

sinusitis, non-pulmonary viral illness).

- Ultimately, the imaging is only one bit of information which must be integrated into clinical context.

## possible approach to imaging in COVID-19

- Below is one possible strategy to use for patients presenting with respiratory symptoms and possible COVID-19.
- The temptation to get a CT scan in all of these patients should be resisted. In most cases, a CT scan will probably add little to chest X-ray and lung ultrasonography (in terms of *actionable* data which affects patient management).
- From a critical care perspective, CT scanning will likely add little to the management of these patients (*all* of whom will have diffuse infiltrates).

### Possible schema for imaging in patients with respiratory symptoms and suspected COVID-19

#### Initial evaluation

- Chest X-ray
- Lung ultrasound (thorough "lawn-mower" exam to look for focal B-lines)

↓ CXR negative.  
Lung US negative.

#### No further imaging.

- May repeat CXR and lung ultrasound if symptoms persist or worsen.

↓ CXR is normal or shows an equivocal abnormality.  
Lung US shows patchy B-lines

#### Consider CT scan only if this would affect management.

↓ CXR shows patchy infiltrates or diffuse abnormality which is *unequivocal*.  
Lung US negative

#### Further imaging probably unnecessary.

- Unlikely to affect management.
- Could be considered in immunocompromised patients if there is concern for other infections (e.g. fungal or pneumocystis pneumonia).

↓ CXR shows patchy infiltrates.  
Lung US shows patchy B-lines.

The optimal imaging strategy remains unknown. Chest X-ray and lung ultrasonography are a sensible place to start. CT scanning could have a role in some equivocal situations, but is generally unlikely to affect clinical management (since treatment for mild COVID-19 is supportive).

-The Internet Book of Critical Care, by @PulmCrit

*more information:*

- [RSNA focus page on coronavirus](#) (contains