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**PRESENTATION**

**NOTABLE SX**
- ~65-80% Cough
- ~45% Febrile initially
- ~15% URI Sx
- Anosmia
- Acute worsening after early mild sx

**INCREASED RISK FOR SEVERE DZ**
- Age >50
- Comorbid diseases:
  - Cardiac, pulm, renal
  - Diabetes, HTN
  - Immunocompromise

**LABS INDICATING SEVERE DZ**
- Elevated D-dimer, CPK, ferritin, trop
- LDH >245, CRP > 100
- Abs lymphocyte count <0.8

**DIAGNOSTICS**

**DAILY LABS**
- CBC with diff (esp. lymphocyte ct)
- CMP
- CK
- D-dimer

**MONITOR FOR WORSENING DISEASE OR DRUG TOXICITY PRN**
- Triglycerides
- Ferritin
- EKG
- CPK
- LFTs
- Trop

**ONE TIME TEST FOR ALL PTS**
- Tracheal aspirate if intubated
- Additional tests for trial enrollment as needed
- Additional testing per ID guidance

**RESPIRATORY FAILURE**

**Transfer to ICU for HFNC vs Intubation**

**Monitor RR, WOB, FI02, O2 Flow**

**CONSIDER EARLY INTUBATION IF FAIL TO IMPROVE ON HFNC**

**LUNG PROTECTIVE VENTILATION**
- Vt 4-6 ml/kg predicted body weight
- Plateau pressure <30
- Driving pressure (Pplat-PEEP) <15
- Target SaO2 90-96%, PaO2>60
- Starting PEEP 8-10 cmH20

**CONSERVATIVE FLUID STRATEGY**
- Post resuscitation: diuresis as tolerated by hemodynamics/Creat, No maintenance fluids

**PEEP TITRATION**
- ARDSnet low PEEP table
- Best PEEP considered w/ ICU attending input

**PRONE**
- Early if cont. hypoxemia (P:F<150) or elevated driving/plateau pressure
- Supine ~qAM, longer proning duration allowed

**ADDITIONAL THERAPIES**
- Paralytics for vent dysynchrony, not routine
- Inhaled NO (no epoprostenol)

**ECMO CONSULT**
if continued hypoxemia or elevated airway pressures

**PATIENCE**
Anticipate possible prolonged intubation

**HEMODYNAMICS**

- Norepinephrine first choice pressor
- IF WORSENING:
  - ? myocarditis-cardiogenic shock
  - Check POCUS, EKG, TTE
  - ? Intestinal ischemia
    Consider imaging/surgical consult

**USUAL CARE**

- Empiric abx per usual approach
- Sedation PRN vent synchrony
- Daily SAT/SBT when appropriate
- ABCDEF Bundle

**CHANGE TO USUAL CARE**

- No routine daily CXR
- VTE PROPHYLAXIS as per hematology guidelines
- MINIMIZE staff contact in room
- BUNDLE bedside procedures
- AVOID nebs, prefer MDIs
- Appropriate guideline-based isolation for aerosol generating procedures including intubation/extubation

**THERAPEUTICS**

- Remdesivir
- Dexamethasone in patients on oxygen or vent and <14 days from ARDS onset
- Consider Tocilizumab if CRP > 75 mg/L on steroids not improving, and no contraindications (immunosupression, infection)
- No benefit to hydroxychloroquine, high dose vitamins or ivermectin specifically for COVID-19

**PAGER NUMBERS**

<table>
<thead>
<tr>
<th>ICU CONSULT:26955</th>
<th>ECMO:29151</th>
<th>BIOTHREATS:26876</th>
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</thead>
</table>

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