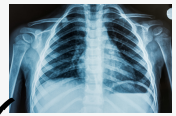
# COVID-19 Management

Non-intubated patients: Top traits of the greats.

## Diagnostics

### Admission



- ☑ CMP
- ☑ CBC with diff
- ☑ CRP
- ☑ D-dimer
- ☑ Troponin HS
- ☑ CXR
- ☑ EKG

### Avoid:

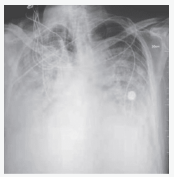
**US liver** if ALT < 10 x ULN

**CT chest** unless clinical suspicion is high for a concurrent process

### Daily

- ☑ BMP
- ☑ CRP*
- ☑ LFTs (if remdesivir)
- ☑ CBC w/o diff
- ☑ AC/HS glucose (if dex)

### Respiratory Decompensation:



Stat CXR, ABG, blood cultures, sputum cx
Desats with exertion are NOT decompensations

### q72 h

☑ D-dimer
(stop if on therapeutic anticoag)

## PE and VTE

### Prophylaxis

**Always put patients on chemical DVT ppx**

**CrCl>30**

- BMI>50 or weight> 130kg → **Lovenox 60mg q12h**
- BMI 40.1-50 or weight 100-130kg → **Lovenox 40mg q12h**
- BMI 18-40 and weight > 50kg → **Lovenox 40mg q24h**
- BMI<18 or weight <50kg → **Lovenox 30mg q24h**

**CrCl 15-30 → Lovenox 30mg q24h**
Stable renal function

**CrCl <15, AKI, or RRT**

- BMI <40 → **5000u sq q8h**
- BMI >/= 40 → **7500u sq q8h**

Monitor dosing with anti Xa levels for both heparin gtt and therapeutic Lovenox.

### Suspected VTE

**Diagnostic limitations**
Can't get CTA if patient on HFNC or BiPAP
Can't perform DVT US on proned patient

**Should I empirically treat?**
Very low threshold to change to therapeutic AC in non-ICU patients.

### Confirmed PE

- ☑ Check TTE, troponin, NT-pBNP
- ☑ Calculate PESI
- ☑ Consider IR consult for intermediate risk PE
- ☑ IR consult for high risk PE

## Management of symptomatic COVID-19

**ROOM AIR**

**0-6L NC**

### Dexamethasone

6mg (IV or PO) daily x 10 days or until D/C

Dexamethasone contraindication?

- **Indications**: <94% O2 on room air or on supplemental O2
- **Benefits**: **Decreases 28 day mortality**
- **Risks**: Hyperglycemia, Superinfections, Latent infection reactivation

**Contraindications:**
**AST/ALT > 10xULN**
Uncontrolled infection
ANC <500
**Platelets <50k**
GI perforation
Immunosuppression

**At Parkland we're substituting bari for toci because we're out of toci**

### Tocilizumab

Weight-based infusion x1: </=40kg: 8mg/kg; 41-65kg: 400mg; 66-90: 600mg; >91kg: 800mg

- **Indications**: CRP >7.5 + on steroids + **within 48h** of HFNC/BiPAP/ventilator initiation
- **Benefits**: Lower risk of death or clinical deterioration
- **Risks**: Superinfections, GI perforations

### Remdesivir

200mg IV x1 then 100mg IV daily x 4 or until D/C

- **Indications**: <94% O2 on room air or requiring low flow nasal cannula
- **Benefits**: Improved time to recovery, less escalation in O2 requirement
- **Risks**: Liver injury

**Contraindication:** eGFR<30

**NRB**

**HFNC**

### Baricitinib

GFR 15-29: 1mg PO daily; GFR: 30 to 59: 2mg PO daily; GFR >60: 4mg PO daily

- **Indications**: Any O2 requirement with steroid contraindication
- **Contraindications**: Concurrent infection, immunosuppression, ANC <500, eGFR <15

**BIPAP**

### Supportive care

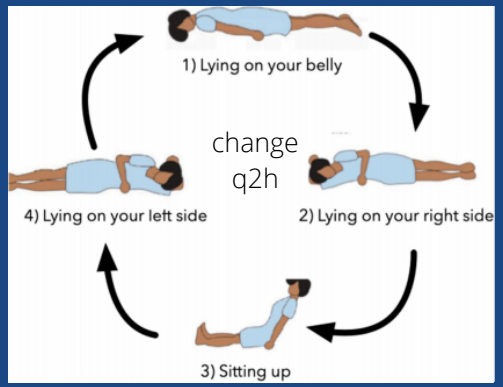
- Antitussives: Scheduled guaifenesin + codeine; consider increasing dose or changing opiates if refractory cough
- Antipyretics: Don't suppressive fever for longer than 48hrs
- Oxygen: Match flow delivery to work of breathing.
- Fluids: Watch for dehydration with fevers, tachypnea but avoid volume overload

**CONSIDER INTUBATION**

### Best practices

- Superinfections uncommon at initial presentation.
- Time meds and labs to limit RN exposure (PO meds preferred!)
- Identify the MDPOA early.

### Self prone positioning




**goal: 6-8 hours/day**