

Clinical Guidance for Management of Covid-19

ANNEXURE-4

Mild

(Fever / Upper Respiratory Tract Infection)

Home isolation as per Govt. policy

- Contact and droplet precautions
- Strict hand hygiene
- Symptomatic management (adequate nutrition & hydration, Paracetamol, Antitussives, Vitamin C)
- Patients with co-morbidities - Inhaled Budesonide (MDI/DPI) 800mcg twice daily for up to 10 days; rinse mouth after use
- Pulse oximeter monitoring with 1- minute sit up/sit down test – twice daily (fall in saturation <95%)
- Self-monitoring of vitals (**Annexure 2**)

Warning symptoms/signs for home isolated patients (**Annexure 1**):

- Difficulty in breathing
- Persistent pain/ pressure in the chest
- Mental confusion or inability to arouse
- Developing bluish discoloration of lips / face
- Decreased urine output

Patients with high risk factors:

Admit to COVID Care Centre (CCC)

- RBS, CBC, ECG, Chest X-ray (symptomatic), RFT (HTN), H1N1 (Influenza suspect)

Investigational Therapies

Ivermectin (0.2 mg/kg for 3 days)

Moderate

Pneumonia with no signs of severe disease
RR ≥24 / min. SPO2 <94% on room air

Dedicated COVID Health Centre (DCHC)

- ECG, RBS, CBC, LFT, RFT
- CRP, D-Dimer every 48-72 hourly
- **Oxygen Support**
- Target SpO₂:92-96% (88-92% in patients with COPD)
- Preferred device for oxygenation: simple nasal cannula / Non-rebreathing face mask
- Awake Proning: Rescue therapy (NIH protocol)

Medical Management

- Remdesivir (high risk patients) 200 mg IV f/b 100mg IV daily for 4 days
- Intravenous dexamethasone: 0.1- 0.2mg/Kg OD x 5 days or more (upto 10 days) ^
- Antimicrobials – see box below[§]
- Prophylactic dose of UFH or LMWH (e.g., Enoxaparin 40mg daily SC)

Shift to DCH/ICU if:

- Increased Work of breathing (use of accessory muscles)
- Hemodynamic instability
- Increase in oxygen requirement

Worsening Hypoxia/Early Cytokine Storm
Suspected by increasing oxygen requirement and rising CRP levels typically more than 30.
Management - Depends upon initial Oxygen Requirement

FiO₂ 0.35-0.60

- Typically, on HFNC or Ventimask
- Plan for **Tocilizumab[#]** if O₂ requirement continues to rise after 24-48 hrs of Dexa

FiO₂ > 0.60 / NIV

- Offer **Tocilizumab[#]**

• If **Tocilizumab not available - Itolizumab** may be considered ^^

If both not available:
High dose Dexa
20mg/day x 3days followed by standard dose.

[#]Tocilizumab to be started after team discussion not later than 10 days after symptoms onset and needs heparin to be changed to therapeutic dose if not contraindicated

Tocilizumab Dosage

40-65kg → 400mg, 65-90kg → 600mg, >90kg → 800mg

Severe

Respiratory distress requiring mechanical ventilation (non-invasive & invasive)

Dedicated COVID Hospital (DCH)

- Cautious trial of CPAP with oronasal mask/ NIV with helmet interface/ HFNC, if work of breathing is low
- Maintain euvoemia
- Intravenous Dexamethasone: 0.1- 0.2 mg/kg OD x 5days or more (upto 10 days) ^
- Consider Inj. Tocilizumab for cytokine storm[#] (If not available – High dose Dexa 20mg/day x 3days followed by standard dose)
- High prophylactic dose of UFH or LMWH (e.g., enoxaparin 40 mg or 0.5 mg/kg BD SC) in patients with thrombi formation, if not at high risk of bleeding*
- Therapeutic doses of LMWH (1mg/kg SC BD) should be considered in patients with incident thromboembolic event or who are highly suspected to have thromboembolic disease
- Consider intubation if work of breathing is high/ not tolerating NIV

Ventilator management

- Use conventional ARDSNet protocol (LTV, proning, etc.)
- Antimicrobials generally needed (See box below for principles of antimicrobial use)[§]
- Use sedation and nutrition therapy as per existing guideline

*Use Validated score for assessing bleeding risk (e.g., HAS-BLED score)
*Use D-Dimer & SIC score for further risk stratification (SIC>4 portends higher thrombotic risk)
*AHA/ESC guidelines if patient is on antiplatelet

- [§]Unnecessary use of antimicrobials should be avoided at all costs.
- [§]For patients requiring hospital management where a diagnosis of COVID is not established, and a differential diagnosis of Community/Hospital Acquired Pneumonia and or Tropical Fever is a possibility, after sending appropriate investigations, empiric antimicrobial(s) may be initiated with aim to deescalate as soon as correct diagnosis is established.
- [§]Patients presenting with sepsis/septic shock, should be classified as potentially having community or hospital acquired infections based on history. For suspected community acquired organisms, ceftriaxone/piperacillin-tazobactam with vancomycin may be initiated. For hospital acquired infections and patient in shock, piperacillin tazobactam OR carbapenem with vancomycin/teicoplanin may be initiated. Appropriate diagnostics should be sent before initiation of antimicrobials with the aim of de-escalation or initiating specific antimicrobial.
- [§]Antifungal use should be limited and as far as possible for lab proven infections.
- [§]All prescriptions must be reviewed at time interval not exceeding 48 hours
- [^]Duration and tapering should be done according to patient's condition
- ^{^^} **Itolizumab Dose - 1.6 mg/kg infusion in 250 mL normal saline over 5-6 hours. A premedication of 100 mg Hydrocortisone (IV) and 30 mg Pheniramine (IV) to be given 30 minutes prior to infusion. If required, 0.8mg/kg may be repeated after 7 days.**

Mental Health issues to be addressed in consultation with psychiatrist /psychologist / voluntary organization