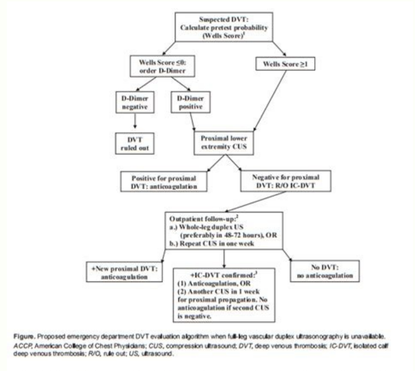

Figure. Proposed emergency department DVT evaluation algorithm when full-leg vascular duplex ultrasonography is unavailable.
ACDP, American College of Chest Physicians; *CUS,* compression ultrasound; *DVT,* deep venous thrombosis; *IC-DVT,* isolated calf deep venous thrombosis; *R/O,* rule out; *US,* ultrasound.

1. The pretest probability of DVT is most frequently assessed with the clinical model developed by Wells, et al.[6] One point is added for each of the following positive findings: (a) active cancer (treatment ongoing or within the previous 6 months, or palliative); (b) paralysis, paresis or recent plaster immobilization of the lower extremities; (c) recently bedridden for 3 days or more, or major surgery within the previous 12 weeks requiring general or regional anesthesia; (d) localized tenderness along the distribution of the deep venous system; (e) entire leg swelling; (f) calf swelling at least 3 cm larger than that on the asymptomatic leg (measured 10 cm below the tibial tuberosity); (g) pitting edema confined to the symptomatic leg; (eh) collateral superficial veins (nonvaricose); and (i) previously documented DVT. Two points are subtracted from the total if an alternative diagnosis is at least as likely as DVT. Based on this checklist the clinical probability of DVT is assessed as low if the score is ≤0, moderate (a score of 1 or 2), or high (a score of ≥ 3). The ability of a negative D-dimer to rule out DVT at a given pretest clinical probability (Wells score) is dependent upon the sensitivity of the specific assay used. When a negative high-sensitivity D-dimer is combined with a low (≤0) or moderate (≤2) Wells score, the negative predictive value for DVT is 99%. This is reflected in the algorithm. Wells, et al. (2006) conclude that with moderate sensitivity D-dimer tests "the negative LRs are not sufficiently low to exclude DVT without ultrasound among patients with moderate and high pretest probability estimates" (Well's score ≥ 1).[6]
2. The practice of providing a bridge of empiric anticoagulation between imaging studies is not supported.[10, 23, 31-34, 38]
3. Per ACDP and others, the decision to anticoagulate confirmed IC-DVT (versus conservative therapy) benefits from a thorough risk/benefit analysis and shared decision-making. Risk factors for extension of confirmed IC-DVT include positive D-dimer, severe symptoms, thrombosis that is extensive or close to the proximal veins, absence of reversible provoking factors for DVT, active cancer, a history of venus thromboembolism (VTE), and inpatient status. Those at higher risk for bleeding complications from anticoagulation may be better served by continued surveillance with compression ultrasonography alone (Kearon, et al.; Table 11).[23,34] The patient's primary provider and/or consultants should be involved in the decision-making whenever possible, with every effort to assure close follow up.

LOADING Last Updated: February 11, 2021 Recommendations Summary Recommendations In patients not hospitalized with COVID-19, there is currently no data supporting the measurement of coagulation markers (e.g., D-dimers, protrombin time, platelet count, fibrinogen) (AIII). In patients hospitalized with COVID-19, hematological parameters and coagulation are commonly measured, although there is currently insufficient evidence to recommend or not use this data to guide management decisions. Patients who receive anticoagulant or antiplatelet therapies for the underlying conditions should continue these medications if they receive a diagnosis of COVID-19 (AIII). For patients who are not hospitalized with COVID-19, anti-platelet anticoagulants and therapy should not be initiated to prevent venous thromboembolism (VTE) or arterial thrombosis unless the patient has other indications for therapy or participate in a clinical trial (AIII). Non-pregnant adults hospitalized with COVID-19 should receive prophylactic dose anticoagulation (AIII) (see recommendations for pregnant persons below). Anticoagulant or anti-aggregating therapy should not be used to prevent arterial thrombosis outside the standard of care for patients without COVID-19 (AIII). There is currently insufficient evidence to recommend for or against the use of thrombolytics or higher than the prophylactic dose of anticoagulation for VTE prophylaxis in patients hospitalized from COVID-19 outside a clinical trial. Patients hospitalized with COVID-19 should not be routinely released from the hospital while in the VTE prophylaxis (AIII). Continuous anticoagulation with a regime approved by the Food and Drug Administration for Prophylaxis Long-term VTE after hospital discharge can be considered for patients with low risk of bleeding and high risk for VTE, according to theFor patients without Covid-19 (see details about the definition of patients at risk below) (BI). There are there insufficient evidence to recommend for or against routine screening for deep vein thrombosis in patients with COVID-19 without signs or symptoms of VTE, regardless of the status of their coagulation markers. Patients hospitalized with COVID-19 who have rapid deterioration of pulmonary, cardiac or neurological function, or sudden localized loss of peripheral perfusion, should be evaluated for thromboembolic disease (AIII). For children hospitalized with COVID-19, the indications for VTE prophylaxis should be the same as for children without COVID-19 (BIII). When imaging diagnosis is not possible, patients with COVID-19 who experience an incidental thromboembolic event or are suspected to have thromboembolic disease should be treated with therapeutic doses of anticoagulant therapy (AIII). Patients with COVID-19 who require extracorporeal membrane oxygenation or continuous renal replacement therapy or who have catheter thrombosis or extracorporeal filters should be treated with antithrombotic therapy according to standard institutional protocols for those without COVID-19 (AIII). If antithrombotic treatment is prescribed during pregnancy prior to diagnosis of DIDOC-19, this treatment should be continued (AIII). In pregnant patients hospitalized with COVID-19, prophylactic dose anticoagulation is recommended unless contraindicated (see below) (BIII). As in non-pregnant patients, VTE prophylaxis after hospital discharge is not recommended in pregnant patients (AIII). Decisions to continue VTE prophylaxis in pregnant or postpartum patients after discharge should be individualized, considering the concomitant risk factors for VTE. The use of anticoagulant therapy during childbirth and childbirth requires specialized care and planning. Pregnant patients with COVID-19 should similar to pregnant patients with other conditions that require anticoagulation during pregnancy (AIII). Non-fractioned heparin, low molecular weightand warfarin does not accumulate in breast milk and does not induce an anticoagulant effect in the newborn; therefore, they can be used by breastfeeding with or without COVID-19 that require prophylaxis or treatment of VTE (AIII). In contrast, the use of direct-acting oral anticoagulants during pregnancy is not routinely recommended due to the lack of safety data (AIII). Recommendations: a = strong; B = moderate; C = Optional classification of evidence: i = one or more random trials without major limitations; IIA = other randomized trials or analysis of randomized test subsets; IIB = non-abandoned trials or observational cohort studies; III = Expert opinion infection with the novel acute coronary syndrome; and acute coronavirus 2 (SARS-COV) and D-dimers.1,2 In some studies, elevations in these markers have been associated with worse clinical outcomes. 3.4 Several studies have reported various incidences of venous thromboembolism (VTE) in patients with COVID-19. A meta-analysis of studies in patients hospitalized with COVID-19 found a general prevalence of AV of 14.1% (CI of 95%, 11.6, 16.9) .5 VTE prevalence was higher in studies that used ultrasound detection (40.3%; 95% CI, 27.0, 54.3) than in studies that did not do (9.5%; 95% CI, 7.5, 11.7). In randomized controlled trials performed prior to the COVID-19 pandemic, the incidence of VTE in non-covid-19 hospitalized patients who received the prophylaxis of the VTE varied from 0.3 per cent to 1 per cent for the symptomatic VTE and from 2.8% to 5.6% for VTE in general. 6-8 The incidence of VTE in random trials in patients with non-covid-19 critical disease who received prophylactic dose anticoagulants ranged from16%, and a prospective cohort study of patients with critical sepsis disease reported a 37% VTE incidence. 9-12 VTE guidelines for non-covid-19 patients haveAgainst routine screening ultrasound scans in patients with critical illnesses because no studies have shown that this strategy reduces the rate of subsequent symptomatic thromboembolic complications.13 Although the incidence of thromboembolic events, especially pulmonary embolism, may be high among patients hospitalized with DIDOC-19, there are no There are published data demonstrating the clinical utility of routine surveillance for deep vein thrombosis with lower extremity ultrasound in this population. A methanolysis performed by a panel of guidelines of the American Society of Hematology compared the probabilities of bleeding and thrombotic outcomes in patients with COVID-19 treated with prophylactic dose anticoagulation versus those treated with intermediate or therapeutic dose anticoagulation.14 Overall The probabilities of VTE and mortality were not differentiated between patients treated with anticoagulation of the prophylactic dose and those treated with higher doses of anticoagulation. In critically ill patients, anticoagulation of the intermediate or therapeutic dose was associated with a lower probability of pulmonary embolism (or 0.09; 95% CI, 0.02 “0.57), but a higher probability of major bleeding (or 3.84; 95% CI, 1.44. â¬ 10.21). In studies in patients with COVID-19, incidences of symptomatic PET ranging from 0% to 0.6% have been reported 30 to 42 days after discharge from hospital.15-17 Epidemiological studies that control clinical characteristics, underlying comorbidities, anticoagulation prophylactic and covid. Therapies related to -19. There are limited prospective data demonstrating the safety and efficacy of the use of therapeutic doses of anticoagulants to prevent TEV in patients with COVID-19. A retrospective analysis of 2,773 hospitalized COVID-19 patients from a single center in the United States reported that the hospital in 22.5 per cent of patients who received therapeutic anticoagulation and 22.8% of patients who did not receive anticoagulation. The study further reported that in a subset of 395 mechanically ventilated.29.1% of patients who received anticoagulation and 62.7% of patients who did not receive anticoagulation died. The study had important limitations: it lacked details about the patient’s characteristics, indications for anticoagulant initiation, and descriptions of other therapies patients received that may have influenced mortality. In addition, the authors did not discuss the potential impact of survival bias on study results. For these reasons, the data are not sufficient to influence the standard of care, and this study further emphasizes the need for future trials to define the potential risks and benefits of therapeutic anticoagulation in patients with COVID-19.18 three international trials (antithrombotic therapy to improve complications of COVID-19 [ATTACC], therapeutic anticoagulation; accelerating therapeutic interventions of COVID-19 and vaccines-4 [ACTIV-4], and the randomized, embedded, multi-factorial adaptable platform trial for pneumonia Community-acquired [REMP-CAP])) Comparing the effectiveness of therapeutic dose anticoagulation and prophylactic dose anticoagulation in reducing the need for organ support for 21 days in moderately ill or critically ill adults. hospitalised for COVID-19. The need for organ support was defined as requiring high-flow nasal oxygen, invasive or non-invasive mechanical ventilation, vasopressor therapy or extracorporeal membrane oxygenation (ECMO). The trials paused the enrolment of patients requiring an intensive care unit (ICU), care levels after an interim pooled analysis demonstrated the uselessness of therapeutic anticoagulation to improve organ support and a concern for safety. The results of the interim analysis are available on the ATTACC website. It is expected the unrestricted data and the additional study results, including the appearance of thrombosis, are reported soon.19 A small randomized and central randomized trial (N = 20) compared therapeutic and prophylactic anticoagulation in mechanically ventilated patients with D-digesÎ1⁄4g/L (according to the VIDAS D-dimer Exclusion II trial). Only patients treated with therapeutic anticoagulation showed improvement in the proportion of partial blood pressure from oxygen to fraction of inspired oxygen (PaO2/Fi) O2.) The number of days free of ventilation was greater in the therapeutic anticoagulation arm than in the prophylactic anticoagulation arm (15 days [IQR 6-16] vs. 0 days [IQR 0-11;] P = 0.028) There was no difference between arms in hospital mortality or 28 days. Two patients treated with therapeutic anticoagulation had minor bleeding, and two patients in each arm experienced thrombosis. 20 Additional evidence of large, multi-center trials is needed, and trial results are expected soon. Several randomized controlled trials have been developed to evaluate the risks and benefits of anticoagulation in patients with COVID-19 (visit ClinicalTrials.gov for the current list of trials). Guidelines on coagulopathy and the prevention and management of VTE in patients with COVID-19 have been published by multiple organizations, including the Anticoagulation Forum,21 the American College of Chest Physicians,22 the American Society of Hematology,23 the International Society of Thrombosis and Haemostasis (ISTH),24 the International Society of Thrombosis and Haemostasis (ISTH) and Italian Society of Thrombosis and Haemostasis,25 and the Royal College of Physicians. 26 In addition, the ISTH, the North American Thrombosis Forum, the European Society of Vascular Medicine and the International Union of Angiology have approved a document that outlines issues related to thrombotic disease with implications for prevention and therapy. 27 All of the above guidelines agree that patients hospitalized with COVID-19 should receive anticoagulation of prophylactic doses for VTE. Some guidelines indicate that intermediate dose anticoagulation may be considered for patients with critical disease. 21.23,26.28 Given the of the incidence of VTE and the unknown risk of bleeding in patients with critical disease with COVID-19, COVID-19,The COVID-19 Treatment Guidelines Panel and the American Society of Hematology and American College of Thorax Physicians guidance panels recommend treating all hospitalized patients with COVID-19, including critically ill patients with prophylactic dose anticoagulation.22,29 Results from clinical trials evaluating the safety and efficacy of different doses of anticoagulants will provide more information on the best prophylactic strategies for patients with COVID-19. Monitoring of coagulation markers in patients with COVID-19 In patients not hospitalized with COVID-19, coagulopathy markers such as D-dimer level, prothrombin time, fibrinogen level, and platelet count (AIII) should not be routinely obtained. Although abnormalities in these coagulation markers have been associated with worse outcomes, there is a lack of prospective data to show that the markers can be used to predict the risk of VTE in people with asymptomatic or mild SARS-CoV-2 infection. In hospitalized patients with COVID-19, haematological and coagulation parameters are commonly measured; however, there is currently insufficient evidence to recommend for or against using these data to guide management decisions. Management of antithrombotic therapy in patients with COVID-19 Selection of anticoagulant or antiplatelet agents for patients with COVID-19 Whenever anticoagulant or antiplatelet therapy is used, possible drug interactions with other concomitant agents should be considered. (AIII). The University of Liverpool has compiled a list of drug interactions. In critically ill hospitalised patients, low molecular weight heparin or unfractionated heparin is preferable to oral anticoagulants because both types of heparin have shorter half-lives, they can be used to reduce the risk of cancer. Therefore intravenous or subcutaneous and have fewer drug interactions (AIII). Chronic anticoagulant therapy or antiplatelet VOCID-19 Ambulatory patients who receive warfarin and are isolated and, therefore, can not receive international international treatment Relationship monitoring may be a candidate for switching to direct oral anticoagulant therapy. Patients receiving warfarin who have a mechanical heart valve, ventricular assistive device, valve atrial fibrillation, or antiphospholipid antibody syndrome or who are breastfeeding should continue treatment with warfarin (AIII). Inpatients hospitalized with COVID-19 who are taking anticoagulant or antiagulant therapy for the underlying medical conditions should continue this therapy unless significant bleeding develops, or other contraindications are present (AIII). Patients with COVID-19 who are administered as outpatients For patients not hospitalized with COVID-19, anticoagulants and antiplatelet therapy should not be initiated for the prevention of VTE or arterial thrombosis unless the patient has other indications for therapy or is participating in a clinical trial (AIII). Inpatients hospitalized with COVID-19 For patients hospitalized with COVID-19, prophylactic dose anticoagulation should be prescribed unless contraindicated (e.g., a patient has active bleeding or severe thrombocytopenia) (AIII). Although the data supporting this recommendation are limited, a retrospective study has shown that there is no evidence of anticoagulation. a reduction in mortality in patients who received prophylactic anticoagulation, especially if the patient had a sepsis-induced coagulopathy score âĦ4.4 For those without COVID-19, anticoagulant or antiagulant therapy should not be used to prevent thrombosis. arterial disease outside the standard of care (AIII). Anticoagulation is routinely used to prevent arterial thromboembolism in patients with cardiac arrhythmias. Although there are reports of stroke and myocardial infarction in patients with COVID-19, the incidence of these events is unknown. When imaging is not possible, patients with COVID-19 who an incident thromboembolic event or suspected to have thromboembolic disease should be given with therapeutic doses of anticoagulant therapy according to the standard of care for patientsCovid-19 (AIII). Currently there is insufficient evidence to recommend either for or against the use of thrombolytic agents or higher than the prophylastic dose of anticoagulation for VTE prophylaxis for patients hospitalized with COVID-19 out of a clinical assay. Three international trials (Activ-4, REMP-CAP and ATTCCC) compared the effectiveness of dose-therapy anticoagulation and anticoagulation of the prophylastic dose to reduce the need for organs support during 21 days in moderately ill adults or patically hospitalized patients for Covid-19. The need for Norgan support was defined as what requires high-flow nasal oxygen, invasive or non-invasive mechanical ventilation, vasopressor or ECMO therapy. The trials paused the inscription of patients who require attention at the level of the ICU in the inscription after an interim grouped analysis demonstrated the futility of the therapy anticoagulation in the reduction of the need to support organs and a concern For safety. The results of the interim analysis are available on the ATTACC website. It is expected that the unbelowed data and the additional study results, including the thrombosis appearance, are reported soon.19 Although there is evidence that the multicarangular failure is more likely in patients with sepsis that develop Coagulopathy, 30 There is no convincing evidence to demonstrate that any specific antithrombotic treatment will influence the results in those with or without Covid-19. Participation is encouraged in randomized trials. Patients with Covid-19 that require ECMO or continuous renal replacement therapy or who have cathetic thrombosis or extracorpreal filters must be treated according to the standard institutional protocols for those without COVID-19 (AIII). Hospitable Children with Covid-19 A recent meta-analysis of publications on Covid-19 in children did not discuss VTE.31 indications for VTE prophylaxis in children hospitalized with COVID-19 should be the same as for children hospitalized without COVID-19 (Biii). Patients with COVID-19 who are discharged. high.The prophylaxis of VTE hospital is not recommended after hospital discharge for patients with Covid-19 (AIII). For certain high-risk patients without Covid-19, it has been shown that post-unloading prophylaxis is beneficial. Food and medicine administration approved the use of Rivaroxaban 10 mg daily for 31 to 39 days in these patients. 32,33 Inclusal criteria for trials that studied Prophylaxis VTE Post-discharge included: International Methic Prevention Registration Modified in Thrombobembolism (Improve) Risk Annotation VTE Â ‰ ¥ 4; o Modified risk record Improve VTE Â ‰ ¥ 2 and D-DIXER level Âš2 times the upper limit of normality. 32 Any decision to use VTE post-discharge prophylaxis for patients with COVID-19 should include the consideration of the individual patient's risk factors for VTE, including reduced mobility, hemorrhagic risks and viability. The participation in clinical trials is encouraged. Special considerations during pregnancy and breastfeeding Because pregnancy is a hypercoagulable state, the risk of thromboembolism is greater in pregnant people than in non-pregnant people. 34 In not known if Covid-19 increases this risk. In several cohort studies of pregnant women with COVID-19 in the United States and Europe, VTE was not reported as a complication even among women with serious illness, although reception of prophylastic or therapy anticoagulation varied through of the studies35-37 The American College of Obstetricians and Gynecologists (ACOG) advises that, although there is no data for the pregnancy of thromboprophylaxis-19 38 if there are no contraindications to use, the society of maternal fetal medicine recommends prophylastic heparin or Low molecular weight heparin in seriously ill pregnant patients or mechanically ventilated. 39 Various Professional Societies, including The American Society of Hematology and Acog, has guidelines that specifically address VTE management in the pregnancy context.40.41 If delivery is threatened, or if there are other risks for bleeding, the risk of bleeding can exceed the benefit VTE potential prophylaxis in pregnancy. There is no data on the use of punctuation systems to predict VTE risk in pregnant people. In addition, during pregnancy, the D-Diver level may not be a reliable VTE predictor because there is a physiological increase in Dimero D throughout the gestation.42-44 In general, preferred anticoagulants during pregnancy are Heparin compounds. Due to its reliability and ease of administration, low molecular weight heparin is recommended, instead of non-fractionated heparin, for prevention and treatment of VTE in pregnancy.41 Direct access anticoagulants are not used routinely During pregnancy due to the lack of security data. In pregnant people .40 The use of warfarin to prevent or treat VTE should be avoided in pregnant individuals, regardless of their state Covid-19, and especially during the first quarter due to concern for teratogenicity. Specific recommendations for pregnant or lactating persons with COVID-19 include: If antitrombotic therapy is prescribed during pregnancy before a Covid-19 diagnosis, this therapy must continue (AIII). For pregnant patients hospitalized for severe VOC-19, anticoagulation of prophylastic dose is recommended, unless it is contraindicated (BIII). As for non-pregnant patients, prophylaxis VTE after the hospital discharge is not recommended for pregnant patients (AIII). Decisions to continue with VTE prophylaxis in the pregnant or postpartum patient must be individualized, taking into account the risk factors concomitant vte. The therapy with anticoagulation during childbirth and delivery requires specialized attention and planning. It should be managed in pregnant patients with COVID-19 similarly to patients who are pregnant with other that require anticoagulation during pregnancy (AIII). Unfractioned heparin, low-molecular heparin and warfarin do not accumulate in the breast milk and do not induce an anticoagulant effect in the newborn; therefore, they may be used in lactating women with or without COVID-19 requiring prophylaxis or treatment of TEV (AIII). On the contrary, the use of direct-acting oral anticoagulants during pregnancy is not routinely recommended due to the lack of security data (AIII) 40.Han H, Yang L, Liu R, et al. Prominent changes in blood coagulation of patients with SARS-CoV-2. Clin Chem Lab Med. 2020. Available at . Driggin E, Madhavan MV, Bikdeli B, et al. Cardiovascular considerations for patients, health professionals and health systems during the 2019 coronavirus pandemic (COVID-19). J Am Coll Cardiol. 2020. Available at . Guan WJ, Ni ZY, Hu Y, et al. Clinical Characteristics of Coronavirus Disease 2019 in China. N English J Med. 2020. . Tang N, Bai H, Chen X, Gong J, Li D, Sun Z. 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