

# COVID-19 Emergency Department Treatment – January 21, 2021 1544

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## Introduction

High quality evidence from randomized controlled trials for therapies continues to evolve. Sources for information include the NIH, Centers for Disease Control and Prevention (CDC), Infectious Diseases Society of America (IDSA), Surviving Sepsis Campaign (SSC), and the World Health Organization (WHO).  
16,42,82,83,84,94

There is no current evidence to necessitate starting any medication in the ED (except for corticosteroids in the appropriate group) or to prescribe antibiotics or antiviral medication to patients with suspected COVID-19 who are being discharged home.

## Medication Summary

1. **Corticosteroids:** NIH recommends for patients requiring hospitalization and supplemental oxygen. IDSA recommends for patients requiring hospitalization and SpO<sub>2</sub> ≤94%. Dexamethasone dose is 6mg IV or PO. If dexamethasone is not available, equivalent doses include prednisone 40mg, methylprednisolone 32mg, hydrocortisone 160mg.
2. **Tocilizumab:** For select patients after admission per hospital algorithm.
3. **Convalescent plasma:** For select patients after admission per hospital algorithm or as part of clinical trial.
4. **Remdesivir:** For select patients after admission per hospital algorithm.
5. **Monoclonal antibodies:** Being provided to select discharged emergency department patients at high risk for compensation. Instructions to be considered for an appointment in the infusion center are automatically prepopulated on the discharge papers.
6. **Hydroxychloroquine +/- azithromycin:** NIH recommends against.
7. **Other antiviral agents:** NIH recommends against.
8. **Empiric antibiotics:** Not indicated unless evidence of bacterial co-infection.
9. **Other immunomodulatory and anti-inflammatory agents:** Not recommended except as part of a clinical trial or per hospital algorithm.
10. **Empiric anticoagulation:** Not recommended in the ED. Inpatients will receive prophylactic dosing

## Critical Care Considerations from the NIH

1. Norepinephrine is the first-choice vasopressor. Vasopressin and epinephrine can be used if norepinephrine is not available or is not sufficient.
2. For patients with worsening hypoxemia despite standard oxygen administration, high-flow nasal cannula (HFNC) is recommended over non-invasive positive pressure ventilation (NIPPV).
3. If HFNC is not available and intubation is not otherwise indicated, NIPPV can be used.
4. For patients with worsening hypoxemia despite HFNC or NIPPV in whom intubation is not yet otherwise indicated, try awake prone positioning.
5. For adult mechanically-ventilated patients with ARDS, use low tidal volume ventilation with 4-8ml/kg ideal body weight
6. In the **presence of shock** NIH and SSC recommend hemodynamic resuscitation similar to management of septic shock (balanced crystalloid resuscitation, optimal fluid volume is not yet known, with vasopressors as needed)

Reference: [COVID 19 Literature Bibliography.docx](#)