

Clinical Recommendations for Treatment of COVID-19 Adult Patients

Written by: Faculty in Infectious Diseases, Emergency Medicine, Pulmonary/Critical Care,
Hospital/General Medicine, & Radiology

Approved by: ACPC

Date: March 13, 2020

Evaluation/Diagnosis

- Suspect or confirmed COVID-19 patients who do not meet admission criteria should NOT have a respiratory pathogen panel performed unless they are immunosuppressed.
- Consideration should be given to testing suspected COVID-19 patients with a rapid flu antigen or empirically treating for influenza with anti-influenza prescription medications as clinically indicated.
- Admission criteria for COVID-19 are identical to those for other viral pneumonias (i.e., influenza).
- Patients to be admitted for COVID-19 should receive the following: CBC with differential, CMP, RPP, and CXR.
- COVID-19 patients should NOT routinely have a D-dimer or procalcitonin, unless another clinical condition warrants this testing.
- Chest CT is NOT recommended in COVID-19 screening and initial diagnosis. Chest CT has been found to be negative in 50% of early cases.
 - o There is no indication for CT scan in COVID-19 positive patients who are well enough to be sent home from the ED or outpatient setting.
 - o Chest CT may be helpful in assessing suspected complications of hospitalized COVID-19 positive inpatients, including abscess or empyema.
 - o Chest PE studies should be limited to clearly appropriate cases.

Management and discharge planning

- Do NOT routinely use telemetry for COVID-19 patients unless the patient meets another telemetry criterion.
- Do not routinely consult pulmonary, infectious diseases, or other specialty services on COVID-19 patients unless there is a specific clinical question.
 - o If a clinical consult is needed and is not urgent, consider deferring until the patient has been transferred to the floor or ICU (rather than in the ED.)
 - o If a clinical consult is indicated, virtual consultation is now available from subspecialist teams and should be used to minimize the number of clinicians exposed to the virus.
- Use extra discretion when ordering ancillary services (e.g., PT/OT/ST) and order only if clinically necessary.
- Information in the below table may be used to guide antiviral treatment recommendations in the absence of an available clinical trial. A clinical trial of remdesivir is anticipated to begin enrollment later this month. (Additional details to follow.)
- Decision to transfer to higher level of care (ICU) should be made using usual IDSA/ATS pneumonia criteria in conjunction with either MICU fellow or rapid response team input.

- Critical illness can develop later in the course of COVID-19 illness (7-10 days s/p symptoms onset), so closer follow-up may be warranted than that needed for other types of viral pneumonia. This advice should be included in the AVS at discharge for patient education.
 - o COVID-19 patients may be scheduled for follow up with Vanderbilt Home Care services. Additional recommendations regarding follow up discharge care to follow. Patients should be discharged with reliable contact information for the team assigned for post-discharge follow-up.
- After discharge to home, patients should self-isolate until 14 days after their positive COVID-19 test AND they have been fever free for 72 hours. At this time, follow up test of cure is not recommended by the Tennessee Department of Health.
- Recommendations for discharge requirements to post-acute care facilities will be forthcoming

Interim SARS-CoV-2 antiviral treatment recommendations
for patients not enrolled in a remdesivir clinical trial

Written by: Infectious Diseases Working Group on SARS-CoV-2 Pharmacotherapeutics

Agent	Eligibility	Dosing and Duration	Contraindications	Monitoring Parameters
Hydroxychloroquine	<p>SARS-CoV-2 PLUS hospital admission PLUS one of ANY of the following categories:</p> <p><u>Age:</u> ≥60</p> <p><u>Comorbidities:</u> COPD, current smoking, congestive heart failure, DM, HTN, immunosuppressive condition (i.e. HIV, organ transplant recipient)</p> <p><u>Clinical worsening after 12 hours:</u> Including, but not limited to, SpO2 <92%, tachypnea >20 breaths/minute, hypotension</p>	<p>400mg BID for 5 days</p> <p>*discontinue therapy is remdesivir is started</p>	<p>Known hypersensitivity to hydroxychloroquine, 4-aminoquinoline derivatives, or any component of the formulation.</p> <p>*Please reference drug information databases to review potential adverse effects and drug interactions.</p>	<ul style="list-style-type: none"> • CBC at baseline and periodically • CMP at baseline and periodically • Blood glucose daily • Baseline QTc
Lopinavir/ritonavir	<p>Consider use if clinical worsening on hydroxychloroquine</p>	<p>400mg/100mg PO BID for 7 days</p>	<p>Hypersensitivity to lopinavir or ritonavir</p>	<ul style="list-style-type: none"> • CMP at baseline and periodically

<ul style="list-style-type: none">Requires approval by ID consult team	(after at least 72 hours of hydroxychloroquine) AND the patient does not require intubation.	*discontinue therapy is remdesivir is started	*Please reference drug information databases to review potential adverse effects and drug interactions.	
--	--	---	---	--