**4C Mortality Risk Score for Covid-19 Infection** <https://isaric4c.net/risk>

Use online calculator

**Co-morbidites**

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**Venothromoembolic Prophylaxis in Covid-19 Infection**

If platelets <50 or deranged clotting discuss with Haematology

* **Mild** ie no O2 requirement- Consider **Standard prophylactic dose LMWH**
* **Moderate/Severe -**on O2 but not ventilatory support.

 Assess **bleeding risk** (VTE-BLEED Algorithm -Microguide)

 If **Low risk** of bleeding (<2): Consider T**reatment dose LMWH** (weight based)

 If **High risk** of bleeding (≥2): Consider **Standard prophylactic dose LMWH**

* **Severe** & on ventilatory support- Consider **Intermediate dosing LMWH (5000units bd)**

Consider step up to intermediate dosing LMWH (based on weight) if previous on standard prophylaxis

 Consider step down to intermediate dosing LMWH (based on weight) if previous on treatment dose

 (unless clinical need for full anticoagulation)

 [The VTE-BLEED Algorithm (practical-haemostasis.com)](https://practical-haemostasis.com/Clinical%20Prediction%20Scores/Formulae%20code%20and%20formulae/Formulae/VTED_bleedng/vte_bleed_score.html)

<https://viewer.microguide.global/guide/1000000295#content,7f081fd3-6d95-403c-b65c-d5d5eb9f92ee>

**IV neutralising Monoclonal Antibodies (see Patient Admission & Management Summary & separate guidance Microguide)**

 

¥ ¥ Spike Covid Antibody interpretation:

If Immunocompetent or Immunosuppressed

>200 Positive – not for nMABS

<50 Negative – strongly consider giving nMABS

50 – 200 Intermediate, discuss with Consultant/Micro, especially if immunosuppressed

See NICE Covid-9 Rapid guideline: Managing Covid-19 (NG191) 3rd Nov 2021 <https://www.nice.org.uk/guidance/ng191>

& Microguide for detailed SFT guidance on managing all aspects Covid-19 infection CST/SLE 3rd Dec 2021v27 p2

**Covid-19 Pneumonia Management Pathway SFT \***

**Admission to Respiratory Care Unit (via RAZ/ward transfer)**

**If Pregnant alert the On call Obstetric Consultant/Labour Ward immediately**

**CXR – alternative diagnosis likely / unclear**

**Clinical Assessment – History/Examination/Risk factors for Covid19/Investigations (bloods/ECG)**

**Moderate Disease - Consider Remdesivir IV 5 days**

**if early stage of severe illness (≤10 days), on O2 and not requiring ventilatory support (See Microguide)**

**Do not give Dexamethasone**

**¥¥ Consider IV nMonoclonal Antibodies (even if well)**

**Be alert for ↑ O2 requirement**

**VTE Prophylaxis**

**Depends on disease severity, ventilatory support**

**& bleeding risk assessment (see below/ Microguide)**

**Mild Disease or (Incidental PCR +ve)**

**Supportive treatment,+/- IV fluids, nutrition, physio, standard VTE prophylaxis, +/- Antibiotics for CAP**

**¥¥ Send urgent blood for SARS-CoV-2 Spike Antibodies**

**Consider Tocilizumab 8mg/kg (max 800mg) IV**

**(or Sarilumab 400mg IV, platelets > 150) \*\*\***

**if requiring supplemental O2 & CRP ≥75 OR < 48hrs of requiring ventilatory support**

**Use with Patient Admission & Management Summary, complete for every patient, can give all drugs if criteria met (Microguide)**

* **Severity assessment-based on clinical review & consider *4C Mortality score*** <https://isaric4c.net/risk> ;

**Severe: Clinical signs of severe pneumonia; tachypneoa, SpO2 ≤90% air, requiring O2 to keep SpO2≥94%; if ↑O2 requirement / ↓SpO2 then re-consider escalation plan/refer ICU; Moderate: No signs of severe disease, SpO2 90-93% on air; Mild – no O2 requirement; SpO2 ≥94% on air; stable**

* **Supportive treatment eg IV fluids, aim for euvolaemia/slightly positive fluid balance/mouthcare ( Microguide/pt info)**
* **VTE prophylaxis: Consider Mild - standard VTE prophylaxis; if Severe requiring ventilatory support (CPAP/NIV/HFNO/IMV) - intermediate dose prophylaxis; Moderate/severe but not on ventilatory support – consider treatment dose dalteparin > bleeding risk assessment** The VTE-BLEED Algorithm (practical-haemostasis.com)
* **Consider complications eg cardiac-myositis/ischaemia, heart failure, arrhythmia, delirium**
* **Consider other investigations at any stage eg CTPA; repeat ECG, ECHO**
* **Regular bloods – daily if severe, to include DIC score /fibrinogen, ferritin, LDH**
* **Consider stopping antibiotics for CAP (Microguide) if no evidence of bacterial infection**
* **¥¥ For Urgent SARS-CoV-2 Spike Antibodies complete Review request, send blood, ring lab Ext 4099 (daytime only), see over**
* **\*\* Escalation plan & CPR status - review daily**
* **Suitability for clinical trial – discuss with Respiratory Team /Clinical Trials team (Ext. 4447/Bleeps 1169/1121)**
* **Ensure patient managed in appropriate ward/ICU in isolation bed according to current Covid IPC**
* **\*\*\*See Respiratory Care Unit (RCU) guidelines for further information (Microguide) including ventilatory support**
* **Be alert for ↑O2 requirement – refer all patients of concern to Respiratory Team (Bleep 1582 weekdays) +/- ICU**

**¥¥ Consider IV nMonoclonal Antibodies 2.4g (1.2g Casirivimab & 1.2g Imdevimab)**

**if PCR +ve, low antibodies to SARS-CoV-2 spike protein**

**and ≥ 12yrs**

See NICE Covid-9 Rapid guideline: Managing Covid-19 (NG191) 3rNOv 2021 <https://www.nice.org.uk/guidance/ng191>

& Microguide for detailed SFT guidance on managing all aspects Covid-19 infection CST/SLE 3rd Dec 21 v 27p1

**Consider ICU referral CPAP/HFNO/IMV**

 **Give Dexamethasone 6mg IV/PO OD**

**for 7 to 10 days *(or Hydrocortisone 50mg IV QDS)***

**Severity assessment\* & Escalation plan\*\* including CPR status**

**Consider other investigations e.g. CTPA, ECHO**

**CXR - Suggestive of CV19 Pneumonia**

**(ensure Covid-19 PCR swab sent)**

**Moderate/Severe Disease**

**Supportive treatment: Awake proning/physio, +/- IV fluids, nutrition,+/- Antibiotics for CAP; CCOT**

**¥¥ Send urgent blood for SARS-CoV-2 Spike Antibodies**

 **Oxygen +/- CPAP/NIV/HFO2/IMV\*\*\***