

## Dr. Daniel Griffin's COVID-19 treatment summary for 4/7/22

**PASSIVE VACCINATION-** EvuSheld I will repeat this the next section, but people can go to a webpage and locate available treatments <https://covid-19-therapeutics-locator-dhhs.hub.arcgis.com>

### **Period of detectable viral replication/*Viral Symptom phase* –**

'The time for monitoring, monoclonals, antivirals, and enrollment in clinical trials' Not for steroids, or antibiotics such as (doxycycline or azithromycin) or zinc or aspirin or any other unproven and potentially harmful potion.

<https://www.covid.gov>

**Paxlovid** - we have the locator <https://covid-19-therapeutics-locator-dhhs.hub.arcgis.com> and the drug interaction checker <https://www.covid19-druginteractions.org/checker>

Monoclonal Rx-now just Bebtolovimab

Remdesivir

Molnupiravir

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<https://covid.cdc.gov/covid-data-tracker/#variant-proportions>

<https://www.idsociety.org/practice-guideline/covid-19-guideline-treatment-and-management/>

<https://www.covid19treatmentguidelines.nih.gov/>

<https://www.who.int/publications/i/item/WHO-2019-nCoV-therapeutics-2022.1>

### ***Early Inflammatory phase-***

Steroids at the right time in the right patient. Anticoagulation, pulmonary support and escalation to tocilizumab, the IL6-R blocker and in some cases Baricitinib, but only in sleet patients at the right time.

Let me spend just a little more time on this section to make sure everyone is up to speed on the current science-based recommendations.

First: If a person is hypoxic, oxygen saturation <94% then we recommend steroids. This would be Dexamethasone 6mg daily (fine to be PO) x 10 days. IF they improve we can stop, in some cases we might exalate but in general we do not recommend a higher dose. The article **Long-term outcomes of dexamethasone 12 mg versus 6 mg in patients with COVID-19 and severe hypoxaemia** looked at across the board higher dose dexamethasone and they assessed 180-day mortality and health-related quality of life measures in a blinded trial where 1000 adults with confirmed COVID-19 receiving at least 10 L/min of oxygen or mechanical ventilation in 26 hospitals in Europe and India were randomized to 6mg versus 12mg of dexamethasone. At 180 days, (33.7%) had died in the 12 mg group versus (38.6%) in the 6 mg group relative risk

0.89; 0.72–1.09;  $P = 0.13$ ] and also no statistically significant differences seen in quality of life measurements.

<https://link.springer.com/article/10.1007/s00134-022-06677-2>

Second: they progress despite steroids-further immunomodulation – then we recommend Tocilizumab the monoclonal antibody that is an IL-6R inhibitor. Studies showing a mortality reduction, reduction in progression to requiring mechanical ventilation but critical to be done with a background of steroids and at the right time. If no steroids we increase mortality. If we wait until after escalation to HFNC or until >48 hours in the ICU or on mechanical ventilation then increase in mortality. So really critical to know what one is doing when using this medication.

We did hear on April 4<sup>th</sup> that U.S. FDA has granted priority review to Roche’s Actemra (TOCILIZUMAB) for the treatment of COVID-19 in hospitalised adults

- **If approved, Actemra/RoActemra would be the first U.S. FDA-approved immunomodulator for the treatment of COVID-19 in hospitalised patients**
- **Since the beginning of the pandemic, more than one million people hospitalised with COVID-19 have been treated with Actemra/TOCILIZUMAB worldwide**

<https://www.roche.com/media/releases/med-cor-2022-04-04b>

I should mention here that the only other immunomodulation strategy other than steroids that has shown promise has been the Janus Kinase inhibitor Baricitinib. Other approaches such as using anakinra to target IL-1 have either not shown benefit or been stopped for futility. Immunomodulation can be challenging.

Third: anticoagulation (not antiplatelet therapy). ICU level patients prophylactic intensity anticoagulation, non-ICU floor patients with COVID therapeutic intensity anticoagulation, but.. the qualifier as these are conditional recommendations *“An individualized assessment of the patient’s risk of thrombosis and bleeding is important when deciding on anticoagulation intensity.”*

<https://www.hematology.org/education/clinicians/guidelines-and-quality-care/clinical-practice-guidelines/venous-thromboembolism-guidelines/ash-guidelines-on-use-of-anticoagulation-in-patients-with-covid-19>