LITERATURE REVIEW SARS-CoV 2 Treatment

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SUPPORTIVE CARE

IMMUNOSUPRESSANTS

- Long duration and excessive doses of steroids may adversely affect recovery due to the inhibition of antiviral immunity and may also result in other side effects related to steroids.
- Discontinuation of immunosuppressants and steroid treatment might help faster recovery from COVID-19 pneumonia.
- The risks and benefits of continuing or discontinuing immunosuppressants should be weighed for each individual case.
- A lower than standard dose of immunosuppressants could be tried in patients requiring immunosuppressants to facilitate and shorten duration of disease with COVID-19

ANTICOAGULATION

- D-dimer and FDP levels may progressively increase with COVID-19 exacerbation, resulting in acro-ischemia.
- The existence of hypercoagulation status in critical COVID-2019 patients should be monitored closely, and anticoagulation therapy can be considered in selected patients.
- Anticoagulant therapy mainly with LMWH appears to be associated with better prognosis in severe COVID-19 patients meeting SIC criteria or with markedly elevated D-dimer.

VENTILATION

- Though mostly anecdotal, there is some evidence on the ventilator settings and differing characteristic of COVID-19 associated ARDS. Ventilator setting recommendations include:
  - Low TV, 6 mL/kg ideal body weight
  - PEEP >10 cm H2O
  - Oxygen administration at an SpO2 < 90% - 96%.
  - Starting RR of 16 breaths/min.
  - Early prone positioning
- The most experienced team member should perform intubation with as few assistants as possible to reduce exposure. Bag-mask ventilation generates aerosols and should be minimized by performing prolonged pre-oxygenation. Rapid sequence induction with muscle relaxants will reduce coughing.
- In patients who develop hypercapnia, increase VT to ~7.7.
- For timing of intubation:
  - If a patient is on nasal high-flow oxygen therapy, the ROX index [SpO2/(FiO2 x RR)] can be used. If after 12 hours, patients have a ROX index of <3.85, initiate intubation.
  - For NCP patients, if PaO2/FiO2 is <150 mmHg (1mmHg = 0.133 kPa), initiate intubation if receiving more than 2 hours of nasal high-flow therapy or non-invasive ventilation.

ECMO

- ECMO should be considered if mortality rate approaches 50%, initiate if 80%.
- ECMO should be considered if one following criteria are met:
  1. PaO2/FiO2<100mmHg
  2. P(A-a) O2>600mmHg
  3. pH<7.2 and plateau pressure >30 cmH2O with respiratory rate > 35 breaths per minute
  4. <65 years old
  5. NO contraindications
  6. Severe air leak syndrome
  7. Complicated by cardiogenic shock or cardiac arrest
- Contraindications include: multi-organ failure, contraindication to anticoagulation, high mechanical vent for more than 7 days

DIRECT ACTING AGENTS

REMDESIVIR

- Remdesivir shows promise for improved clinical outcomes in one compassionate-use cohort study. Study limitations: lack of control group, lacK of uniformity of supportive care, small sample size (n=53).
- Preliminary results from randomized control trial (ACTT-1, n= 1063) show 31% faster median recovery (11 vs 15 days) and improved mortality (8% vs 11.6%)
- Adverse events occur more commonly in ventilated patients. Most common adverse events: increased hepatic enzymes, diarrhea, rash, renal impairment, hypotension.

HYDROXYCHLOROQUINE (HQ)/CHLOROQUINE

- There is no clear evidence for the benefit of hydroxychloroquine in the treatment of patients hospitalized with COVID-19. If a patient is treated with HQ, they should ideally be enrolled in a clinical trial whenever possible.
- If hydroxychloroquine is used:
  - 400 mg x2 doses (loading dose) then 200 mg BID x4 days
  - Monitor for prolonged QTc and for other less common adverse events: hypoglycemia, neuropsychiatric effects, drug–drug interactions and idiosyncratic hypersensitivity reactions

HQ +AZITHROMYCIN

- Though two studies (total n = 110) suggest that adding Azithromycin to HQ reduces viral load and decreases duration of illness, these studies are not reliable for a number of reasons (samples are too small, studies are not controlled, and patients included are not severely ill). The most reliable study (biggest sample size n = 368, control included) suggests that all-cause mortality increases with the use of HQ + Azithromycin

TOCILIZUMAB

- Retrospective study in China suggests that Tocilizumab may reduce inflammation in COVID, as indicated by IL-6 levels. This study also suggests that Tocilizumab may be more effective when given in multiple doses to critically ill patients.
  - Study limitations: small sample size (n = 15), all patients treated with methylprednisolone concomitantly

IVERMECTIN

- Ivermectin has been shown to be an effective treatment for SARS-CoV-2 by inhibiting viral replication in vitro. In vivo trials are merited.

TENOFOVIR

- Tenofovir can tightly bind to the RdRp of the SARS-CoV-2 strain and thus may be used to treat the disease.

For details and references please visit **https://oume.uthscsa.edu/longco/**