Dr. Daniel Griffin's COVID-19 treatment summary for 5/21/22

Passive Vaccination

EvuSheld.

Authorized for use in adults and pediatric individuals (12 years of age and older weighing at least 40 kg):

Who have moderate to severe immune compromise due to a medical condition or receipt of immunosuppressive medications or treatments **and** may not mount an adequate immune response to COVID-19 vaccination **or**

For whom vaccination with any available COVID-19 vaccine, according to the approved or authorized schedule, is not recommended due to a history of severe adverse reaction to a COVID-19 vaccine(s) and/or COVID-19 vaccine component(s).

https://www.fda.gov/media/154701/download

Period of detectable viral replication/*Viral Symptom phase*

I did want to just point out the subtle difference between the detailed EUA Fact sheet for Paxlovid and the FDA eligibility tool.

In the EUA it says the approval is for patients with positive results of direct severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) viral testing who are at *high risk* for progression to severe COVID-19, including hospitalization or death.

In the FDA eligibility tool it has the box to check of "Has one or more risk factors for progression to severe COVID-19[1] (Risk factors have changed over time, and additional risk factors [such as being unvaccinated or having not received a booster] and this then links to the CDC page with a pretty extensive list.

[1]Paxlovid – with an 89-88% reduction in progression if given in the first 3-5 days. We have many resources the **PAXLOVID Patient Eligibility Screening Checklist Tool for Prescribers** and https://www.fda.gov/media/158165/download

This CDC list of what makes a person at risk of progression

https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

The IDSA guide for managing paxlovid drug interactions https://www.idsociety.org/paxlovid .

And the EUA for Paxlovid. https://www.fda.gov/media/155050/download

we have the locator https://covid-19-therapeutics-locator-dhhs.hub.arcgis.com

and the drug interaction checker https://www.covid19-druginteractions.org/checker

And we hear the NIH is in talks with Pfizer to study longer courses of Paxlovid in certain cases. https://www.reuters.com/business/healthcare-pharmaceuticals/us-study-whether-longer-paxlovid-course-needed-combat-reinfections-2022-05-18/

2 -Remdesivir (the order changed!) -we have the 3-day early IV data suggesting an 87% reduction in progression if given in those first 5 days. Does it need a new name?

https://www.vekluryhcp.com/?utm_id=iw_sa_11453738585_111635246813&utm_medium=cpc&utm_term=medicine+remdesivir&gclid=CjwKCAjwj42UBhAAEiwACIhADocodyE-OQCnF5PXs6x5nuFnH230Tc-4V3iFulmtEoxHgYAY1Tr7hhoCTOoQAvD_BwE&gclsrc=aw.ds
https://files.constantcontact.com/17b067e5501/04046d2f-51dc-490f-89e1-edb5c535eeb6.pdf?rdr=true

3-Monoclonal Rx-now just Bebtelovimab. in adults and pediatric patients (12 years of age and older weighing at least 40 kg) https://www.fda.gov/media/156152/download

4-Molnupiravir – a last option with 30% reduction in progression so less impressive but no renal issues or drug interactions. Be careful w woman of childbearing age and get that negative pregnancy test, and NOT authorized for those under 18.

5-Avoid: let us not do harmful things

- Steroids given prior to the early inflammatory phase and during the viral replication phase increase the risk of progression to hospitalization and death
- Zinc causes GI distress without benefit
- Unnecessary antibiotics

Unproven therapies…we have treatments that work

Early Inflammatory phase-

1-Steroids at the right time in the right patient at the right dose. Dexamethasone 6mg per day x 10 days if resting room air saturations are less than 94% and then if they improve and get discharged it is generally recommended that they be discharged off steroids. We have literature to show we are not having inferior outcomes if we stop steroids at discharge in. terms of readmission. Long COVID?

2-Anticoagulation –

- prophylactic-intensity anticoagulation for patients with COVID-19-related ***critical illness*** (ICU patients) that would be for instance 40mg subcutaneous once per day

2. therapeutic-intensity anticoagulation for patients with COVID-19 related ***acute illness*** (*hospitalized but not in ICU*). That would be 1mg/kg subcutaneous twice per day

3. no anticoagulant outpatient thromboprophylaxis in patients with COVID-19 who are being discharged from the hospital unless they are high risk of have another reason

"An individualized assessment of the patient's risk of thrombosis and bleeding is important when deciding on anticoagulation"

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

3-Pulmonary support

4-Maybe Remdesivir if early, not if they are on a ventilator

5-Tocilizumab, the IL6-R blocker and in some cases Baricitinib, but only if there is progression and benefits outweigh risks

6-AVOID: unnecessary antibiotics and unproven therapies