

# NATIONAL CLINICAL GUIDELINES

## The Diagnosis and Management of Common Cold in Adults and Children Above Two Years

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المبادئ الإرشادية السريرية لدولة قطر  
NATIONAL CLINICAL GUIDELINES FOR QATAR



وزارة الصحة العامة  
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## Version History

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2.0	Updated Version	24 <sup>th</sup> July 2019	Guidelines Team	Updated Published Version.
3.0	Updated Version	23 <sup>rd</sup> May 2023	Guidelines Team	Updated Published Version.

## Citation

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## Abbreviations

The abbreviations used in this guideline are as follows:

<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>MERS</b>	Middle East Respiratory Syndrome
<b>OTC</b>	Over the Counter
<b>RSV</b>	Respiratory Syncytial Virus
<b>CYP2D6</b>	Cytochrome P450 2D6
<b>URTI</b>	Upper Respiratory Tract Infections
<b>COVID-19</b>	Coronavirus Disease 2019

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# 1 Information About This Guideline

## 1.1 Objective and Purpose of the Guideline

The purpose of this guideline is to define the appropriate diagnosis and management of the 'common cold' in adults and children aged over two years. The objective is to reduce inappropriate prescribing and referral of patients presenting to any provider organisation (i.e. hospitals or clinics) in Qatar. It is intended that the guideline will be used primarily by primary care physicians.

## 1.2 Scope of the Guideline

This guideline covers the following aspects of care:

- Presentation and management of the 'common cold' in adults and children aged over two years.

Aspects of care not covered in this guideline are:

- Management of complications or bacterial infection of the upper respiratory tract e.g. tonsillitis or rhinosinusitis.
- Management of influenza.
- Non-infectious causes of rhinitis.
- Management of immunocompromised patients.
- Children aged less than two years.

## 1.3 Editorial Approach

This guideline document has been developed and issued by the Ministry of Public Health of Qatar (MOPH), through a process which aligns with international best practice in guideline development and localisation. The guideline will be reviewed on a regular basis and updated to incorporate comments and feedback from stakeholders across Qatar.

The editorial methodology, used to develop this guideline, has involved the following critical steps:

- Extensive literature search for well-reputed published evidence relating to the topic.
- Critical appraisal of the literature.
- Development of a draft summary guideline.
- Review of the summary guideline with a Guideline Development Group, comprised of practising healthcare ... professionals, subject matter experts and patient representatives, from across Qatar.
- Independent review of the guideline by the National Clinical Guidelines & Pathways Committee, appointed by the MOPH, from amongst stakeholder organisations across Qatar.

Whilst the MOPH facilitates the development of the guideline, the MOPH has not influenced the specific recommendations made within it.

## 1.4 Sources of Evidence

The professional literature has been systematically queried using specially developed, customised, and tested search strings. Search strategies are developed to allow efficient yet comprehensive analysis of relevant publications for a given topic and to maximise retrieval of articles with certain desired characteristics pertinent to a guideline.

All retrieved publications have been individually reviewed by a member of the Editorial Team and assessed in terms of quality, utility, and relevance. Preference is given to publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals.
3. Address an aspect of specific importance to the guideline in question.

Further information about the literature search and appraisal process is included in the appendix.

## 1.5 Evidence Grading and Recommendations

Recommendations made within this guideline are supported by evidence from the medical literature and where possible the most authoritative sources have been used in the development of this guideline. In order to provide insight into the evidence basis for each recommendation, the following evidence hierarchy has been used to grade the level of authoritativeness of the evidence used, where recommendations have been made within this guideline.

Where the recommendations of international guidelines have been adopted, the evidence grading is assigned to the underlying evidence used by the international guideline. Where more than one source has been cited, the evidence grading relates to the highest level of evidence cited:

- **Level 1 (L1):**
  - Systematic reviews of randomised controlled studies.
  - Randomised controlled trials with meta-analysis.
  - Randomised controlled trials.
- **Level 2 (L2):**
  - Observational studies, examples include:
    - Cohort studies with statistical adjustment for potential confounders.
    - Cohort studies without adjustment.
    - Case series with historical or literature controls.
    - Uncontrolled case series.
    - Statements in published articles or textbooks.
- **Level 3 (L3):**
  - Expert opinion.
  - Unpublished data, examples include:
    - Large database analyses.
    - Written protocols or outcomes reports from large practices.

In order to give additional insight into the reasoning underlying certain recommendations and the strength of recommendation, the following recommendation grading has been used, where recommendations are made:

- **Recommendation Grade A (RGA):** Evidence demonstrates at least moderate certainty of a net benefit from the recommendation.
- **Recommendation Grade B (RGB):** Evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.
- **Recommendation Grade C (RGC):** Evidence demonstrates potential harm that outweighs benefit; additional research is recommended.
- **Recommendation of the GDG (R-GDG):** Recommended on the basis of the clinical experience of the Guideline Development Group members.

## 1.6 Guideline Development Group Members

The following table lists members of the Guideline Development Group (GDG) nominated by their respective organisations and the Clinical Governance Group. The GDG members have reviewed and provided feedback on the draft guideline relating to the topic. Each member has completed a declaration of conflicts of interest, which has been reviewed and retained by the MOPH.

Guideline Development Group Members		
Name (ordered by surname)	Title	Organisation
Dr Mariam Al Hitmi	Specialist, Family Medicine	Primary Health Care Corp
Dr Abdulla Alnaama	Senior Consultant, Family Medicine	Primary Health Care Corp
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Dr Sakir Thurempurath	Consultant, Family Medicine	Aster DM Care

## 1.7 National Clinical Guidelines & Pathways Committee Members

The following table lists members of the National Clinical Guidelines & Pathways Committee (NCGPC), appointed by the MOPH. The NCGPC members have reviewed and provided their feedback and approval of the guideline document. Each member has completed a declaration of conflicts of interest, which has been reviewed and retained by the MOPH.

National Clinical Guidelines & Pathways Committee (NCGPC) Members		
Name	Title	Organisation
Ms Huda Amer Al-Katheeri	Chair of the NCGPC, Director of Strategic Planning & Performance Department	Ministry of Public Health
Shk Dr Mohammed Hamad J. Al Thani	Co-Chair of the NCGPC, Director of Public Health	Ministry of Public Health
Dr Hani Ben Hassen Al Kilani	Senior Consultant, Executive Director for Corporate Clinical Policy and Guidelines	Hamad Medical Corporation
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Dr Paul Dijkstra	Director of Medical Education	ASPETAR
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Dr Dahlia Mustafa Hassan	Senior Consultant Family Medicine	Primary Health Care Corp
Dr Ghassan Youseph Hommos	Senior Consultant Endocrinology	Al Emadi Hospital
Dr Marwan Abu-Hijleh	Professor and Acting Dean	College of Medicine, Qatar University

## 1.8 Responsibilities of Healthcare Professionals

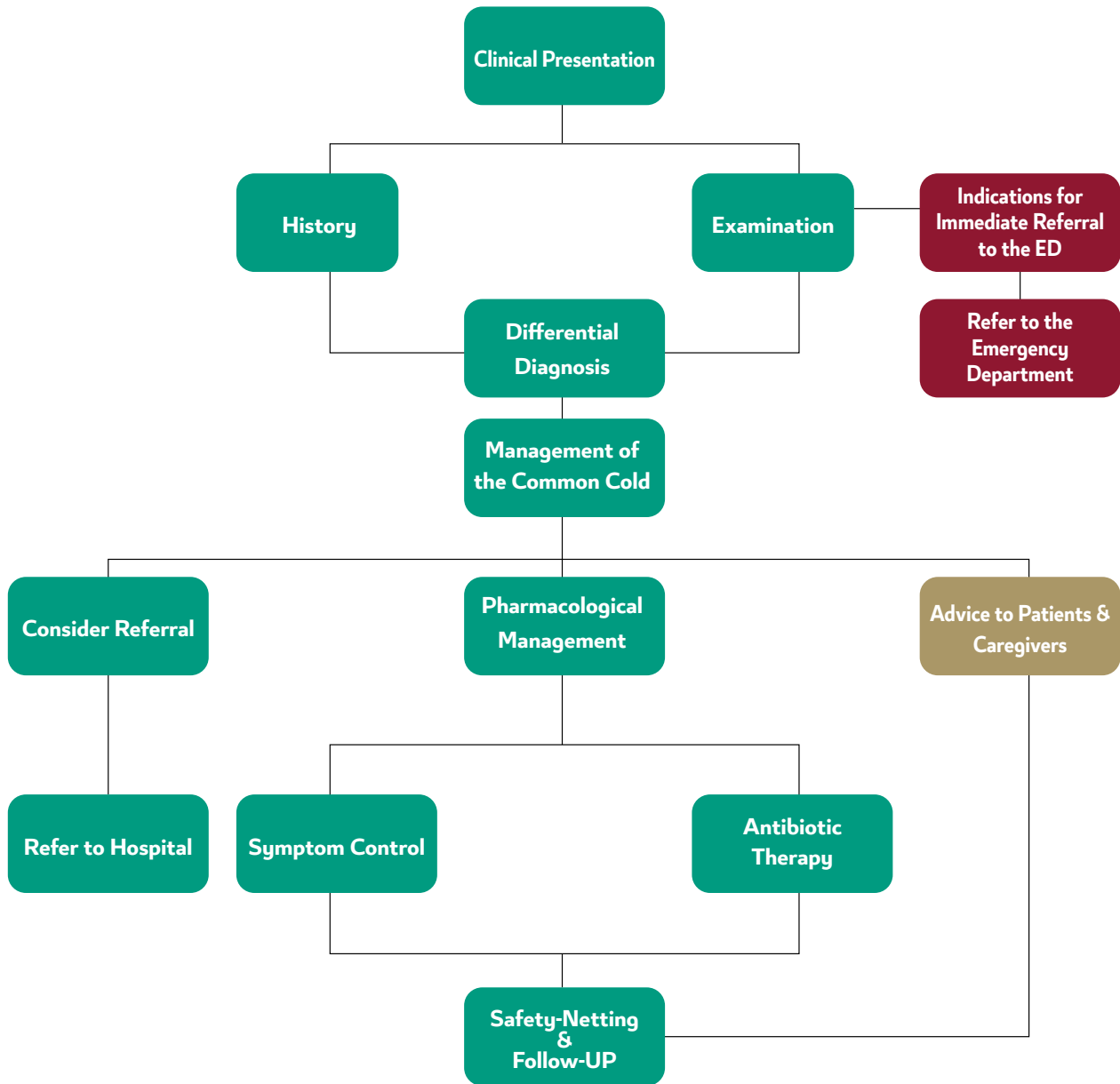
This guideline has been issued by the MOPH to define how care should be provided in Qatar. It is based upon a comprehensive assessment of the evidence as well as its applicability to the national context of Qatar. Healthcare professionals are expected to take this guidance into account when exercising their clinical judgement in the care of patients presenting to them.

The guidance does not override individual professional responsibility to take decisions which are appropriate to the circumstances of the patient concerned. Such decisions should be made in consultation with the patient, their guardians, or carers and should consider the individual risks and benefits of any intervention that is contemplated in the patient's care.

## 2 Common Cold Pathway

Click on a box below to see the relevant page of the Pathway.

- Information about this Guideline
- Background Information
- Key Recommendations of the Guideline
- Abbreviations used in the Guideline
- Performance Measures



- Information
- Red Flags
- Primary Care
- Self-Care



### 3 Key Recommendations of the Guideline

The key recommendations of this guideline are as follows:

#### Care Settings:

- The common cold is a condition that should primarily be managed in a primary care setting **[R-GDG]**.
- Management in a secondary care setting should only be considered in patients with or at risk of serious complications **[R-GDG]**.

#### Investigation:

- Routine investigation of the common cold is not required <sup>1-4</sup> **[L2, RGA]**.
- Since the viral symptoms are often clinically similar and difficult to distinguish bacterial symptoms, inappropriate antibiotic prescriptions are higher than estimated, the use comprehensive and rapid PCR test, may improve the patient outcomes and antimicrobial stewardship may potentially be achieved<sup>18</sup> **[L2, RGA]**.

#### Treatment:

- Routine treatment should primarily be symptomatic<sup>5,6</sup> **[L1, RGA]**.
- To prevent adverse effects of unreasonable use of antibiotics and avoid emergence of antibiotic resistance, antibiotics should be reserved for groups of patients who are at particular risk of developing complications<sup>7,8</sup> **[L1, RGA]** **[R-GDG]**.

## 4 Background Information

### 4.1 Definition

The common cold is the conventional term used to describe<sup>9</sup>:

- A mild, self-limiting upper respiratory tract infection characterised by rhinorrhoea or nasal congestion.

### 4.2 Aetiology

- There are more than 200 viral causes of common cold, the commonest being rhinoviruses. Other viruses include<sup>1</sup>:
  - Coronavirus.
  - Enteroviruses.
  - Respiratory syncytial virus (RSV).

Transmission may be by<sup>1</sup>:

- Direct contact.
- Airborne transmission via inhalation of droplets.

### 4.3 Natural History

- For the majority of patients, the following apply<sup>4,10</sup>:
  - A common cold is a self-limiting illness.
  - Symptoms peak at 3-5 days and then decrease.
  - Typically resolves within 7 days but may last up to 14 days.
  - Patients with comorbidities experience more severe symptoms.

### 4.4 Complications

- Potential complications of the common cold include<sup>4,11</sup>:
  - Acute rhinosinusitis.
  - Acute otitis media in younger children.
  - Croup in young children.
  - Lower respiratory tract infection.
  - Acute exacerbation of bronchial asthma.
  - Acute exacerbation of chronic obstructive pulmonary disease (COPD).

### 4.5 Higher Risk Groups

- People most at risk of developing more severe disease and complications include<sup>1</sup>:
  - People with comorbidities especially:
    - Chronic lung disease.
    - Chronic heart disease.
    - Chronic kidney disease.
    - Chronic liver disease.
    - Chronic neurological disease.
    - Immunosuppression.
    - Diabetes mellitus.
  - Pregnant women.
  - People aged 65 years and older.

## 5 Presentation

### 5.1 Clinical Presentation

The common cold, is characterised by<sup>4,7,9,10,12</sup> :

- Rhinorrhoea.
- Nasal congestion.
- Sore throat: Usually occurs on the first day and resolves shortly after.
- Cough, usually appears few days after onset of illness.
- Headache.
- Fever:
  - Fever is unusual in adults and if present will be low-grade.
- General feeling of malaise and being unwell.
- Young children may present with:
  - Mild irritability.
  - Loss of appetite.
  - Disturbed sleep.
  - Reduced activity.
  - Lack of interest.
  - Gastrointestinal symptoms.

Symptoms usually<sup>4</sup>:

- Peak at 3-5 days.
- Resolve within 7 days but may last up to 14 days.

NB: A mild cough may persist at night for 2-3 weeks.

### 5.2 Indications for Immediate Referral to the Emergency Department

It is important to recognise serious illness by looking for the following symptoms and signs, and ensure patients are assessed and managed immediately in an appropriate secondary care setting<sup>4</sup>. If indicated, transfer to hospital should be by ambulance [**R-GDG**].

Possible serious illnesses include:

- Upper airway complication<sup>4</sup>:
  - Characterised by:
    - Stridor.
    - 'Air hunger'.
    - Respiratory distress.
    - Toxic appearance.
    - Cyanosis.
    - Drooling.
    - Inability to swallow.
    - Trismus.
  - May be caused by:
    - Epiglottitis.
    - Peritonsillar/retropharyngeal abscess.
    - Croup (in younger children).

- Lower airway complication<sup>4</sup>:
  - Characterised by moderate or severe respiratory distress.
  - May be caused by:
    - ◻ Pneumonia.
    - ◻ Exacerbation of chronic obstructive pulmonary disease or bronchial asthma.
    - ◻ Foreign body inhalation.
    - ◻ Cardiac condition.
- Severe headache<sup>4</sup>:
  - May be described as 'the worst headache of their life'.
  - Accompanying symptoms may include:
    - ◻ Neck stiffness.
    - ◻ Vomiting.
    - ◻ Severe headache.
    - ◻ Focal neurological symptoms.
  - May be caused by meningitis.

## 6 History

Adults and children presenting with symptoms that suggest the common cold, should be offered a clinical assessment<sup>7</sup>. Ask specifically about the following<sup>2,4,5,13</sup> :

- Presenting symptoms and duration.
- Use of over-the-counter medication.
- All current medication or any other self-medication including recent courses of antibiotics.
- In children, ask about:
  - Feeding.
  - Irritability.
  - Urine output.
- Fever/rigors.
- Past medical history.
- Potential complicating factors:
  - Chronic illness such as:
    - ◻ Chronic lung disease e.g. COPD, bronchial asthma, cystic fibrosis.
    - ◻ Congestive heart failure.
    - ◻ Sickle-cell disease.
    - ◻ Diabetes.
  - Recurrent streptococcal pharyngitis.
  - Elderly patients.
  - History of rheumatic fever.
  - Immunocompromise.
  - Pregnancy.
  - Smoking history.
- Symptoms of whooping cough or recent exposure.
- Travel history to areas at with recent or current respiratory epidemics.
- Contact with farm animals or close contact with camels.

## 7 Examination

### 7.1 Clinical Examination

General examination is recommended in all patients and should be extended according to symptoms and signs. At a minimum, examination should include the following<sup>5,14</sup>:

- Measurement of vital signs.
- Examination of the chest to exclude pneumonia.

In children, consider examining<sup>3,7,9,10,12</sup>:

- Cervical lymph nodes.
- The eardrum.
- The throat:

NB: Do not examine the throat if epiglottitis is suspected as this may cause complete airway obstruction (see *Section 9*).

### 7.2 Recognising the Unwell, At-Risk Feverish Child

A child with fever is considered at high-risk and should be referred to a Paediatric Emergency Centre if he/she: <sup>5</sup> [L1, RGA]:

- Displays a change in the colour of the skin lips or tongue (paleness, blue, blotchy, ashen).
- Is unresponsive to social signals.
- Cannot wake up or stay awake.
- Unstoppably or loudly crying.
- Has a capillary refill rate 3 seconds or more?
- Has reduced skin turgor.
- Develops non-blanching rash.
- Shows signs of neck stiffness.
- Has focal neurological signs or seizures.
- Has a respiratory rate greater than 40 breaths per minute?
- Has an oxygen saturation of 95% or lower?
- Develops respiratory grunting.
- Has moderate or severe chest in-drawing.
- Has status epilepticus.

## 8 Investigations

There are no specific investigations to diagnose the common cold<sup>7,9,10,12</sup> [L2, RGA].

## 9 Differential Diagnosis

Differential diagnoses of the common cold include the following:

- Influenza<sup>4,9</sup>:
  - Is a common cause of upper respiratory tract infection (URTI).
  - Has the potential to be more serious.
  - Milder symptoms are often misdiagnosed as the common cold.
  - Characterised by a rapid onset of:
    - Fever.
    - Myalgia.
- Bacterial rhinosinusitis<sup>4,15</sup>:
  - Usually follows an URTI.
  - Acute rhinosinusitis is usually viral initially, but antibiotics may be needed for bacterial superinfection if symptoms are severe.
  - Features include:
    - Prolonged upper respiratory tract symptoms.
    - One or more of the following factors present:
      - ✗ Facial pain or headache.
      - ✗ Fever.
      - ✗ Purulent nasal discharge.
      - ✗ Cough.
- Streptococcal pharyngitis/tonsillitis<sup>3,4,16,17</sup>:
  - Can be difficult to distinguish from a viral cause.
  - Symptoms vary in intensity but include:
    - Pharyngeal pain.
    - Painful swallowing.
    - High temperature.
  - More likely if the patient has the following features.

NB: The following features make up the Centor score and are used to assess the likelihood of streptococcal infection (see National Clinical Guideline for *Tonsillitis*):

- Tonsillar exudate (follicular).
  - Tender anterior cervical lymph nodes.
  - Fever ( $\geq 38.3^{\circ}\text{C}$ ).
  - Absence of cough.
- Infectious mononucleosis<sup>4,9</sup>:
    - Features include:
      - Prolonged fever.
      - Severe sore throat.
      - Fatigue.
      - Swollen lymph nodes.
      - Marked tonsillar exudate.
      - Abdominal pain.

- Acute otitis media<sup>4</sup>:
  - Features include:
    - Ear pain with or without discharge.
    - Hearing loss.
    - In children, symptoms and signs may also include fever; cough; poor feeding; irritability; pulling an ear.
  
- Pneumonia/bronchitis<sup>4,5</sup>:
  - Features include:
    - Fever.
    - Cough.
    - Purulent mucus.
    - Chest tightness.
    - Dyspnoea.
    - Pleuritic chest pain.
    - Crepitations.
    - Wheezing/rhonchi.
  - Particularly consider if the patient:
    - Is a smoker.
    - Is asthmatic; or has other lung disease.
  - Particularly consider in children with:
    - Vomiting
    - Oxygen saturation of 95% or less.
    - Cyanosis.
    - Tachypnoea
    - Nasal flaring.
    - Chest in-drawing.
    - Chest crepitations on auscultation.
    - Abdominal pain.
  
- Epiglottitis<sup>4</sup> (Supraglottic Laryngitis):
  - Features include:
    - Severe sore throat.
    - Difficulty and painful swallowing.
    - Drooling.
    - Sitting up and leaning position (patient avoid lying supine).
    - Change in voice (occurs commonly in adults but may occur in older children).
    - Stridor.

NB: If suspected, do not examine the throat.

- Whooping cough (pertussis)<sup>4,9</sup>:
  - Prodromal symptoms may be similar to the common cold, but it is distinguishable once the characteristic cough develops.
  - Features include:
    - Paroxysmal cough.
    - Characteristic 'whoop'.
    - Vomiting after coughing.

- Croup<sup>4</sup>:
  - Features include:
    - Change in voice.
    - Stridor.
    - Barking cough.
- Non-infectious/allergic rhinitis<sup>4</sup>.
  - Features include:
    - History of aggravating factors.
    - Itching of eyes, nose or ears.
    - Watery rhinorrhoea.
    - Postnasal drip.
    - Sneezing.
    - Nasal congestion.
- Bacterial meningitis<sup>4,5,9</sup>:
  - Features include:
    - Fever.
    - Severe headache.
    - Photophobia.
    - Vomiting.
    - Loss of appetite.
    - Neck stiffness.
    - Non-blanching rash.
    - Decreased conscious level or confusion.
- Foreign body<sup>4</sup>:
  - Consider in children with unilateral nasal obstruction or discharge.
  - Child may present with a foul-smelling, unilateral, nasal discharge.
- COVID-19

Since the viral symptoms are often clinically similar and difficult to distinguish bacterial symptoms, inappropriate antibiotic prescriptions are higher than estimated, the use of comprehensive and rapid PCR test, may improve the patient outcomes and antimicrobial stewardship may potentially be achieved <sup>18</sup> [L2, RGA].



## 10 Management

If clinical features are consistent with the common cold, management generally consists of self-care advice, appropriate symptomatic treatment and safety-netting<sup>2,5</sup> [L1, RGA].

### 10.1 Advice to Patients, Parents and Carers

Advise patients, parents and carers on the following aspects of management:

- The natural history of the illness<sup>2,4</sup> [L1, RGA]:
  - Symptoms of a common cold, typically:
    - Peak at 3-5 days.
    - Resolve within 7 days but may last up to 14 days.

NB: A mild cough may persist at night for 2-3 weeks.

- Prevention<sup>4</sup> [L1, RGA]:
  - Hand washing or hand sanitisers prevent the spread of the common cold.
  - Avoid sharing towels and toys.
  - Encourage and support mothers to continue breastfeeding for an appropriate time as this can protect babies from infection.
  - Children should not be sent to nurseries or schools while the fever persists.
  - Exclusive breastfeeding can prevent multiple respiratory illnesses in some children up to at least 6 months of age<sup>18</sup> [L1, RGA].
- Sick leave<sup>4</sup> [L1, RGA]:
  - There are no specific recommendations on when people should avoid going to work.
  - If the patient has a fever, they should be advised to rest at home.
  - Duration of sick leave should be based on individual patient circumstances [R-GDG].
- Managing symptoms:
  - Temperature control<sup>15</sup> [L1, RGB]:
    - Do not perform Tepid sponging.
    - Children must be dressed adequately so that they do not overheat or get cold.
  - Fluid intake<sup>5</sup> [L1, RGA]:
    - Warm fluids can soothe irritated throats.
    - Adequate fluid should be taken to compensate for water lost through sweating and rhinorrhoea.
    - Children with fever should be encouraged to drink more fluids.
  - Rest<sup>4</sup> [L1, RGA]:
    - The amount of rest needed is indicated by how the person feels.
    - Normal activity should not prolong the illness.
  - Comfort measures:
    - Steam or mist<sup>19</sup> [L1, RGB]:
      - ✗ May help to relieve symptoms.

- ✘ However, trials are inconsistent so not routinely recommended.
- ✘ As scalding/burns have been reported with use of steam, it is advisable to consider hot showers or the steam generating from running hot water in the bathroom as an alternative source
- Nasal saline irrigation<sup>4,19</sup> [L1, RGB]:
  - ✘ May help loosen secretions and relieve nasal congestion.
  - ✘ Commercial or homemade drops/sprays can be used.
- Vapour rubs<sup>4</sup> [L2, RGB]:
  - ✘ Although evidence is lacking, some children may experience some symptom relief.
- Salt water gargle for sore throat<sup>4</sup> [L2, RGB]:
- Evidence is lacking but is unlikely to be harmful.
- Elevate the head of the bed<sup>5</sup> [L2, RGA].

## 10.2 Pharmacological Treatment

Explain to patients that<sup>4,20,21,5,18,19</sup> [L1, RGA]:

- There are no treatments that can 'cure' the common cold.
- Most available treatments are of limited efficacy in relieving symptoms.
- Some over-the-counter treatments should not be used in children aged under 6 years.

### 10.2.1 Over-the-counter (OTC) and Symptom-Control Medications

- Paracetamol<sup>5,22</sup> [L1, RGA]:
  - Consider using paracetamol or ibuprofen for children and adults:
    - Do not give both simultaneously.
    - They do not prevent febrile convulsions in children.
    - Continue only if the child is distressed with fever.
    - Consider other diagnoses and treatments if symptoms persist.
    - Note that the evaluation of the seriousness of the condition in children should not be based on the fever status after antipyretics use
- Over-the-counter (OTC) cough medication use in children<sup>4,8,21</sup> [L1, RGB]:
  - There is no good evidence for or against the effectiveness of OTC cough medication.
  - Only consider for children aged 6 to 12 years if not contraindicated, and after basic measures have been tried:
    - Do not give more than one preparation at a time.
    - Restrict use to 5 days or less.
    - Take care to give the correct dose.
- Codeine-containing and codeine-like medications<sup>8,23</sup> [L1, RGB]:
  - There is limited evidence that codeine is effective for treating cold symptoms in children.
  - Are contraindicated in the following groups of patients:
    - Children under 12 years of age.
    - Known CYP2D6 ultra-rapid metabolisers.
    - Breastfeeding women.
  - Are not recommended for adolescents (12-18 years) with breathing problems.

- Topical (intranasal) decongestants (e.g. xylometazoline)<sup>8,21</sup> [**L1, RGA**]:
  - Can improve symptoms of nasal congestion in the short term.
  - Can lead to rebound congestion when withdrawn.
  - Should usually be used for no longer than 5 days.
  - Should not be used in children under 6 years.
- Oral decongestants e.g. pseudoephedrine<sup>8,21</sup> [**L1, RGB**]:
  - May not be as effective as local preparations.
  - Should not be used in children under 6 years.
- Topical ipratropium bromide<sup>24</sup> [**L1, RGA**]:
  - Limited trials show ipratropium bromide is likely to be effective in treating rhinorrhoea but not in managing nasal obstruction.
- Antihistamines<sup>6</sup> [**L1, RGA**]:
  - Evidence suggests that antihistamine-analgesic-decongestant combinations have some ..... general benefit in adults and older children.
  - These benefits must be weighed against the risk of adverse effects.
  - There is no evidence of effectiveness in young children.
  - Pseudoephedrine is generally safe (up to 7 days) to relieve nasal congestion in children with common cold<sup>25</sup> [**L1,RGA**].
- Expectorants<sup>8,21</sup> [**L1, RGC**]:
  - Containing guaifenesin or ipecacuanha should not be used in elderly and children under 6 years.
- Simple cough remedies<sup>4,20,26</sup> [**L1, RGB**]:
  - Generally, have little benefit for cough and cold symptoms.
  - May have a placebo effect.
  - Some are licensed for children under 6 years.
  - For children over age 2 years, a warm drink of honey and lemon can be given [**R-GDG**].
- Herbal therapy
  - Herbal therapy with (Jinhaoartemisia antipyretic granules and Huoxiangzhengqi oral liquids) could significantly reduce the risks of the common cold in community dwelling, herbal medicine may be a useful approach for public health intervention to minimize preventable morbidity during COVID-19 outbreak<sup>27</sup> [**L1, RGA**].
  - Chinese herbal medicine bimin decoction (BMD) helps relieve the symptoms of perennial AR and improves rhinitis-related quality of life<sup>28</sup> [**L1, RGA**].
  - Further research is needed on effectiveness and Safety of other herbs <sup>27</sup>.
- Micronutrient Supplement
  - There was no significant impact of micronutrient supplement on treatment of common cold, further is needed investigation and meticulous experimental<sup>29</sup> [**L1, RGB**]
  - Vitamin C could be used as a supplementary therapy along with antiviral therapy to relieve the symptoms of common cold <sup>30</sup> [**L1, RGA**]
  - Vitamin D sufficiency reduced the severity of URTI symptoms in adults<sup>31</sup> [**L1, RGA**].
  - There is no adequate evidence the association between Vit D Deficiency (VDD) and the incidence of severity of common cold. However, existing evidence suggests that VDD is likely to lead to longer ARI duration. Future research is recommended before considering supplementation for ARI prevention and management<sup>29</sup> [**L1, RGB**].

- Probiotics
  - The use Probiotics founded to be beneficial to children and reduced the severity of common colds<sup>28,30</sup> [L1, RGA].
  - Fermented milk containing probiotics can be used to mitigate URTI symptoms in adults<sup>30</sup> [L1, RGA].

NB: Vitamin D supplements have a controversial role in reducing the risk of acute URTIs<sup>34,35</sup>. Probiotics may boost the baseline state of innate immunity<sup>36-38</sup>

- Other alternative therapies<sup>4,32,33</sup> [L1, RGB]:
  - The following are generally **NOT** recommended due to lack of supporting evidence or unfavourable risk/benefit balance:
    - Z zinc lozenges
    - Echinacea.
    - Vaccines to prevent common cold.

The use of Broncho-Vaxom/Imocur (OM-85 BV), found to be effective in prevention of recurrent respiratory tract infections, especially to children with a proven high susceptibility to RTIs<sup>35</sup> [L1, RGA].

## 10.2.2 Antibiotic Therapy

Antibiotics<sup>4,39</sup> [L1]:

- Have no effect on virus induced URTIs such as common cold.
- Functional role is limited to bacterial infections.
- May result in undesired adverse events such as bacterial resistance.

A 'No-antibiotic' or 'Delayed-antibiotic'<sup>12</sup> approach may be followed for common cold [L1, RGA]:

- 'No-antibiotic' prescribing strategy<sup>2</sup> [L1, RGA]:
  - Explain to the patient that antibiotics are of no benefit at this stage of illness and may in fact induce harm if prescribed.
  - Suggest a follow up examination if the patient does not recover or the condition deteriorates with time.
- 'Delayed-antibiotic' prescribing strategy (i.e. having a prescription ready for collection or with the patient in case of worsening of symptoms)<sup>2</sup> [L1, RGA]:
  - Reassure the patient as described above.
  - Explain to the patient what triggers the use the prescription.
  - Recommend a follow up for examination if the patient's condition is substantially deteriorating despite using the antibiotic.
- **Immediate antibiotics and/or further investigation and management**, should be only offered to adults and children if<sup>2,14</sup> [L1, RGA]:
  - They are systematically ill.
  - A complication or more serious condition is anticipated.
  - Considered high-risk group, for instance:
    - Significant heart, lung, renal, liver or neuromuscular disease.
    - Immunosuppression.
    - Cystic fibrosis.

NB: Referral to secondary care should also be considered.

- o Patients have acute cough, are aged 65 years and above with at least two of the below mentioned criteria or those above 80 with at least one criterion:
  - o Been hospitalized during the last 12 months.
  - o Diagnosed with Type 1 or type 2 diabetes.
  - o Currently prescribed oral glucocorticoids
  - o Previously had congestive heart failure.

### 10.3 Safety-Netting and Follow-Up

Parents/carers of children with a fever should be advised<sup>5</sup> [**L1, RGA**]:

- To seek help if signs of dehydration develop, including:
  - o Dry mouth.
  - o Sunken eyes.
  - o Absence of tears.
- How to recognise a non-blanching rash.
- To check their child during the night.

Children should return for further assessment if <sup>4,5</sup> [**L1, RGA**]:

- Fever lasts 3 days or more.
- Symptoms worsen after 3-5 days, or new symptoms appear.
- Symptoms have not improved after 7-10 days.
- The parent/carer feels that the child is less well than when they previously sought advice.
- They have developed:
  - o Loss of appetite leading to dehydration.
  - o Laboured breathing.
- 'Red flag' symptoms develop – see *Section 5.2*.
- The caregiver is not confident or unsure about the quality of care they are providing the child.

Adults should return if <sup>4</sup> [**L1, RGA**]:

- Symptoms worsen after 3-5 days or have not improved after 14 days.
- New symptoms develop.

## 11 Referral to Specialist Care

The common cold should be managed in a primary care setting with admission to hospital only indicated if the patient is at risk of serious complications [**R-GDG**].

Refer to the *Section 5.2* for the indications for immediate referral to an Emergency Department.

## 12 Key Considerations for Patient Preferences

Patient preferences refer to patient perspectives, beliefs, expectations, and goals for health and life, and to the steps employed by individuals in assessing the potential benefits, harms, costs, and limitations of the management options in relation to one another. Patients may have preferences when it comes to defining their problems, identifying the range of management options and selecting or ranking the outcomes used to compare these options.

It is important for healthcare professionals to develop an understanding of the patient as an individual and the unique way in which each person experiences a condition and its impact on their life.

The following recommendations are therefore made for physicians and other healthcare professionals regarding general principles of patient care in Qatar:

- **Respect Patients:** Treat patients with respect, kindness, dignity, courtesy and honesty regardless the patient dresses or appears. Ensure that the environment is conducive to discussion and that the patient's privacy is respected, particularly when discussing sensitive, personal issues. Ask the patient how they wish to be addressed and ensure that their choice is respected and used.
- **Maintain Confidentiality:** Respect the patient's right to confidentiality and avoid disclosing or sharing patients' information without their informed consent. In this context, students and anyone not directly involved in the delivery of care should first be introduced to the patient before starting consultations or meetings, and let the patient decide if they want them to stay.
- **Clarify Third-Party Involvement:** Clarify with the patient at the first point of contact whether and how they like their partner, family members or carers to be involved in key decisions about their care or management and review this regularly. If the patient agrees, share information with their partner, family members or carers.
- **Obtain Informed Consent:** Obtain and document informed consent from patients, in accordance with MOPH policy and guidance.
- **Encourage Shared Decision Making:** Ensure that patients are involved in decision making about their own care, or their dependent's care, and that factors that could impact the patient's participation in their own consultation and care including physical or learning disabilities, sight, speech or hearing impairments and problems with understanding, reading or speaking English are addressed.
- **Disclose Medical Errors:** Disclose errors when they occur and show empathy to patients.
- **Ensure Effective Communication:** Explore ways to improve communication including using pictures, symbols or involving an interpreter or family members. Avoid using medical jargon. Use words the patient will understand and confirm understanding by asking questions.
- **Ensure Continuity of Care:** Provide clear and timely sharing of patient information between healthcare professionals especially at the point of any transitions in care.

## 13 Performance Measures

A list of performance measures is given in the table below. Healthcare organisations are encouraged to monitor service performance using the indicator definitions below.

Number	Numerator	Denominator
CC01	Number of patients who have had a laboratory or radiological investigation.	All patients with a recorded diagnosis of common cold or viral URTI.
CC02	Number of patients referred by the Primary Care Physician to an Emergency Department.	All patients within the Primary Care Clinic, with a recorded diagnosis of common cold or viral URTI.
CC03	Number of patients diagnosed with a common cold or viral URTI.	All patients seen in an Emergency Department setting.

**Table 13.1:** Performance measures.

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## Appendix: Detailed Description of the Literature Search

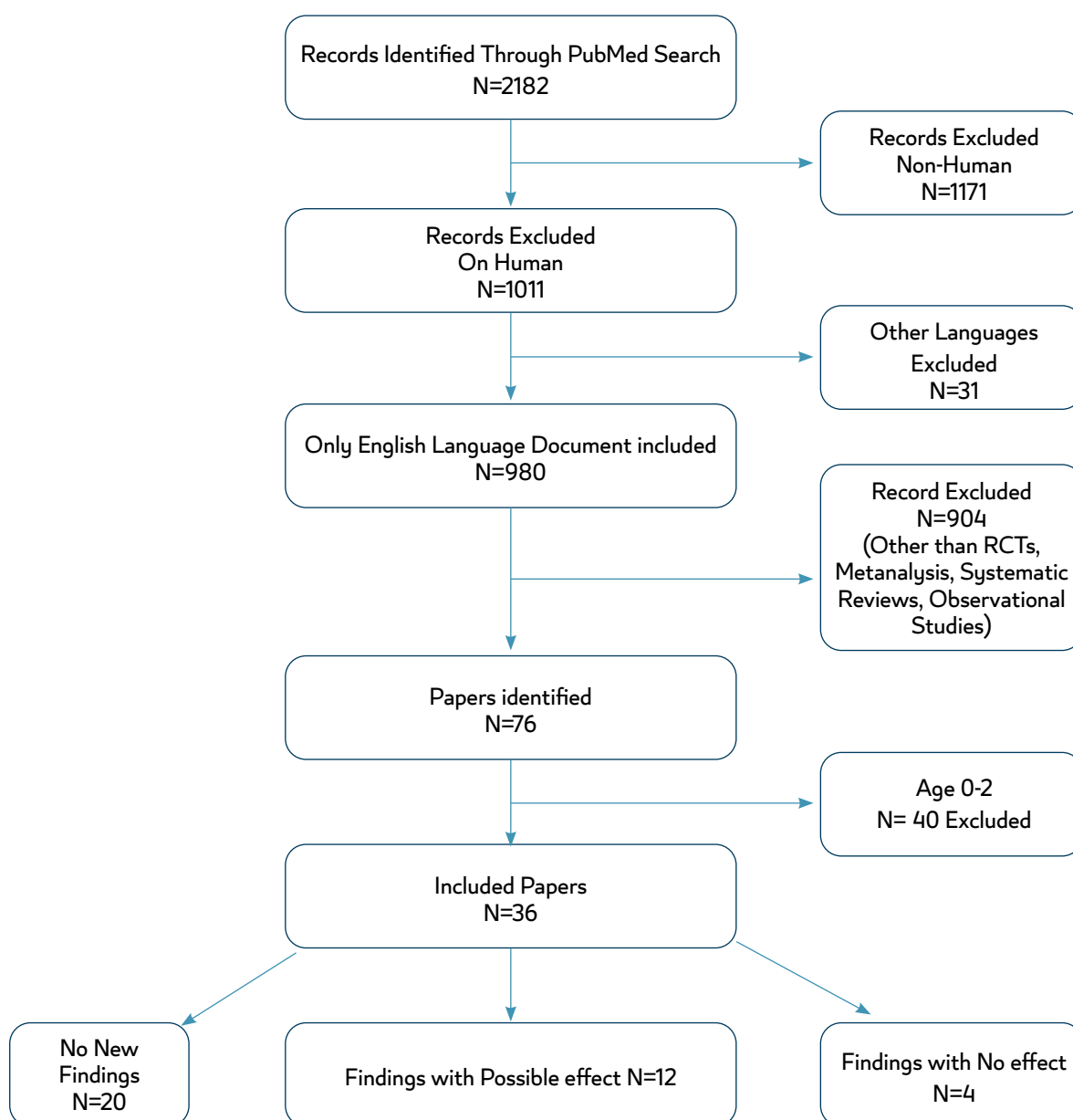
All existing references were evaluated and where necessary and applicable, the latest version of the specific manuscript was used to update the guideline and replace the older reference. The search for clinical practice guidelines on common cold diagnosis and/or management was performed in the PubMed database and websites of relevant organisations and societies. The present guideline is primarily based on UK NICE guidelines and is supplemented with other relevant studies.

The literature search identified 2182 unique studies. Of which, 36 studies were eligible and included in the final review (met inclusion criteria as per the guidelines scope and publication of the latest version of the NCG (24/7/2019- 1/1/2022).

The included publications were identified using the term “common cold” and specified with the following terms in combinations:

*guidelines, disease, rhinorrhoea, nasal congestion, fever, cough, sore throat, fatigue, children, emergency, management, prevention, treatment, upper respiratory tract infection, respiratory simplex virus, rhinovirus, antibiotic, antihistamine, over-the-counter, paracetamol, ibuprofen, vitamin C, vitamin D, probiotics.*

Furthermore, to investigate any emerging evidence, the literature has been searched as described in the below mentioned diagram:



**Fig A.1:** Literature search results and application of exclusion criteria.

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وزارة الصحة العامة في دولة قطر 2020.

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