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RECOMMENDATIONS FOR DIAGNOSIS

1. The adequate specimen for Real Time-Polymerase Chain Reaction (RT-PCR) testing is naso- and oro-pharyngeal sampling. Prefer lower respiratory tract (expectorated sputum, endotracheal aspirate, or bronchoalveolar lavage) when readily available (for example, in mechanically ventilated patients). Quality of RT-PCR testing is a crucial issue. Both pre-analytical and analytical variables should be carefully considered, and a validation process should be performed according to ISO 15189 (3 protocols) (9).
2. Many of the most common symptoms of novel coronavirus disease (COVID-19) are similar to those of common flu or cold. So, it is also suggested knowing which common symptoms of flu or cold are not symptoms of COVID-19. COVID-19 infection seems to rarely cause a runny nose.
3. The most common COVID-19 symptoms are: fever (88%), dry-cough (68%), fatigue (38%), thick sputum production (34%), shortness of breath (19%), arthromyalgia (15%), sore throat (14%), headache (13.6%), chills (11%), nausea/vomiting (5%), nasal congestion (4.8%), diarrhoea (3.7%) (11).
4. Beware of patients with gastrointestinal symptoms or unexplained hypo-, an- or dysgeusia to avoid omitted or delayed diagnoses (11, 12).
5. Vital signs measurements (mind the respiratory rate, please) and blood gas analysis in room air, if SpO₂ <94%, at triage or as soon as possible, are essential to correctly assess patients coming to the emergency room (13, 14).
6. Do not rely only on PO₂ <60 for the diagnosis of respiratory failure, always calculate the PaO₂/ FiO₂ ratio (P/F ratio), especially in young subjects.
7. Define a "COVID-19 profile" for the rapid order entry of blood tests (blood count, C-RP, creatinine, electrolytes, blood glucose, albumin, AST ALT, LDH, bilirubin, pneumococcal and legionella urinary agents, PT-INR, troponin and procalcitonin).
8. Chest X-rays have limited sensitivity in early stages of COVID-19 pneumonia, CT scan can raise logistical problems, so use chest US, but disinfect US probes after contact with every COVID-19 suspected patient (15).
9. Monolateral lung infiltrates do not exclude COVID-19 (15).
10. The most common laboratory abnormalities are: Lymphopenia (35-75%), increased C-RP (75-93%), LDH (27-92%), ESR (up to 85% of cases), hypoalbuminemia (50-98%) and anemia (41-50%) (16).
11. Leukocytosis, neutrophilia, increased procalcitonin, LDH, AST, ALT, total bilirubin, creatinine, troponin, d-dimer, PT and hypoalbuminemia, lymphopenia and thrombocytopenia, but also history of smoking, respiratory failure, maximum body temperature on admission $\geq 37.3^{\circ}\text{C}$ have been related to worse prognosis (16, 17).
12. Do not forget other respiratory infections (legionella, pneumococcus, mycoplasma, chlamydia, other respiratory viruses) even if during epidemics, so look for other pathogens and consider antibiotics (avoid availability bias).
13. Use disease severity stratification for the choice of the treatment setting (home, ordinary, sub-intensive or intensive care unit).
14. Pay attention to elderly people and immunocompromised subjects as they can present vague and/or atypical symptoms (2).
15. Immediately notify the Public Health Officials of COVID-19 positive patients (use infectious disease notification forms) (19).

