AIIMS, New Delhi

INTERIM CLINICAL GUIDANCE FOR MANAGEMENT OF COVID-19 (Version 1.6)

7th April 2021

COVID-19 patient

Mild disease

Upper respiratory tract symptoms (&/or fever) WITHOUT shortness of breath or hypoxia

Home Isolation

- ✓ Contact & droplet precautions; strict hand hygiene
- ✓ Symptomatic management
- ✓ Stay in contact with treating physician
- Seek immediate medical attention if:
  - Difficulty in breathing
  - High-grade fever/ severe cough
  - A low threshold should be kept for patients with high-risk factor*
- ❖ Peripheral oxygen saturation (by applying a SpO2 probe to fingers) should be monitored at home

- ❖ Tab Ivermectin (200 mcg/kg once a day for 3 to 5 days) may be considered in patients with high-risk features*
- ❖ Steroids should NOT be used in patients with only mild disease

Moderate disease

Any one of:
1. Respiratory rate ≥ 24 /min
2. SpO2 < 94% on room air

ADMIT IN WARD

Oxygen Support:
- ➢ Target SpO_2: 92-96% (88-92% in patients with COPD)
- ➢ Preferred devices for oxygenation: non-rebreathing face mask
- ➢ Awake proning may be used in those with persistent hypoxia despite use of high flow oxygen (sequential position changes every 1-2 hours)

Antiviral therapy
- ➢ Inj Remdesivir 200 mg IV on day 1 f/b 100 mg IV daily for 5 days (can be extended upto 10 days in case of progressive disease)
- ➢ Convalescent plasma (CP) may be considered in carefully selected patients

Anti-inflammatory or immunomodulatory therapy
- ➢ Inj Methylprednisolone 0.5 to 1 mg/kg (or equivalent dose of dexamethasone) IV in two divided doses for 5 to 10 days

Anticoagulation
- ➢ Low dose prophylactic UFH or LMWH## (weight based e.g., enoxaparin 0.5mg/kg per day SC)

Monitoring
- ➢ Clinical Monitoring: Work of breathing, Hemodynamic instability, Change in oxygen requirement
- ➢ Serial CXR, HRCT Chest (if worsening)
- ➢ Lab monitoring: CRP, D-dimer & Ferritin 48-72 hrly; CBC, LFT, KFT 24-48 hrly; IL-6 levels to be done if deteriorating (subject to availability)

Severe disease

Any one of:
1. Respiratory rate > 30 /min
2. SpO2 < 90% on room air

ADMIT IN ICU

Respiratory support
- Consider use of HFNC in patients with increasing oxygen requirement, if work of breathing is LOW
- A cautious trial of NIV with helmet interface (if available otherwise face mask interface)/CPAP with oro-nasal mask may also be considered
- Intubation should be prioritized in patients with high work of breathing /if NIV is not tolerated ^^
- Conventional ARDSnet protocol for ventilatory management

Antiviral therapy
- Antivirals may be considered if duration of illness < 10-14 days

Anti-inflammatory or immunomodulatory therapy
- Inj Methylprednisolone 1 to 2mg/kg in 2 divided doses for 5 to 10 days (or equivalent dose of dexamethasone)
- Tocilizumab may be considered on a case-to-case basis preferably within 24 to 48 hours of progression to severe disease

Anticoagulation
- Intermediate dose prophylactic UFH or LMWH (e.g., Enoxaparin 0.5mg/kg/dose BD SC) ##

Supportive measures
- Maintain euvolemia
- If sepsis/septic shock: manage as per existing protocol and local antibiogram

Monitoring
- ➢ Serial CXR, HRCT Chest (if worsening)
- ➢ Lab monitoring: CRP, D-dimer & Ferritin 24-48 hrly; CBC, LFT, KFT daily; IL-6 levels to be done if deteriorating (subject to availability)

After clinical Improvement discharge as per revised discharge criteria

*High-risk for severe disease or mortality
- ✓ Advanced age particularly > 60 years
- ✓ Cardiovascular disease including hypertension and CAD
- ✓ DM (Diabetes mellitus) and other immunocompromised states
- ✓ Chronic lung/kidney/liver disease
- ✓ Cerebrovascular disease
- ✓ Obesity

^^Higher chances of NIV failure

LMWH: Low Molecular Weight Heparin: if no contraindication or high risk of bleeding; UFH: Unfractionated heparin

EUA/Off label (use based on limited available evidence):

- ➢ Remdesivir (EUA) to be considered in
  - Moderate to severe disease (NOT to be used in those with only mild disease)
  - No renal or hepatic dysfunction (eGFR <30 ml/min/m2; AST/ALT >5 times ULN) (Not an absolute contraindication)
- ➢ Tocilizumab (Off-label) may be considered when all of the below criteria are met
  - Severe disease
  - Significantly raised inflammatory markers (CRP &/or IL-6)
  - Not improving despite use of steroids
  - No active bacterial/ fungal infections

  The recommended dose is 4 to 8mg/kg (with a maximum dose of 800 mg at one time) in 100 ml NS over 1 hour (dose can be repeated once after 12 to 24 hours depending on clinical response)
- ➢ Convalescent plasma may be considered when following criteria are met
  - Early moderate disease (preferably within 7 days of disease onset and if seronegative)
  - Availability of high-titre plasma

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