



MASSACHUSETTS GENERAL HOSPITAL

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Frequently Asked Questions for COVID Management Support Document

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1) Which patients should I start on hydroxychloroquine (HCQ)?

Hydroxychloroquine is not a proven therapy for COVID-19 and we strongly recommend referral to clinical trials as first line for all patients. HCQ may be used on a case-by-case basis only for those who are not eligible for a clinical trial or when clinical trial enrollment is not feasible. If HCQ is to be used, we would only recommend considering it for hospitalized patients with Category 2 or 3 risk factors for COVID disease progression (see main guidance document). This includes individuals with vital sign or significant laboratory abnormalities. **Please discuss HCQ initiation questions with the ID COVID Advice Team 8am-8pm.**

Azithromycin is not proven to be an adjunctive therapy with HCQ for COVID-19. Only start if there are other indications for azithromycin (see Q#5 below).

2) Should hydroxychloroquine be given for longer than 5-days?

We recommend against giving hydroxychloroquine for longer than 5 days or at a higher dose than the standard dose of 400 mg q12hours x2 doses, then 400mg daily for 4 additional



days (5-days total, unless discharged from hospital). The half-life of hydroxychloroquine is > 3 weeks. Longer durations may place patients at risk for toxicity without known added benefit for treatment of COVID-19.

3) What is the QTc?

The QTc is an interval on an electrocardiogram (ECG) measured in milliseconds. A normal QTc is ≤ 470 ms for males and ≤ 480 ms for females. A prolonged QTc may place a patient at a higher risk for an abnormal cardiac rhythm. Certain drugs prolong QTc, and therefore QTc needs to be monitored closely.

All COVID-19 patients starting on hydroxychloroquine should have a baseline ECG. If they have a prolonged QTc at baseline (particularly if QTc > 500 ms), then hydroxychloroquine should not be started without talking with a cardiologist.

4) How to monitor QTc?

Please refer to guidance document on [QTc monitoring](#).

5) Should antibiotics be started on my patient?

We do not recommend starting antibiotics on all patients with confirmed COVID-19. It can be considered on a case by case basis if the primary care team is worried about bacterial superinfection or if the diagnosis of COVID-19 is not clear. If the COVID-19 diagnosis is clear or highly suspected and imaging is characteristic, this favors observation off antibiotics.

If started because the diagnosis is not clear or because of lobar infiltrate, ceftriaxone (IV 1 g daily) with doxycycline (100 mg PO BID) or azithromycin (500 mg x1, then 250 mg daily x4 days) are standard empiric treatments for bacterial community acquired pneumonia. Doxycycline is preferred over azithromycin as of 4/10/2020 to reduce the need for QTc monitoring. Azithromycin is preferred over doxycycline for pregnant patients or **patients unable to remain upright for 30 minutes to prevent pill esophagitis**. Whether antibacterial agents should be continued may be reassessed on a daily basis.

We do not recommend empiric addition of azithromycin to HCQ for patients with COVID-19. There are no good data supporting the role of azithromycin for COVID-19 at this time and both agents prolong QTc and put patients at risk for cardiac arrhythmias.

A procalcitonin < 0.20 ng/mL is most consistent with a viral pneumonia. In COVID-19 a higher pro-calcitonin does not necessarily indicate a bacterial pneumonia, although it is reasonable to try to obtain a sputum culture for these patients and some may warrant antibiotics.

6) Can I give steroids to my patient with asthma or COPD?

We currently do not recommend routine steroid administration for COVID patients. However, those with other indications for steroids (including COPD and asthma exacerbations)



can receive the usual steroid regimen for these issues. In general wheezing seems to be unusual for COVID alone and should raise suspicion for a concomitant condition such as asthma or COPD (which might require steroids). The pulmonary service is available to consult on patients with lung disease and COVID-19.

7) For which patients should I order a procalcitonin?

Procalcitonin does not have to be ordered routinely on all patients with COVID-19. Procalcitonin is a serum biomarker that has some utility in distinguishing viral from bacterial infections, particularly of the lower respiratory tract. From COVID studies to date, procalcitonin seems to remain low in the first 7-10 days of symptoms and can rise later on, even without bacterial superinfection.

It may be helpful in at least 2 situations: first, if a patient with COVID-19 is presenting with a short duration of symptoms and there is concern for possible bacterial pneumonia, a low value would be reassuring at that point in terms of not requiring systemic antibiotics. Additionally, if a patient has clinical progression or worsening a low value (< 0.25) in the setting of clinical deterioration would make bacterial superinfection less likely. However, a higher value has less specificity later in the disease course as they could be consistent with either progressive COVID or bacterial superinfection. Please see [FLARE from April 9](#) on this topic.

8) What are the guidelines indications for stating a statin?

Patients with guidelines indications for statins include those with known coronary artery disease, those with hyperlipidemia with an ACC/AHA 10-year risk score > 10% (see online calculator for: Cardiovascular risk assessment in adults 10-year, ACC/AHA 2013) and those with diabetes. Additional risk factors for cardiovascular disease where statins may be considered include hypertension, cigarette smoking, premature family history of CVD, chronic kidney disease, obesity, and people living with HIV or other chronic infections. A risk calculator is found at this website: <http://tools.acc.org/ASCVD-Risk-Estimator-Plus/#!/calculate/estimate/>. EPIC also has dotphrases: .ascvdrisk or .ascvd2018.

9) How to find an active COVID-19 treatment clinical trial at MGH?

COVID-19 treatment trials are being updated on a daily basis. Study teams are constantly searching the list of active COVID-19 patients for patients to enroll and will approach the primary clinical team if they think your patient is a good candidate. If you think your patient is a candidate for a specific trial and have not heard from the study team, please reach out to the clinical trial coordinator for your floor. The updated list with active trials is found on the Apollo website under the Clinical Trials tab.



10) How do I know if my patient with COVID is ready for discharge?

There are no universal discharge criteria for patients with COVID. We recommend cases be considered on an individual basis by primary care teams.

We recommend looking at:

- [MGH COVID Floor Operations](#)
- University of Washington's "Home Discharge Checklist for Patients with COVID19" at <https://covid-19.uwmedicine.org/Pages/default.aspx>.
- In general, we recommend that patients have a general trend of clinical improvement and be off supplemental oxygen (or on their baseline amount of O2), with improving laboratory studies.

As of April 21, 2020, all patients discharged from MGH are eligible for mobile cardiac telemetry (MCT). On day of discharge planning just "HOLTER LAB" (pager 20017) with patient identifier and the Cardiac Arrhythmia service will arrange for MCT.

11) What do I do with hydroxychloroquine or other medications started for COVID for patients discharged before they complete their course?

Hydroxychloroquine should be discontinued at the time of discharge, because the patient is improving, HCQ has a long half-life, and there is no established duration. If the suspicion for bacterial superinfection is low, antibiotics such as ceftriaxone and/or azithromycin may also be discontinued.

12) What should I do about statins that were started in the hospital for patients with COVID?

If a patient has a primary care provider and a good follow up plan, statins can be continued after discharge, if the primary care team communicates the plan with the patient's primary care provider.

More questions? The Biothreats Inpatient COVID Management Advice, MGH (CAT) is available 8am to 8pm to answer questions (pager 26926).