IMA TNSB COVID UPDATE-29.04.2021

1. REQUIREMENTS FOR COVID CARE CENTERS:

1.1. The COVID Care Centers shall offer care only for cases that have been clinically assigned as mild or very mild cases or COVID suspect cases.

1.2. The COVID Care Centers are makeshift facilities. These may be set up in hostels, hotels, schools, stadiums, lodges etc., both public and private. If need be, existing quarantine facilities could also be converted into COVID Care Centers. Functional hospitals like CHCs, etc, which may be handling regular, non-COVID cases should be designated as COVID Care Centers as a last resort. This is important as essential non COVID Medical services like those for pregnant women, newborns etc, are to be maintained.

1.3. Wherever a COVID Care Center is designated for admitting both the confirmed and the suspected cases, these facilities must have separate areas for suspected and confirmed cases with preferably separate entry and exit. Suspect and confirmed cases must not be allowed to mix under any circumstances.

1.4. As far as possible, wherever suspect cases are admitted in the COVID Care Center, preferably individual rooms should be assigned for such cases.

1.5. Every Dedicated COVID Care Centre must necessarily be mapped to one or more Dedicated COVID Health Centres and at least one Dedicated COVID Hospital for referral purpose (details All suspect cases (irrespective of severity of their disease) will be tested for COVID-19. Further management of these cases will depend on their (i) clinical status and (ii) result of COVID-19 testing. All three types of facilities will be linked to the Surveillance team (IDSP) All these facilities will follow strict infection prevention and control practices All the selected facilities must be dedicated for COVID management. Three types of COVID dedicated facilities are proposed in this document. All 3 types of COVID Dedicated facilities will have separate ear marked areas for suspect and confirmed cases. Suspect and confirmed cases should not be allowed to mix under any circumstances. Guiding principles given below).

1.6. Every Dedicated COVID Care Centre must also have a dedicated Basic Life Support Ambulance (BLSA) equipped with sufficient oxygen support on 24x7 basis, for ensuring safe transport of a case to Dedicated higher facilities if the symptoms progress from mild to moderate or severe.

1.7. The human resource to man these Care Centre facilities may also be drawn from AYUSH doctors. Training protocols developed by AIIMS is uploaded on MoHFW website. Ministry of AYUSH has also carried out training sessions. The State AYUSH Secretary/ Director should be involved in this deployment. State wise details of trained AYUSH doctors has been shared with the States. Their work can be guided by an Allopathic doctor.

2. REQUIREMENTS FOR Dedicated COVID Health Centre (DCHC):

2.1. The Dedicated COVID Health Centre are hospitals that shall offer care for all cases that have been clinically assigned as moderate.

2.2. These should either be a full hospital or a separate block in a hospital with preferably separate entry\exit/zoning.

2.3. Private hospitals may also be designated as COVID Dedicated Health Centres.
2.4. Wherever a Dedicated COVID Health Center is designated for admitting both the confirmed and the suspect cases with moderate symptoms, these hospitals must have separate areas for suspect and confirmed cases. Suspect and confirmed cases must not be allowed to mix under any circumstances.

2.5. These hospitals would have beds with assured Oxygen support.
2.6. Every Dedicated COVID Health Centre must necessarily be mapped to one or more Dedicated COVID Hospitals.

2.7. Every DCHC must also have a dedicated Basic Life Support Ambulance (BLSA) equipped with sufficient oxygen support for ensuring safe transport of a case to a Dedicated COVID Hospital if the symptoms progress from moderate to severe.

3. REQUIREMENTS FOR Dedicated COVID Hospital (DCH):

3.1. The Dedicated COVID Hospitals are hospitals that shall offer comprehensive care primarily for those who have been clinically assigned as severe.
3.2. The Dedicated COVID Hospitals should either be a full hospital or a separate block in a hospital with preferably separate entry\exit.

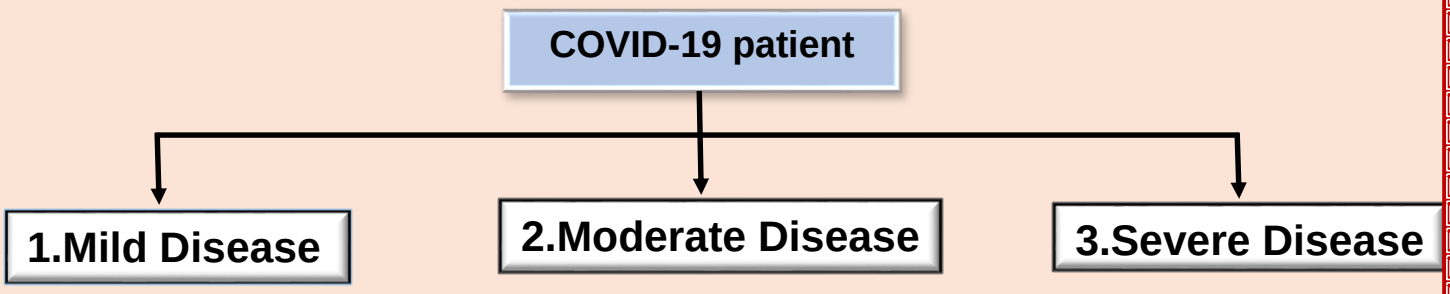
3.3. Private hospitals may also be designated as COVID Dedicated Hospitals.
3.4. These hospitals would have fully equipped ICUs, Ventilators and beds with assured Oxygen support.

3.5. These hospitals will have separate areas for suspect and confirmed cases. Suspect and confirmed cases should not be allowed to mix under any circumstances.
3.6. The Dedicated COVID Hospitals would also be referral centers for the Dedicated COVID Health Centers and the COVID Care Centers.

All these facilities will follow strict infection prevention and control practices.

AIIMS/ ICMR-COVID-19 National Task Force/Joint Monitoring Group (Dte.GHS)
Ministry of Health & Family Welfare, Govt. of India

CLINICAL GUIDANCE FOR MANAGEMENT OF ADULT COVID-19 PATIENTS - 22nd April 2021



1. Mild Disease:

Upper respiratory tract symptoms (&/or fever) WITHOUT shortness of breath or hypoxia.

Home Isolation & Care:

MUST DOs:

- ✓ Physical distancing, indoor mask use, strict hand hygiene.
- ✓ Symptomatic management (hydration, anti-pyretics, antitussive, multivitamins).
- ✓ Stay in contact with treating physician.
- ✓ Monitor temperature and oxygen saturation (by applying a SpO2 probe to fingers).

Seek immediate medical attention if:

- ✓ Difficulty in breathing
- ✓ High grade fever/severe cough, particularly if lasting for >5 days
- ✓ A low threshold to be kept for those with any of the high-risk features*

MAY DOs:

Therapies based on low certainty of evidence:

- ➢ Tab Ivermectin (200 mcg/kg once a day for 3 days). Avoid in pregnant and lactating women.

OR

- ➢ Tab HCQ (400 mg BD for 1 day f/b 400 mg OD for 4 days) unless contraindicated.
- ❖ Inhalational Budesonide (given via Metered dose inhaler/ Drypowder inhaler) at a dose of 800 mcg BD for 5 days) to be given if symptoms (fever and/or cough) are persistent beyond 5 days of disease onset.

2. Moderate disease:

Any one of:

1. Respiratory rate > 24/min, breathlessness
2. SpO2: 90% to < 93% on room air

ADMIT IN WARD:

Oxygen Support:

- Target SpO2: 92-96% (88-92% in patients with COPD).
- Preferred devices for oxygenation: non-rebreathing face mask.
- Awake proning encouraged in all patients requiring supplemental oxygen therapy (sequential position changes every 2 hours).

Anti-inflammatory or immunomodulatory therapy:

- Inj. Methylprednisolone 0.5 to 1 mg/kg in 2 divided doses (or an equivalent dose of dexamethasone) usually for a duration of 5 to 10 days.
- Patients may be initiated or switched to oral route if stable and/or improving.

Anticoagulation:

- Conventional dose prophylactic unfractionated heparin or Low Molecular Weight Heparin (weight based e.g., enoxaparin 0.5mg/kg per day SC). There should be no contraindication or high risk of bleeding.

Monitoring:

- Clinical Monitoring: Work of breathing, Hemodynamic instability, Change in oxygen requirement.
- Serial CXR; HRCT chest to be done ONLY If there is worsening.
- Lab monitoring: CRP and D-dimer 48 to 72 hrly; CBC, KFT, LFT 24 to 48 hrly; IL-6 levels to be done if deteriorating (subject to availability).

After clinical improvement, discharge as per revised discharge criteria. (Refer page no. 6-7)

3. Severe Disease:

Any one of:

1. Respiratory rate >30/min, breathlessness
2. SpO2 < 90% on room air

ADMIT IN ICU:

Respiratory support:

- Consider use of NIV (Helmet or face mask interface depending on availability) in patients with increasing oxygen requirement, if work of breathing is LOW.
- Consider use of HFNC in patients with increasing oxygen requirement.
- Intubation should be prioritized in patients with high work of breathing /if NIV is not tolerated.
- Use conventional ARDSnet protocol for ventilator management.

Anti-inflammatory or immunomodulatory therapy:

- Inj. Methylprednisolone 1 to 2mg/kg IV in 2 divided doses (or an equivalent dose of dexamethasone) usually for a duration 5 to 10 days.

Anticoagulation:

- Weight based intermediate dose prophylactic unfractionated heparin or Low Molecular Weight Heparin (e.g., Enoxaparin 0.5mg/kg per dose SC BD).
- There should be no contraindication or high risk of bleeding.

Supportive measures:

- Maintain euvolemia (if available, use dynamic measures for assessing fluid responsiveness).
- If sepsis/septic shock: manage as per existing protocol and local antibiogram.

Monitoring:

- Serial CXR; HRCT chest to be done ONLY if there is worsening.
- Lab monitoring: CRP and D-dimer 24-48 hourly; CBC, KFT, LFT daily; IL-6 to be done if deteriorating (subject to availability).

After clinical improvement, discharge as per revised discharge criteria. (Refer page no. 6-7)

***High-risk for severe disease or mortality**

- ✓ Age > 60 years
- ✓ Cardiovascular disease, hypertension, and CAD
- ✓ DM (Diabetes mellitus) and other immunocompromised states
- ✓ Chronic lung/kidney/liver disease
- ✓ Cerebrovascular disease
- ✓ Obesity

EUA/Off label use (based on limited available evidence and only in specific circumstances):

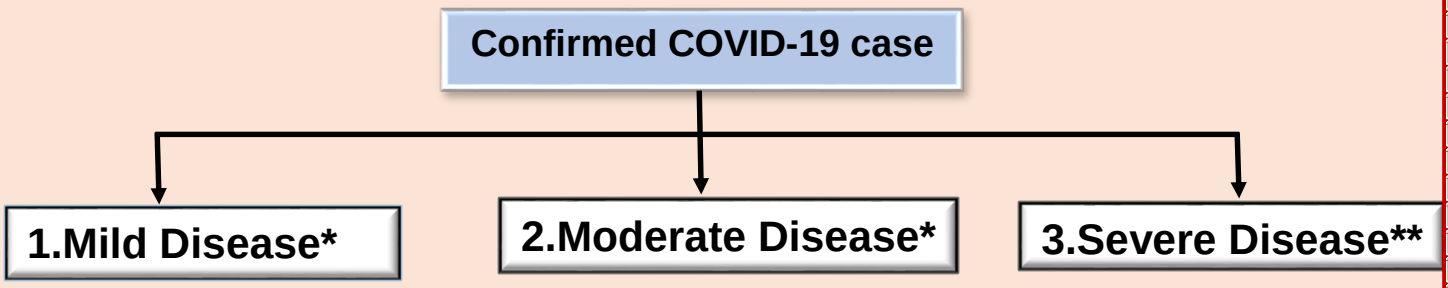
- **Remdesivir (EUA)** may be considered ONLY in patients with
- ✓ Moderate to severe disease (requiring SUPPLEMENTAL OXYGEN), AND
- ✓ No renal or hepatic dysfunction (eGFR <30 ml/min/m2; AST/ALT >5 times ULN (Not an absolute contradiction), AND
- ✓ Who are within 10 days of onset of symptom/s.
  - ❖ Recommended dose: 200 mg IV on day 1 f/b 100 mg IV OD for next 4 days.
- ✓ Not to be used in patients who are NOT on oxygen support or in home settings

- **Tocilizumab (Off-label)** may be considered when ALL OF THE BELOW CRITERIA ARE MET
- ✓ Presence of severe disease (preferably within 24 to 48 hours of onset of severe disease/ICU admission).
- ✓ Significantly raised inflammatory markers (CRP &/or IL-6).
- ✓ Not improving despite use of steroids.
- ✓ No active bacterial/fungal/tubercular infection.
- ✓ ❖ Recommended single dose: 4 to 6 mg/kg (400 mg in 60kg adult) in 100 ml NS over 1 hour.

- **Convalescent plasma (Off label)** may be considered ONLY WHEN FOLLOWING CRITERIA ARE MET
- ✓ Early moderate disease (preferably within 7 days of symptom onset, no use after 7 days).
- ✓ Availability of high titre donor plasma (Signal to cut-off ratio (S/O) >3.5 or equivalent depending on the test kit being used).

Revised Discharge Policy for COVID-19

The revised discharge policy is aligned with the guidelines on the 3 tier COVID facilities and the categorization of the patients based on clinical severity (Available at: https://www.mohfw.gov.in/pdf/FinalGuidanceonMangaementofCovidcasesversion2.pdf)



1. Mild/very mild/pre-symptomatic cases

- ✓ Mild/very mild/pre-symptomatic cases admitted to a COVID Care Facility will undergo regular temperature and pulse oximetry monitoring. The patient can be discharged after 10 days of symptom onset and no fever for 3 days. There will be no need for testing prior to discharge.
- ✓ At the time of discharge, the patient will be advised to isolate himself at home and self-monitor their health for further 7 days.
- ✓ At any point of time, prior to discharge from CCC, if the oxygen saturation dips below 95%, patient is moved to Dedicated COVID Health Centre (DCHC).
- ✓ After discharge from the facility, if he/she again develops symptoms of fever, cough or breathing difficulty he will contact the COVID Care Centre or State helpline or 1075. His/her health will again be followed up through tele-conference on 14th day.

2. Moderate cases admitted to Dedicated COVID Health Centre (Oxygen beds)

2.1. Patients whose symptoms resolve within 3 days and maintains saturation above 95% for the next 4 days

Cases clinically classified as “moderate cases” will undergo monitoring of body temperature and oxygen saturation. If the fever resolve within 3 days and the patient maintains saturation above 95% for the next 4 days (without oxygen support), such patient will be discharged after 10 days of symptom onset in case of:

- ✓ Absence of fever without antipyretics
- ✓ Resolution of breathlessness
- ✓ No oxygen requirement

There will be no need for testing prior to discharge.

At the time of discharge, the patient will be advised to isolate himself at home and self-monitor their health for further 7 days.

2.2. Patient on Oxygenation whose fever does not resolve within 3 days and demand of oxygen therapy continues

Such patients will be discharged only after

- ✓ Resolution of clinical symptoms.
- ✓ Ability to maintain oxygen saturation for 3 consecutive days.

3. Severe Cases including immunocompromised (HIV patients, transplant recipients, malignancy)

Discharge criteria for severe cases will be based on

- ✓ Clinical recovery
- ✓ Patient tested negative once by RT-PCR (after resolution of symptoms)

**Clinical categorization of patients as per guidelines.
(https://www.mohfw.gov.in/pdf/FinalGuidanceonMangaementofCovidcasesversion2.pdf)

Dr.P.Ramakrishnan
President IMA TNSB

Dr.A.K.Ravikumar
Hony.Secretary IMA TNSB