Current Guidance for the Management of Adult Hospitalized Patients with COVID-19

Prepared By: The COVID-19 Antimicrobial Management Working Group, Alberta Health Services

Note: This document represents updated guidance (previous update September 21, 2020) and this document will be updated as relevant new information becomes available. As such, the most current web-based version of this document should preferentially be used.

The COVID-19 Antimicrobial Management Working Group has updated the evolving evidence base for this document as best as possible but recognizes that future updates will be required based on ongoing therapeutic trials and emerging evidence. Supportive care remains an important component of therapy for individuals infected with SARS-CoV-2. Updated COVID-19 management guidelines from the Public Health Agency of Canada (PHAC), Association of Medical Microbiology and Infectious Diseases (AMMI), Canada/Canadian Critical Care Society (August 17, 2020), the Infectious Diseases Society of America (September 15th, 2020) has been reviewed in preparing this update. Full details are available in these latter hyperlinked and the referenced documents below.

Consultation with other specialties (e.g. Infectious Diseases, Respiratory Medicine, Critical Care, General Internal Medicine) who are most likely to be familiar with the rapidly evolving literature can be considered to help assess the risks and benefits for an individual patient. As recommended by AHS Ethics, any off-label use of medication requires the prescriber’s careful consideration of risk/benefit, consultation between experts and attending physician as needed, and documenting consent from the patient or caregiver after discussion of the current state of evidence of benefit and harms. Adverse events with respect to off-label use of medications for inpatient treatment should be documented and reported by clinicians through the AHS Reporting and Learning System for Patient Safety.

The guidance provided in this document does not replace best clinical judgment and/or expert consultation but rather is meant to inform clinicians of the most current management guidelines to facilitate best use of therapeutic options for patients with COVID-19.
Current Practice Guidance

1. General Considerations

- Patients with mild suspected or confirmed COVID-19 should not require hospitalization, unless there is a clinical concern for rapid deterioration, significant underlying co-morbidities, extenuating sociodemographic circumstances, or an inability to return promptly to hospital. Patients with mild COVID-19 and their caregivers should be provided with information on symptom management and informed of the signs and symptoms of complications that should prompt medical re-evaluation.

- Patients with moderate suspected or confirmed COVID-19 (i.e. with clinical signs of pneumonia, SpO2 ≥ 90% on room air, but no signs of severe pneumonia) who are not determined to be at high risk of deterioration may not require hospitalization, but they should self-monitor and be counseled along with their caregivers about the signs and symptoms of complications that should prompt medical re-evaluation.
• Patients with severe suspected or confirmed COVID-19 and respiratory distress, hypoxaemia or shock should receive supplemental oxygen therapy immediately with target saturations of > 94% SpO2 during resuscitation. Patients with severe illness should be closely monitored for signs of clinical deterioration, specifically rapidly progressive respiratory failure or shock.

• In hospitalized adult patients who meet criteria for severe disease (defined by the IDSA as SpO2 <94% on room air), and requiring supplemental oxygen, mechanical ventilation or extracorporeal mechanical oxygenation, clinicians should strongly consider offering dexamethasone 6 mg IV/PO daily for 10 days, or until off oxygen or until discharge if earlier, or equivalent glucocorticoid dose. Glucocorticoids are not recommended in patients who do not have hypoxemia requiring supplemental oxygen.

2. Antibacterials

• For those patients with suspected or confirmed mild to moderate COVID-19, antibiotics should not be routinely prescribed unless there is clinical suspicion of a bacterial infection.

• For those patients with suspected or confirmed severe COVID-19, empiric antibacterial agents should be considered to treat all likely pathogens causing severe acute respiratory bacterial infection and sepsis as soon as possible, and optimally within 1 hour of initial patient assessment for patients with sepsis. Empiric antibiotic treatment should be based on the working clinical diagnosis (e.g., community-acquired pneumonia, health care-associated pneumonia or sepsis), local epidemiology, and susceptibility data.

• Use of antibacterial therapy should be judicious with a reassessment after 3 days for de-escalation and/or optimization of therapy, in accordance with the principles of stewardship, after review of the clinical status, laboratory and radiologic findings, culture and susceptibility results.

• Empiric management of patients with severe pneumonia while COVID-19 is being confirmed and bacterial infection excluded, and management of potential bacterial superinfection are available in references such as Bugs & Drugs.

3. Antivirals/Immunomodulators

• Remdesivir - At this time, remdesivir is available in very limited quantities, and currently is being made available only to patients enrolled in the CATCO Trial (A Multi-centre, Adaptive, Randomized, Open-label, Controlled Clinical Trial of the Safety and Efficacy of Investigational Therapeutics for the Treatment of COVID-19 in Hospitalized Patients [in conjunction with the Public Health emergency SOLIDARITY trial through the World Health Organization]), which is available at eight acute care
hospital sites, all of which are located in Calgary and Edmonton. This position will be reconsidered with evolving evidence for remdesivir benefit, and when a sustainable supply of remdesivir can be confirmed.

- Consideration of all other investigational antivirals or immunomodulators (e.g. tocilizumab, ritonavir/lopinavir, famotidine, convalescent plasma, ivermectin, bamlanivimab and baricitinib) should be only under ethics approved, controlled trials.

- The use of hydroxychloroquine, or any hydroxychloroquine combinations (e.g. hydroxychloroquine plus azithromycin) are not recommended as a treatment in patients with COVID-19.

4. General Investigations

*Please note the listed investigations below are for clinical consideration and not required tests. Work is underway to standardize the laboratory tests and investigations in standing orders and care pathways. Please use the Laboratory tests and Investigations incorporated into care pathways and order sets if there are differences between those and the list below.*

4.1 General Laboratory tests:

Laboratory tests may not be required in otherwise ambulatory patients who are clinically stable, and not felt to be at elevated risk of decompensation. In the presence of higher clinical severity and/or comorbidities, the following laboratory tests may be considered:

- **CBC & differential - low lymphocyte count and/or neutrophil/lymphocyte ratio of >3.13 may be suggestive of COVID-19/more severe disease**
- AST, ALT, bilirubin, Cr, CRP
- Blood cultures
- COVID-19 PCR and RVP swabs OR sputum or ET aspirate for COVID-19 PCR

Also consider for select patients:
- HIVAb
- Sputum (or endotracheal (ET) aspirate if intubated) for Gram stain and culture. NB: Do not do bronchoscopy only to procure specimens.
- MRSA nasal swab (to determine need for empiric MRSA pneumonia coverage pending cultures)

4.2 CXR - AP (portable) or PA/LAT depending on site policies for ED based COVID-19 patients
4.3 Laboratory tests that can be considered in specific patients based on clinical status and comorbidities (NB: the current literature does not support a specific role for these parameters in guiding clinical management but they may be useful in evolving prognostic models):

- ABG
- INR
- D-dimer
- fibrinogen
- ferritin
- troponin
- If immunocompromised and clinically indicated, ET aspirate, bronchoscopy (if required), or induced sputum for PJP and/or mycobacterial and /or fungal assessment

5.0 Other considerations

- Clinical progression to more severe disease usually begins between 5-7 days after symptom onset. Risk factors for disease progression include older age and presence of underlying medical conditions (e.g. hypertension, obesity, diabetes, chronic lung diseases, and immunocompromised state). However, younger, previously healthy individuals can develop severe illness
- Avoid nebulized medications and do not do bronchoscopy unless clinically indicated for obtaining specimens (ET aspirate preferred) to reduce aerosolization risk
- If oxygen demand is increasing, consider early referral for appropriate respiratory supports depending on access and infrastructure, as patient outcomes may be superior and planned intubations are at a lower risk for infection transmission than emergent ones.
- There is no evidence that ACE Inhibitors and Angiotensin Receptor Blockers need to be stopped. There is a theoretic concern about ACE inhibition and viral receptors but there are no clinical data supporting risk. Major cardiovascular societies (Hypertension Canada Statement on COVID-19 ACEi/ARB) recommend that suspect and confirmed COVID-19 patients on ACE inhibition should be maintained on their therapy if it is otherwise indicated to avoid decompensation of cardiac disease.
- There is no specific contraindication to NSAIDS: AHS SAG Use of NSAIDs Review. There is current anecdotal concern about the antecedent use of NSAIDs in patients with severe disease, but no clinical data are yet available. As other symptomatic therapy can be substituted (acetaminophen, appropriately dosed) it may be reasonable to prefer acetaminophen to NSAIDS for COVID-19 symptoms, but patients with inflammatory conditions on stable doses of NSAIDS should remain on them.
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References


