MANAGEMENT OF SEVERE COVID-19 DISEASE AFTER CONFIRMATION OF TESTS

RAPID SEQUENCE INTUBATION

- Intubation should be done in ICU/ controlled isolation in order to reduce aerosol dispersal.
- Preparation of ventilator in advance to avoid Ambu-bag use for prolonged periods after intubation.
- Assume and prepare for difficult intubation: boogie, styles, video scopes or Fiber optic flexible laryngoscope if available.
- Check functionality of your suction apparatus.
- Only 3 people at a time during intubation. Nurse 1 to administer drugs, Nurse 2 to hand suction and other equipment, expert clinician to perform the intubation.
- If possible, use disposable equipment at all times.

COURSE AND MANAGEMENT OF RESPIRATORY COMPLICATIONS

- Once intubated, connect on to the machine and set to the following:
  - FIO$_2$ 1 (100%) and adjust as shown on the chart.
  - Respiratory rate 15 breaths per minute (aim is to achieve adequate oxygenation; disregard hypercarbia). (Children under 14 years, start at a higher rate).
  - If on Volume Control Mode, set tidal volume to 6mls/kg ideal body weight (IBW) (Kg) = Height (cm) MINUS 100 (males) or MINUS 105 (females)).
  - If on Pressure Control Mode, set the driving pressure to aim at a tidal volume of 6mls/kg IBW.
  - If necessary, adjust tidal volumes downwards to keep plateau pressures less than 30cmH$_2$O.
  - Begin with PEEP 10 cm H$_2$O; increasing as shown on the chart.
  - I:E Ratio starting at 1:1 and adjusting as shown on the chart
  - Closed suction system and HME HEPA filters should be preferred to prevent aerosol spread.
  - Nurse head raised.
  - Hourly chest physiotherapy to clear secretions out; use closed circuit suction systems with chest percussions.
  - Inspect breathing tubes for kinks, fluid collections or accidental disconnections.
  - Use End Tidal capnography if available.
  - Proning should be tried when P/F <150 and an adequate number of trained staff are available. (P/F ratio is arterial oxygen concentration divided by fraction of inspired oxygen).
  - Do not attempt to extubate the patient within 3 days of mechanical ventilation (MV), because the initial relief provided by MV leads to a false sense of wellbeing in many patients.
  - Weaning off MV should be as per clinician discretion or as per the weaning guidelines provided below.

MV Settings Courtesy ARDSNET: Inclusion Criteria

- Acute onset PaO$_2$/FiO$_2$ ratio < 300.
- CXR diffuse infiltrates or patchy infiltrations.
- No clinical evidence of left heart failure.
- PH goal 7.30 – 7.45.
- Acidosis management (PH 7.15 – 7.30).
- Increase RR till PH > 7.30 or PaCO$_2$ < 25 (maximum RR 35).
- If PH < 7.15 despite all above; increase RR to 35; increase Tidal Volume by 1ml/kg till PH >7.15. NB: Plateau pressure of 30 cm H$_2$O may be exceeded.
- Alkalosis management: PH>7.45; reduce RR if possible.

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**SEDATIVES**
Change frequency depending on availability of PPE’s.
- Aim at RASS 0 (alert and cooperative) to Negative 2 (responding to mild stimulation).
- Choice depends upon availability.
- I.V. Midazolam 1-5 mg every hour, or 4 – 20 mg every 4 hours (running in the maintenance fluid).
  - Or, Oral Midazolam 15 mg BID crushed and fed through the oral gastric tube.
- I.V. Diazepam 10mg BID/TDS.
- Ketamine 2-4mg/Kg bolus followed by 125mg per hour or 500mg every 4 hours (running in the maintenance fluid).
- I.M Morphine 10mg stat then 2 - 5 mg per hour; alternatively, 10 -15 mg every 4 hours, (running in the maintenance fluid and rate depending on haemodynamics).
- I.V. Fentanyl 100mcg stat then 50mcg per hour or 200mcg every 4 hours running in the maintenance fluid.
- If syringe pumps available, you may use either:
  - Dexmedetomidine 0.2 – 1.4 mcg/kg/hour. (Avoid loading doses) OR
  - Remifentanil 0.05 – 0.3mcg/kg/minute.

**INTRAVENOUS FLUIDS**
Change frequency of administration depending on availability of PPE’s.
- 1.5mls per kg per hour OR 6mls/kg every 4 hours (keep patient ‘dry’). Assess urine output as the patient may have been dehydrated due to prior fever, sweating and reduced oral intake.
- Use the 4:2:1 ratio for children under 14 years.

The total fluid intake per day is inclusive of all medications plus oral feeds.

**ANTIVIRALS**
Change frequency depending on availability of PPE’s.
- No recommendations to date.
- Trials using hydroxychloroquine, azithromycin and/ or a combination of lopinavir/ ritonavir in a fixed drug combination are ongoing for patients with severe illness (contact the national Infectious disease unit before commencing).

**ANTIBIOTICS**
Change frequency depending on availability of PPE’s.
- If rising White Cell Count (Neutrophilia); urinary casts; rising Procalcitonin levels.
- The ratio of neutrophils to lymphocytes exceeding 3:1 on the blood film is a marker of severe disease progression.
- Consider empirical broad spectrum antibiotics according to institutional antibiogram profiles.
- Consider escalating or de-escalating once culture/sensitivity results are back.

**ANTIPYRETICS**
Change frequency depending on availability of PPE’s.
- If >50kg and normal liver function, Paracetamol 1g TDS per oral OR
- IV Paracetamol 1g every 4 hours to a maximum of 4 g per 24 hours.
- NSAIDS worsen progress and outcomes.

**MONITORING INTERVENTIONS**
Change frequency depending on availability of PPE’s.
- Insert a CVC line regardless of need for vasoressors at the earliest opportunity.
- Insert an Arterial line if transduction is possible (for ease of doing laboratory works), at the earliest opportunity.
- Arterial blood gas analysis every four hours and with every change in ventilator settings.
- Hourly urine collecting system if available, otherwise use regular urine bag and estimate by pouring into a measuring container, once, every 4 hours.
- Thromboprophylaxis (use Enoxaparin/ Warfarin/ or Pneumatic devices).
- Ulcer prophylaxis using oral Ranitidine 150mg twice daily, OR I.V. Ranitidine 50 mg twice daily or Proton Pump Inhibitor of choice.
- Glycaemia control with soluble Insulin as determined by random blood sugars.
- Pressure area care as per hospital protocols.
- Nutritional support either enteral or parenteral as condition may dictate.

**MANAGEMENT OF CARDIOVASCULAR COMPLICATIONS**
- Keep MAP>65mmHg in adults and if necessary, use vasopressors as per hospital protocol: paediatric MAP is age related and refer to appropriate age guides.
- Monitor for myocarditis by performing Troponin levels and looking at the ECG on telemetry (avoid performing bedside 12 lead ECG as this involves increased workload for already stressed staff).
- Call cardiology consult if vasopressor requirements suddenly increase.
- Treat any arrhythmias.
- Correct electrolytes.
- CCSK is recommending non-mechanical CPR for the time being.

**MANAGEMENT OF RENAL COMPLICATIONS**
- Encourage diuresis by giving occasional frusemide boluses of 20mg I.V. ONLY IF patient well hydrated.
- COVID-19 associated AKI maybe pre-renal.
- Aggressively replete electrolytes especially Potassium (>4.5), Magnesium (>2.5) and Phosphate (>2.5). (Measure 4 hourly).
- Rising Creatinine does not mean hypovolaemia (spin urine for casts as renal damage may occur).
- Have a low threshold for haemodialysis for volume management.

**MANAGEMENT OF NEUROLOGICAL COMPLICATIONS**
- Marked encephalopathy and hypertensive ICD delirium is common.
- If these develop treat with I.V. Haloperidol and discontinue Benzodiazepines.
- Use only enough sedation to achieve lowest level of RASS at negative 2 but lighten sedation as MV requirements decrease.

**MANAGEMENT OF GASTROENTEROLOGICAL COMPLICATIONS**
- Pass an oral gastric tube immediately after performing the endotracheal intubation and confirm positioning via palpation for turbulence caused by gas entering the stomach.
- Subsequent CXR post intubation can be used to confirm position of NGT tip.
- Attach feeding lines and run as appropriate.
- Ulcer prophylaxis as indicated above.
- Bowel movement as natural but inspect diapers for soiling and change accordingly at the 4 hourly interval.
- Test for swallowing capability before extubation.