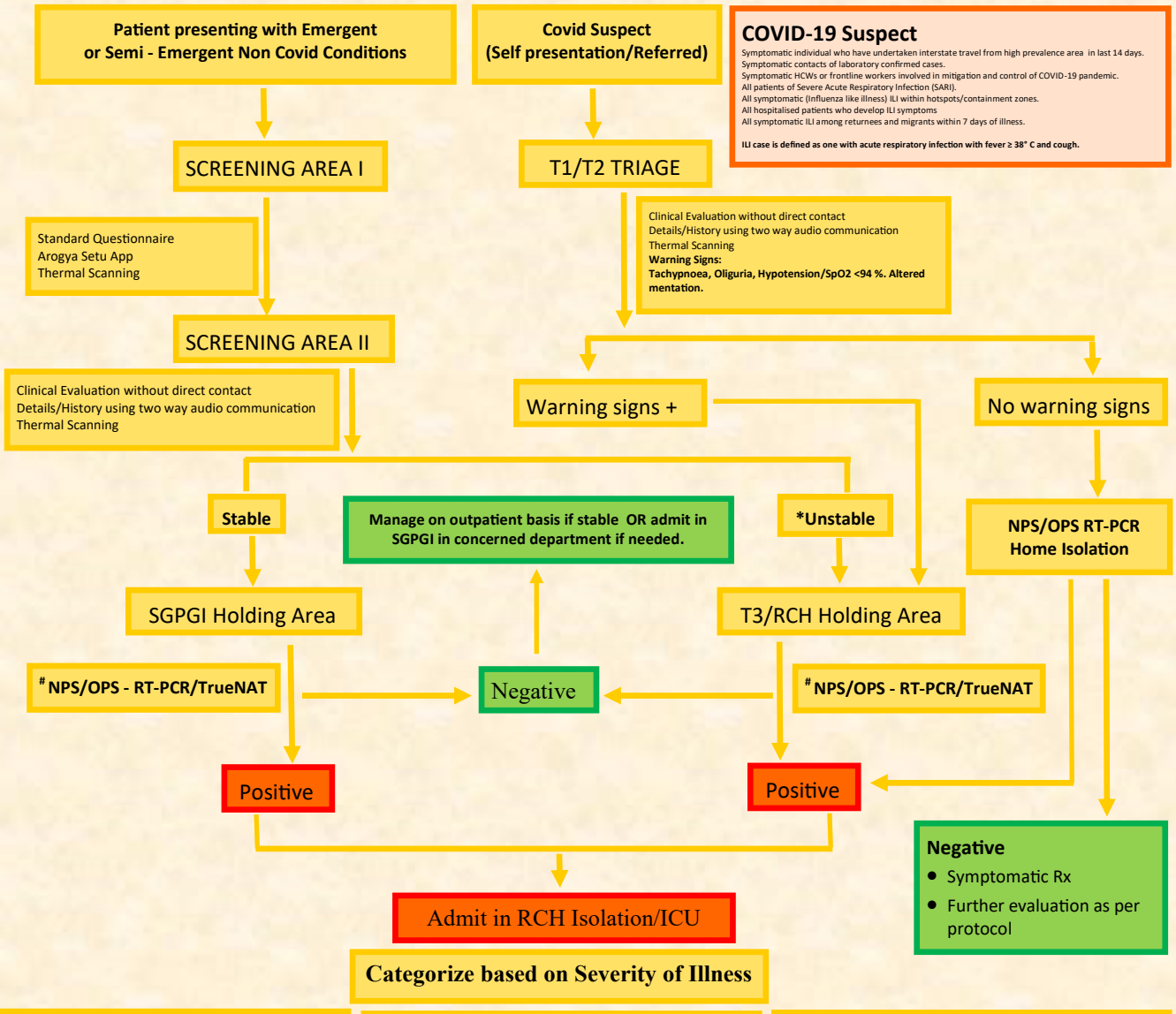
COVID-19 Management Protocol
SGPGIMS, Lucknow
Version 1.3.1

August 20, 2020



Categorize based on Severity of Illness

Mild
Fever, Mild URTI
No dyspnoea,

- Admit in Isolation Ward
- Contact and Droplet precautions
- Strict hand hygiene
- Tab. Hydroxychloroquine (400mg) BD on 1st day followed by 200mg 1 BD for 4 days for patients with high risk of severe disese[1]. (after ECG Assessment) with Tab Azithromycin 500 mg OD x 5 days
  OR
- Tab Ivermectin 12mg OD x 3day s with Tab Doxycycline 100 mg BD x 5 days
  OR
- Tab. Favipirivir 1800mg BD on Day 1, followed by 800mg BD x 13 days
- Tab. Vit C 500mg BD
- Tab Zinc 50mg BD
- Symptomatic treatment for cough and fever (bronchodilators, mucolytic, paracetamol)
- Monitor closely for warning signs
  - Chest pain, dyspnoea
  - Tachypnoea, cyanosis, altered mentation

Moderate
Pneumonia with no signs of severe disease
RR ≥ 24/ min, SPO2 ≤ 94 % on Room Air

- Admit in ICU/HDU
- Oxygen Support through nasal cannulae
- Target SpO2: 92-96% (88-92% in COPD).
- Awake proning as a rescue therapy.
- All patients should have daily 12-lead ECG
- Follow CRP, D-dimer & Ferritin, Fibrinogen, Procalcitonin every 48-72 hourly; CBC, KFT/LFT daily
- Inj. Remdesevir 200 mg IV on Day 1 followed by 100mg OD for 4 days
- Consider IV methylprednisolone 0.5 - 1 mg/kg or dexamethasone 0.1- 0.2 mg/kg for 3-5 days (within 48 hours of admission or if oxygen requirement is increasing and if inflammatory markers are increased)
- Prophylactic dose of UFH[2] or LMWH[2] (e.g., enoxaparin 40 mg per day SC)
- Inj. Thiamine 100 mg IV OD, Inj. Vit C 1.5gm IV 6 hourly
- Antibiotics if suspecting infection according to llocal policy
- Control of co-morbid condition.
- **Monitor for: Increased WOB, Hemodynamic instability , Increase in oxygen requirement**

Severe
Respiratory distress requiring assisted vent.
RR ≥ 30/min, SPO2 ≤ 90% on Room Air

- Cautious trial of CPAP/NIV, HFNC to avoid intubation
- Inj. Remdesevir 200 mg IV on Day 1 followed by 100mg OD for 4 days
- IV methylprednisolone 1.0 to 2 mg/kg or dexamethasone 0.1- 0.2 mg/kg for 5-7 days if not already given
- Therapeutic dose of UFH or LMWH (after excluding coagulopathy or thrombocytopenia or high risk of bleeding[3]
- Inj. Thiamine 100 mg IV OD, Inj. Vit C 1.5gm IV 6 hourly
- Monitor inflammatory markers daily
- ** Inj. Tocilizumab or Methylprednisolone pulse for Mx of Cytokine storm and ARDS (Off Label, Individualise))
- Mechanical ventilation if unable to maintain saturation, increased work of breathing or development of hemodynamic instability
  - Conventional ARDS Net strategy
  - Proning, recruitment manoeuvres
- Management of septic shock as per SSC guidelines and local antibiotic policy
- Convalescent Plasma (Under Trial Setting) or rescue therapy on compassionate grounds

Testing
While attending suspect case as per above protocol based on clinical assessment, testing shall be resorted to and if negative—manage in Non-Covid facility according to clinical diagnosis

Discharge
After clinical improvement, discharge according to state discharge policy

1. High risk patients for Severe Disease
   - Age > 60 years
   - HTN, Diabetes Mellitus and other immunocompromising conditions.
   - Chronic lung, kidney or liver disease
   - Cerebrovascular disease
   - Obesity BMI > 25 kg/m^2

2. LMWH: Low Molecular Weight Heparin: if no contraindication or high risk of bleeding: UFH: Unfractionated Heparin
3. Risk of Bleeding: Use validated score for assessing bleeding risk (e.g. HAS-BLED Score), Use D-Dimer and SIC for further risk stratification (SIC score ≥ 24 portends high thrombotic risk)

* **Apply Emergency Severity Index (ESI): ESI: 1-2—Unstable, ESI: 3—Borderline, ESI: 4-5—Stable**
\# **Nasopharyngeal/Oropharyngeal Swab**
** **Informed consent mandatory before use of off label drugs.**

Source: MoHFW/ICMR