INITIAL EVALUATION for COVID 19 PUI (ER or CLINIC) REQUIRING ADMISSION*

Initial Evaluation

- Fever present at presentation in <50%
- Avoid OVER-aggressive fluid resuscitation
  - Goal of <30mL/kg crystalloid
- Admissions for hypoxia
- +/- Emp CAP tx
  - Azithromycin +/- Ceftriaxone
- MUST Address Code status
- ICU eval in pts with NEWS ≥5 & >4L O2 requirement

Labs for PUI/Positive Admission

- Resp Biofire PCR (to include Flu)
- COVID test
- CBC with diff
- LDH, ferritin, CRP, ESR, D-dimer
- Procalcitonin
- Troponin, BNP, EKG
- CXR

WARD EVALUATION AND TREATMENT

PPE for Medical Wards

- Droplet and Contact precautions
  - FOR PUI and positive
- Avoid aerosolizing procedures
- NO Nebs
- Limit no. of providers

COVID Negative PUI (with high suspicion)

- Consider repeat COVID test

Medical Ward Algorithms

- Triage patient to COVID risk category (CovRC)
- Consider treatment outlines based on CovRC
- Cont. pulse ox, consider tele for QTc eval.
- Empiric bacterial PNA coverage
- Care as normal for viral pneumonia
- Avoid steroids for treatment of PNA
- ICU eval for ↑ O2 requirement of >6L, NEWS ≥5 & >4L O2 requirement

Covid-19 Risk Categories for Severe Dx

Demo Risk Factor (DRF)

- Age >55, pulm disease, CKD, hx of HTN, Hx of CAD, immunosuppressed

Vital sign Risk Factor (VRF)

- Resp Rate >24
- HR >125
- >2L O2 requirement for sat of 90%

Laboratory Risk Factor (LRF)

- Lymphocyte <0.8,
- D-Dimer >1000
- CRP >100, LDH >245, Ferritin >300
- ↑ Trop

Covid-19 Therapy *Suggestions*

General

- Avoid steroids (unless tubed ARDS)
- Avoid NSAIDs
- Continue/start statin therapy

Mild Disease Category

- 1 DRF, No VRF or LRF
- Supportive care

Moderate/Sever Risk Category

- ≥1 DRF +/- ≥ 1 VRF or LRF
- Consider HCQ+Azi or Remdecivir **
  - May require clinical trial
  - Please review dosing on back

ICU Transfer

*This algorithm is intended for inpatients requiring admission for further observation based on comorbidities, clinical presentation. Utilize clinical expertise to determine need for admission

This is a suggested algorithm and is subject to change (3/25/2020)

**Monitor HCQ+AZM tx for QTc prolongation
QTc of >470 associated with Torsades de Pointes
Consider ID consult for HCQ OR COVID+

Treatment Considerations for SARS-CoV-2 Infection (COVID-19)

Disease severity	Therapy Options	Specifics
Mild • Outpatients OR • Hospitalized patients with no oxygen requirement (SpO2 >94%) and NO radiographic evidence of pneumonia	• Supportive therapy only **OR** • Azithromycin (AZM) for 5 days	Consider admission for: • Hypoxia, HR>125, RR>24 • Age >55 • Underlying pulmonary disease, CKD, Coronary Artery Dx • Immunosuppression
Moderate • Hospitalized patients with SpO2<94% • Radiographic evidence of pneumonia	• Supportive therapy only **OR** • Consider Remdesivir** clinical trial protocol • Consider Hydroxychloroquine*+ Azithromycin(HCQ+AZM) ¥ • If discharged, discontinue hydroxychloroquine	• Robust clinical data on hydroxychloroquine (HCQ) is limited. Consult ID prior to use. • ECG is required prior to initiation of hydroxychloroquine, repeated after initiating thearpy. • Prolonged QTc may result in Torsades de Pointes • Avoid other QTc prolonging medications
Severe disease with hypoxic respiratory failure • Mechanical ventilation° Caveats: • Not on vasopressors • CrCl>30 ml/min • ALT < 5x ULN	• Consider Remdesivir** per compassionate use or clinical trial protocol **OR** • Consider HCQ+AZM¥ **AND** • Consider Methylpred 1-2 mg/kg/day for 5-7 days (*ONLY in ARDS pts*)	• **Remdesivir should not be used concomitantly with hydroxychloroquine or other antivirals** • ECG is required prior to initiation of hydroxychloroquine, repeated after initiating thearpy. • Prolonged QTc may result in Torsades de Pointes • Avoid other QTc prolonging medications
Severe disease with multi-organ failure • Mechanical ventilation° **AND (any one of the following)** • Vasopressors • CrCl<30 ml/min (or requiring RRT) • ALT > 5x ULN	• Consider Remdesivir** per compassionate use or clinical trial protocol **OR** • Consider HCQ+AZM¥ • Consider Inhaled nitric oxide (ineligible for remdesivir unless via trial protocol)	• ECG is required prior to initiation of hydroxychloroquine • Avoid other QTc prolonging medications
Cytokine release syndrome/Secondary hemophagocytic lymphohistocytosis • Unremitting fever • Cytopenias • Hyperferritinemia • Elevated Hscore • Elevated IL-6, Fibrinogen, d-dimer, CRP	Very limited clinical experience. Seek expert guidance. • Consider tocilizumab/anakinra/sarilumab • Medication availability and ongoing clinical trials to dictate care • Consider Heme/onc consult regarding HLH pathologic eval.	

°For mechanical ventilation, target ARDSnet high PEEP lower FiO2, lung-protective tidal volume (4-8 mL/kg ideal body weight), and lower inspiratory pressures (plateau pressure <30 cm H2O)

*Hydroxychloroquine is currently restricted due to limited supply and minimal robust data. Consult ID for use.
¥ HCQ+AZM: Hydroxychloroquine of 400mg PO daily q12hr x 2doses, 400mg PO daily thereafter for 5-10 days + Azithromycin for 5 days
**Remdesevir is available via compassionate use or clinical trial
Use of Hydroxychloroquine may preclude entering into trial. Consult ID for direction

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