17th Nov 2020

Annexure - 5

Clinical Guidance for Management of Covid-19 Cases

Mild (Fever / Upper Respiratory Tract Infection)	**Moderate** Pneumonia with no signs of severe disease RR ≥24 / min. SPO_2 <94% on room air	**Severe** Respiratory distress RR ≥30 / min, SPO_2 < 90% on room air
Home isolation as per Govt. policy (L-1)	**Dedicated COVID Health Centre (DCHC) (L-2)**	**Dedicated COVID Hospital (DCH) (L-3)**
• Contact and droplet precautions • Strict hand hygiene • Symptomatic management (adequate nutrition & hydration, Paracetamol, Antitussives, Vitamin C Vitamin D & Zinc Tab) • *Ivermectin 12 mg OD x 3 days + Doxycycline 100 mg BD x 5 days • Pulse oximeter monitoring with 1-minute sit up/sit down test – twice daily (fall in saturation <94) • Self-monitoring of vitals (Annexure 2) **Warning symptoms/signs for HOME isolation patients** (Annexure 1): • Difficulty in breathing • Persistent pain/ pressure in the chest • Mental confusion/ inability to arouse • Bluish discoloration of lips / face • Decreased urine output ***Patients are advised to be in touch with their medical teams/personal physician*** **For patients with High Risk Factors** (Age > 60 years, immunocompromised, CVD, diabetes, chronic lung/liver/kidney disease, cerebrovascular disease, obesity, pregnant women): • Consider admission to COVID Care Centre (CCC) • RBS, CBC, ECG, Chest X-ray (symptomatic), CRP, D-Dimer, RFT (HTN). • AVOID IL-6 & CT CHEST in proven cases	• ECG, RBS, CBC, LFT, RFT • CRP, D-Dimer every 48-72 hourly • LDH, Ferritin, IL-6, CT chest (if needed) **Oxygen Support** • Target SpO_2:92-96% (88-92% in patients with COPD) • Preferred device for oxygenation: Non-rebreathing face mask (if HFNC or simple nasal cannula is used, N95 mask should be applied over it) • Active awake proning **Medical Management** • Remdesivir 200 mg IV f/b 100 mg IV daily for 4 days (total 5 days) • Intravenous dexamethasone: 6mg OD x upto 10 days* • Antibiotics if required • Prophylactic dose of UFH or LMWHZ (e.g. Enoxaparin SC 40mg OD for <100 kg, BD >100 kg) **Shift to DCH/ICU (L3)** if: • Increased Work of breathing (use of accessary muscles) • Hemodynamic instability • Increase in oxygen requirement * Duration and tapering should be done as per patient condition. Close monitoring for hyperglycemia & infections including fungal **Investigational Therapies** Plasma therapy (PLACID Trial)	• Cautious trial of CPAP with oro-nasal mask/ NIV with helmet interface/HFNC, if work of breathing is low • Maintain euvolemia • Continue dexamethasone or shift to IV methylprednisolone 1 to 2 mg/kg per day for 5-7 days (in 2 divided doses) as per physician preference. • Therapeutic dose of UFH or LMWH for patients at high risk of thrombotic complications* (e.g. Enoxaparin SC 1mg/kg BD) • Consider intubation if work of breathing is high/ not tolerating NIV **Ventilator management** • Use conventional ARDS net protocol (LTV, proning, etc,) • If sepsis/ septic shock: Manage as per existing protocol and local antibiogram • Use sedation and nutrition therapy as per existing guideline *Use Validated score for assessing bleeding risk (eg HAS-BLED score) *Use D-Dimer & SIC score for further risk stratification (SIC>4 portends higher thrombotic risk) **Investigational Therapies** Consider single dose of Inj. Tocilizumab for cytokine storm (after team meeting)

Consider HCQ prophylaxis for High Risk contacts & Frontline Healthcare workers

Mental Health issue should be managed in consultation with psychiatrist /psychologist / voluntary organization

*** Current evidence supporting the use of ivermectin/doxycycline is limited. Few preliminary studies have shown clinical benefit.**