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COVID-19 infection masquerading as recurrent apnoea in acute opioid overdose

Seyed Mostafa Mirakbari

Qazvin University of Medical Sciences, Qazvin, Iran

Dear Editor,

As a global health problem, the coronavirus disease (COVID-19) pandemic has revealed many unknowns around the manifestations and outcome of infection with SARS-CoV-2 and its constantly emerging new variants. We have seen an increase in extrapulmonary and atypical clinical presentations that may mislead and delay diagnosis and treatment (1). In addition, COVID-19 may imitate a particular presentation that typically occurs in other situations, which is called masquerading of COVID-19. I would like to present my experience with COVID-19 masquerading as recurrent apnoea in acute opioid poisoning.

A 29-year-old man with no prior history of acute illness presented to my emergency department with a decreased level of consciousness (GCS 13), myosis, and shallow breathing that subsequently became apnoeic. Examination revealed body temperature of 36.9 °C, regular pulse of 70 beats/min, blood pressure of 100/70 mm Hg, respiratory rate of 12 breaths/min, and pulse oximetry of 90 % on room air. His brother told us that the patient had a history of methadone abuse. Other general physical and systemic features were within normal limits and so were routine laboratory tests, which is why he was diagnosed with acute methadone overdose. The patient was immediately ventilated with Ambu-bag and received a loading intravenous bolus dose of 2 mg naloxone. As soon as he started to breathe spontaneously, the naloxone dose was set to 0.8 mg/h and rehydration started with infusion of 3.5 L of saline over the next 24 h. Supplemental oxygen was provided via nasal cannula at the flow rate of 4 L/min. The patient was transferred to intensive care in the poisoning ward and monitored for 72 h. Twelve hours into discontinuation of naloxone and supplemental oxygen, he was about to be discharged, but at that point, he became apnoeic again and had to be resuscitated, intubated, and put on mechanical ventilation at the emergency department. Computed tomography of the chest showed multiple lung opacities indicating COVID-19 pneumonia. The patient was transferred to the isolated corona ward and COVID-19 confirmed by a positive real-time polymerase chain reaction (RT-PCR) test. More history taking revealed that he was unvaccinated against COVID-19. Following specific COVID care and administration of remdesivir, corticosteroids, and supplemental oxygen therapy, the patient recovered over nine days and was discharged home with medical advice.

After this incident, we found reports of COVID-19 masquerading as substance withdrawal (2), acute surgical abdomen (3), Chikungunya fever (4), myositis and myopericarditis (5), primary mediastinal large B-cell lymphoma (6), heart failure (7), and stroke (8).

However, this is the first report of COVID-19 masquerading as recurrent apnoea in a patient hospitalised for acute opioid poisoning, and I hope it will raise the awareness of such possibility among my colleague clinicians at the emergency and intensive care units.

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Corresponding author: Seyed Mostafa Mirakbari, Qazvin University of Medical Sciences, Bu Ali Hospital, Department of Clinical Toxicology, Clinical Research Development Unit, Qazvin, Iran, E-mail: *drmirakbari@yahoo.com*