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HOW TO MANAGE THE NON-CRITICAL COVID-19 INPATIENT: PRACTICAL TIPS AND EXPERT Q&A

Webinar recording: **April 28, 2020**
URL: https://ubccpd.ca/how-manage-non-critical-covid-19-inpatient-practical-tips-and-expert-qa

Disclaimer: Information on COVID-19 is changing rapidly and much of the research is preliminary. Assessment and management protocols are suggestions only; they do not take the place of clinical judgement. Please check with your own health authorities and local medical health officers as policies and support for the suggested approaches to patient care may vary between regions.

This summary was prepared by Dr. Simon Moore and the speakers.

Webinar Summary

Brief Summary of Clinical Pearls

- **High D-Dimer? Increase anticoagulant dose**
  Though not all patients with COVID-19 have a positive D-dimer, consider increasing the DVT prophylaxis dose in COVID-19 patients with a high D-dimer.
  Note: Anticoagulation dose information is available at http://www.bccdc.ca/Health-Professionals-Site/Documents/Guidelines_Unproven_Therapies_COVID-19.pdf

- **Always consider COVID-19…**
  COVID-19 may have atypical presentations (neurologic, dermatologic). When community transmission rates are high, consider screening more patients.

- **…but it is not always COVID-19.**
  Other diseases can present similarly to COVID-19 with shortness of breath, cough, and fever. In BC, CT scan is not used to diagnose COVID-19 (as it has been used in other regions). As is the

case with bedside ultrasound, it is not used to diagnose COVID-19 but it can be used to rule out other causes of the patient's symptoms.

- **The test is imperfect**
  Reported sensitivity of the nasal swab PCR is 60-70%. This is a rule-in test, not a rule-out test! In patients in whom pre-test probability is moderate or high and the test is negative, repeat testing, alternative diagnostic modalities (imaging, sputum PCR, etc.), and continued isolation are warranted.

- **Know the three phases of COVID-19**
  Be cognizant of the proposed bi-phasic disease model, and patients typically deteriorate during the pulmonary or immune hyperactivation phases of the disease. Lab markers such as CRP, D-dimer, fibrinogen, ferritin, transaminases, and troponin may all be normal in sick patients, but may clarify your patient's position on the disease trajectory. This is available in a chart format at https://marlin-prod.literatumonline.com/cms/attachment/16b6c896-8d57-4844-b6f6-18192a215304/gr1_lrg.jpg (see Disclaimer above)

- **Creative approaches can reduce exposure**
  Use innovative ways of managing hospital inpatients to reduce disease exposure and transmission. For example, videoconference rounds with physician & patients if safe and possible, or limit dosing frequency / giving all medications in the evening when possible.

- **Creative positioning can improve oxygenation**
  Prone positioning, which has been used in ICUs for acute respiratory distress syndrome for several years, has been found beneficial in COVID-19. As well, awake patients may improve hypoxemia by being placed in the prone position.

- **Rural and requiring hospitalization? Think about transfer**
  Patients in urban hospitals that do not have an ICU are typically transferred to a hospital for an ICU. If a patient with COVID-19 in a rural area requires hospital admission, early transfer should be considered due to the risk of rapid deterioration.

- **Our knowledge is constantly evolving**
  Things we believe this week may turn out to be incorrect a month or two down the road. We are all doing the best we can with the knowledge we have at this moment. Staying up to date on the literature and latest recommendations is crucial as things are still rapidly evolving; as is, having an open mind and being ready to admit that you were wrong!

End of Life Care Tips for COVID-19 Patients

- Current cohorting plans in some regions exclude transporting end of life patients. As the elderly are more often symptomatically affected, it may be the most common management most physicians will provide.
- Early, Clear discussions about goals of care and conversations are key
- Treat dyspnea, not O_2 saturation
- Fans (low flow air across face for subjective dyspnea, used commonly in palliative care) unfortunately are not ideal due to theoretical potential for viral spread
- Opiates (morphine or hydromorphone) oral or subcutaneous for subjective dyspnea, increase dosing by 25% if not opiate naïve
- Use PRNs liberally
- Benzos (lorazepam → midazolam) for anxiety
- For difficult to manage agitation trial levomepromazine
- Most of above agents are available in most places

Resources

- **Symptom Management for Adult Patients with COIVD-19 Receiving end-of-life supportive care outside of the ICU:** https://med-fom-fpit.sites.olt.ubc.ca/files/2020/03/End-of-Life-Symptom-Management-COVID-19.pdf
- **Centre for Disease Control:** https://www.cdc.gov/coronavirus/2019-nCoV/index.html
- **EMCrit Internet Book of Critical Care – COVID-19:** https://emcrit.org/ibcc/covid19/
- **Canadian Association of Emergency Physicians:** https://caep.ca/covid-19/
- **LitCOVID: central hub for new COVID literature**: https://www.ncbi.nlm.nih.gov/research/coronavirus/
- **Viruswatch podcast** - currently available on VCH intranet and Slack; soon to come to iTunes/public domain

Thanks to the speakers on the video:

- **Dr. Satpal Dhillon**, Hospitalist – Nanaimo Regional General Hospital
- **Dr. Sayeeda Hudani**, Hospitalist – Royal Columbian Hospital
- **Dr. Katie Wiskar,** General Internal Medicine – Vancouver General Hospital
- **Dr. Simon Moore (moderator)**, Family Physician