QUICK GUIDE FOR MANAGEMENT OF PATIENTS WITH COVID19: HOSPITALIST GUIDE + INITIAL WORK-UP

FIRST STEPS: *use interpreter phone if English is not first language*

- At admission: HCP form +/- MOLST filled out and updated
- Attending to discuss realistic goals re. intubation and CPR
- Check baseline EKG

LAB WORK-UP:

- Covid19 PCR testing (Biothreats p#30331) + Rapid viral panel

At admission →	CBC with differential, BMP, Magnesium, CRP, LFT, CPK, LDH, PTT, INR procalcitonin, troponin, NT-proBNP, d-dimer, soluble IL2 receptor
Daily →	CBC with differential, BMP, Magnesium If patient is in ICU add: troponin, CPK
Every other day →	LFT, CPK, troponin, CRP, LDH, d-dimer, fibrinogen, PTT, INR, (If on propofol also: triglyceride)
2x per week →	soluble IL2 receptor
If clinically worse →	LFT, CPK, troponin, CRP, procalcitonin, LDH, ferritin, d-dimer, fibrinogen, PTT, INR

LAB RESULTS TO EXPECT: *potential marker of disease severity

Normal WBC	Elevated AST*/ALT*
Lymphopenia*	Elevated CRP*
Mild thrombocytopenia	Elevated LDH*
BMP with elevated Cr	Elevated d-dimer*
Normal procalcitonin	Elevated troponin*

RESPIRATORY CARE: See Respiratory Failure Quick Guide for details
Titrate 1-6L/min NC for goal SpO2 92 - 96% or PaO2 >75
Call Respiratory Therapy if requiring >6L/min: trial venturi or oximyzer
COVID ICU Triage (p39999) @ oximyzer 10L/min or venturi FiO2 50%
****if respiratory decompensation or rapid increase in FiO2 call COVID airway pager 39265 for intubation****

ISOLATION: Remember these basics for covid + or rule-out patients

- Contact (gown + gloves) +Droplet (mask + eye protection)
- If aerosolizing procedure or ICU patient use N95 mask
- Aerosolizing procedures in negative pressure room only
- Avoid unnecessary aerosolizing procedures e.g. nebulization (switch to inhalers), high flow nasal canula, non-invasive ventilation (CPAP, BiPAP)
- OK to continue chronic night-time non-invasive ventilation, switch to BWH mask + machine because less aerosol risk

CONSULTS to CALL: Upfront consults or when to call

- INFECTIOUS DISEASE → on ALL patients (discuss therapies)
- ANESTHESIOLOGY → if @6L/min NC or rapidly increasing FiO2
- RESPIRATORY THERAPY → if requiring 6L/min NC O2
- ICU TRIAGE → @6L/min NC or if concern for clinical worsening
- CARDIOLOGY → if concern for new heart failure, ACS, VT/VF, or cardiogenic shock
- ONCOLOGY → call primary oncologist at time of admission

INITIAL MANAGEMENT CONSIDERATIONS:

CT chest:	NOT necessary for diagnosis, recommend minimizing use of CT given challenges with isolation and transport
Daily CXR:	NOT necessary unless it will change management plan
IV fluids:	Conservative fluid management is important to mitigate risk of progression of respiratory failure
Steroids:	Avoid using empirically, only use if other indication
Antibiotics:	Follow BWH guidelines for empiric antibiosis based on patient risk factors, talk to ID consult about concerns
Code Blue:	For covid + or covid rule-out, tell page operator this is covid patient; use normal protocol for donning of PPE prior to entering room, even if this delays CPR.

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To check for the most up to date recommendations, please visit the full manual or use the QR code here →
For urgent questions please consult the BWH ICU triage pager (#39999)

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