Co-infection in patients with COVID-19

The COVID-19 pandemic has placed incredible pressure on our healthcare systems worldwide. In past seasonal and pandemic influenza outbreaks, co-infections have been associated with more severe outcomes, highlighting the importance of syndromic testing to identify multiple causative agents and appropriate treatment.

Publication: Meta-analysis across 30 studies showed 7% of COVID-19 patients had bacterial co-infections (14% in ICU) and 3% had viral co-infections (5% in ICU) (1). With rising levels of antibiotic resistance, accurate and comprehensive diagnosis of patients allows for better treatment and efficient use of resources.

Study Design

N=3,834 patients

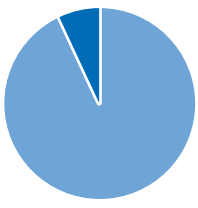
30 studies included

Searched from 1 Jan to 17 April 2020

Study Findings

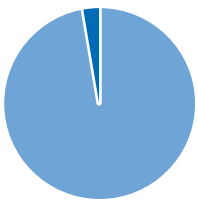
Hospitalized patients

Bacterial infections



7%
n=2,183

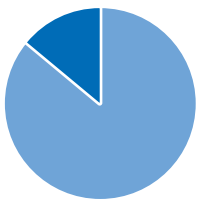
Viral infections



3%
n=1,014

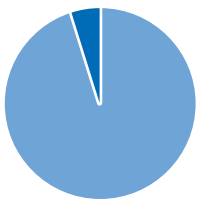
ICU patients

Bacterial infections



14%
n=204

Viral infections



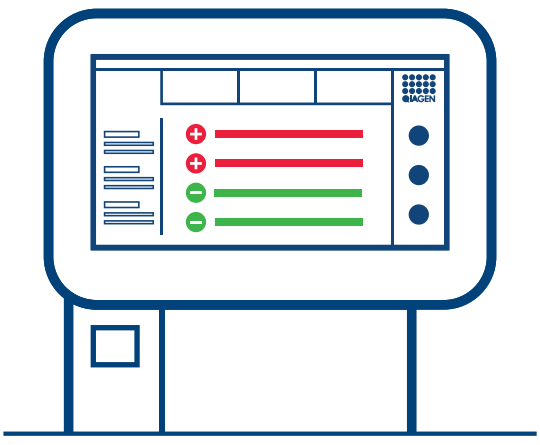
5%
n=42

Most common bacterial infection: *M. pneumonia* (42% of detections)
Most common viral infection: RSV (17% of detections), influenza A (16%)

Laboratory-confirmed co-infections were identified by bacterial or fungal culture, antigen detection methods or PCR detection.

The QIAstat-Dx Respiratory SARS-CoV-2 Panel can detect co-infections

Multiplex respiratory testing with the QIAstat-Dx Respiratory SARS-CoV-2 Panel provides qualitative results for 20+ bacterial and viral targets, including SARS-CoV-2, in about an hour. Detecting co-infections aids in diagnosis and treatment of hospital and ICU patients. The panel may save time, reduce costs and improve quality of care.



- Supports efficient, timely patient-centered care
- Helps reduce diagnostic uncertainty
- Provides actionable, comprehensive pathogen identification

QIAstat-Dx Respiratory SARS-CoV-2 Panel is intended for in vitro diagnostic use under Emergency Use Authorization Only. Testing is limited to laboratories certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), 42 U.S.C. §263a, to perform high complexity and moderate complexity tests.

The QIAstat-Dx Respiratory SARS-CoV-2 Panel has not been FDA cleared or approved;

The QIAstat-Dx Respiratory SARS-CoV-2 Panel has been authorized by FDA under an EUA for use by authorized laboratories;

The QIAstat-Dx Respiratory SARS-CoV-2 Panel has been authorized only for the detection and differentiation of nucleic acid of SARS-CoV-2 from multiple respiratory viral and bacterial organisms; and

The QIAstat-Dx Respiratory SARS-CoV-2 Panel is only authorized for the duration of the declaration that circumstances exist justifying the authorization of emergency use of in vitro diagnostic tests for detection and/or diagnosis of COVID-19 under Section 564(b)(1) of the Act, 21 U.S.C. § 360bbb-3(b)(1), unless the authorization is terminated or revoked sooner.

Discover QIAstat-Dx – the next generation of syndromic insights

Visit **QIAstat-Dx.com** for more info

References:
1. Lansbury et al. (2020) Co-infections in people with COVID-19: a systematic review and meta-analysis. J Infect. **81**, 266–75.
*Hospitalized/ICU studies; NS, no significant difference; RSV, respiratory syncytial virus

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