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**PRESENTATION**

**NOTABLE SX**
- ~65-80% Cough
- ~45% Febrile initially
- ~15% URI Sx
- ~10% GI Sx
- Anosmia
- Acute worsening after early mild sx

**INCREASED RISK FOR SEVERE DZ**
- Age >55
- Comorbid diseases:
  - Cardiac, pulm, renal
  - Diabetes, HTN
  - Immunocompromise

**LABS INDICATING SEVERE DZ**
- Elevated D-dimer
- LDH >245
- Abs lymphocyte count <0.8

**DIAGNOSTICS**

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

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

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

**RESPIRATORY FAILURE**

**CONSIDER EARLY INTUBATION IN ICU**

**WARNING SIGNS:** Inc FiO2, Dec SaO2, CXR worse

**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

**THERAPEUTICS**

**HEMODYNAMICS**
- Norepinephrine first choice pressor
- IF WORSENING:
  - ? myocarditis/cardiogenic shock
  - Obtain POCUS, EKG, trop, lactate, CVO2 (formal TTE if high concern)

**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
- HIGH THRESHOLD for bronchoscopy
- HIGH THRESHOLD to travel
- BUNDLE bedside procedures
- AVOID nebs, prefer MDIs
- Appropriate guideline-based isolation for aerosol generating procedures including intubation/extubation

**ALL ICU ADMISSIONS**
- Clinical trial enrollment if eligible
- Examples of investigational tx:
  - Remdesivir
  - Hydroxychloroquine
  - Tocilizumab
- NO ROUTINE STEROIDS for COVID-19, consider in s/o additional indication

**PATIENCE**
- Anticipate possible prolonged intubation

**PAGER NUMBERS**
- ICU CONSULT: 26955
- ECMO: 29151
- BIOTHREATS: 26876

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A living document by Division of Pulmonary and Critical Care in collaboration with the Dept. of Anesthesia, Critical Care, and Pain Medicine, Division of Cardiology, and Respiratory Care. May be updated or modified as situation evolves.

Version created 4/14/20