

Letters to the Editor

A Case of COVID-19 Infection: Chief Symptom, Diarrhea

To the Editor: A 67-year-old man with a history of chronic obstructive pulmonary disease, coronary artery disease, and diabetes mellitus presented with a five-day history of diarrhea. He reported three to four watery, nonbloody bowel movements per day. He did not report fevers, chills, cough, or shortness of breath. On presentation, he was afebrile and hemodynamically stable. He was breathing comfortably with oxygen saturation at 92% on his usual 3 L of oxygen at home. His lungs were clear to auscultation. Laboratory testing was notable for thrombocytopenia with a platelet count of 102×10^3 per μL (102×10^9 per L) and an elevated aspartate transaminase level of 96 U per L (1.60 μkat per L). He was negative for *Clostridium difficile* infection. Twelve hours into his hospitalization, he had a fever of 102°F (38.9°C) and a new cough. His oxygen requirement increased to 6 L to maintain an oxygen saturation greater than 88%. Chest radiography demonstrated bilateral interstitial opacities. Testing for coronavirus disease 2019 (COVID-19) was performed, and treatment with broad-spectrum antibiotics, and albuterol and ipratropium (Atrovent) through a metered-dose inhaler were initiated. He became increasingly hypoxic, requiring intubation and transfer to the intensive care unit. His COVID-19 test result subsequently returned positive.

Most patients with COVID-19 present with respiratory symptoms and signs. The Centers for Disease Control and Prevention currently recommends testing patients who have fever, cough, or shortness of breath, prioritizing those who are hospitalized or who are at highest risk of complications.¹ A case series of 138 hospitalized patients found that the most common symptoms of COVID-19 are fever (98.6%), fatigue (69.6%), dry cough (59.4%), myalgias (34.8%), and dyspnea (31.2%). Gastrointestinal symptoms

such as diarrhea (10.1%), nausea (10.1%), vomiting (3.6%), and abdominal pain (2.2%) were less common.² However, another report suggests that many patients with COVID-19 may experience gastrointestinal symptoms, with 50.3% ($n = 103$) reporting a digestive symptom (anorexia, diarrhea, vomiting, or abdominal pain) at the time of admission.³ A case series of 1,141 patients hospitalized with COVID-19 found that 183 patients (16%) presented with only gastrointestinal symptoms.⁴

The clinical spectrum of COVID-19 is wide and not completely understood. Unexplained digestive symptoms, such as diarrhea, should raise the level of suspicion for COVID-19, even in the absence of respiratory features.

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Care of the Military Veteran Should Include Screening for Substance Use Disorders

Original Article: Care of the Military Veteran: Selected Health Issues

Issue Date: November 1, 2019

See additional reader comments at: <https://www.aafp.org/aafp/2019/1101/p544.html>

To the Editor: The article from Drs. Yedlinsky, Neff, and Jordan provides insight into the complexity of four areas of military veteran health care. However, the critically relevant topic of substance use was not discussed. Substance use disorders are pervasive within the veteran population, with rates from 11% to 32%.^{1,2} Substance use disorders are three to four times more prevalent in the veteran population, likely related to specific stressors of military service.^{1,2} Substance use disorders are also rising, with reports showing an increase of more than 50% in recent years.² Substance use ►

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This series is coordinated by Kenny Lin, MD, MPH, deputy editor.

disorders lead to an array of health issues affecting multiple different organ systems. Although gastrointestinal and cardiovascular diseases predominate, substance use disorders can also manifest with central nervous system issues, pulmonary complaints, or infectious diseases.³

Substance use disorders can occur in isolation, but they are more common as a comorbid condition. One study of returning veterans showed that 82% to 93% of those with mental health disorders also had a substance use disorder, rates that closely mirror studies on Vietnam-era veterans.^{1,4} Another report indicated that 30% of completed suicides in veterans were preceded by alcohol or drug use.¹ Substance use disorder is strongly associated with chronic pain, and active duty soldiers experience 1.6 million musculoskeletal injuries annually, which is troubling given the well-established link between chronic pain and mental health diagnoses. More than half of veterans seen in the outpatient setting report experiencing pain on a regular basis, and in 2009, 24% of Department of Veterans Affairs patients received prescriptions for opioids.¹ Although opioid prescribing rates have decreased over the past few years, this is still concerning in a population already prone to abuse potential.⁵

Shame, denial, and stigma are personal barriers to substance use disorder treatment, as well as systematic barriers such as finances and access.⁶ Veterans may be particularly vulnerable to barriers related to health care benefits and more sensitive to the perceptions of fellow service members regarding mental health and substance use disorder.

Substance use disorders are prevalent in the veteran population, are comorbid with many common veteran health issues, and are likely to compound other health complaints. Complete care of the veteran should include regular screening for substance use disorders and intervention strategies that are informed by veterans' unique risk factors, barriers to care, and comorbidities.

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The opinions and assertions contained herein are the private views of the authors and are not to be construed as official or as reflecting the views of the Department of the Army, Department of the Air Force, Department of Defense, or the U.S. government.

Editor's Note: This letter was sent to the authors of "Care of the Military Veteran: Selected Health Issues," who declined to reply.

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Correction

Incorrect Title: In the Cochrane for Clinicians "Intrapartum Omega-3 Fatty Acid Intake and Length of Gestation," (January 1, 2020, p. 17) the title of the department and the title of the accompanying table should have used antepartum rather than intrapartum. The correct title for the department should have read "Antepartum Omega-3 Fatty Acid Intake and Length of Gestation," and the title of the summary table should have read "Illustrative Outcomes of Pregnancies in Which Mothers Used Antepartum Omega-3 Fatty Acids." The online version of this Cochrane for Clinicians has been corrected. ■