SUSHRUTA
HEALTH POLICY & OPINIONS

COVID-19 Summary Guidelines

British Association of Physicians of Indian Origin (Wales Chapter) - Scientific Working Group –

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Evidence based guidelines

Low and Medium Income Countries- May 2021

We note with concern, potential misinformation regarding treatment options being recommended to patients in India. We suggest the following evidence-based practice for the management of SARS CoV2 infection.

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Approach to Diagnosis & Infection Control

	Test/Agent	Details
RT-PCR	CE marked Reverse Transcriptase - Polymerase Chain Reaction (RT- PCR) assays detect all variants.	The ideal time for PCR testing is between day 1-5 of symptoms.
Imaging	CT scan should not be the first line tool in diagnosing COVID-19, which is mostly a clinical and PCR diagnosis.	If required for inpatient care, the CT should be done in a COVID 19 safe environment
Asymptomatic cases	Nearly 1/3rd of cases are asymptomatic or pre-symptomatic.	Transmission from such cases can be prevented by effective self-isolation (10 days), hand hygiene and social distancing.
Infectivity	The period of infective exposure starts from about 48 hours prior to onset of symptoms in the index case up to about 10 days in community cases, and 14 days in hospitalised, due to being a more vulnerable population.	Contact tracing, testing and appropriate isolation of such individuals, is key to infection control

Approach to Therapy

	Treatment	Details
Antibiotics	There is no role for the use of antibiotics when there is no clear evidence of bacterial infections in patients with SARS CoV-2 infection.	The indiscriminate use of broad-spectrum antibiotics is likely to increase the risk of Multi Drug Resistant (MDR) bacterial infections.
Corticosteroids	Steroids are recommended for severe illness[1]	High dose steroids – 1 to 2 mg/kg/day methylprednisolone are known to cause severe immune suppression and an increased risk of opportunistic infections

	Test/Agent	Details
Corticosteroids II	Data from multiple trials has shown that steroids should be trialled for a limited period of 3 to 10 days [2,3]	In patients with signs of clinical deterioration in infection, heralded by hypoxia with SpO2 <92%
Corticosteroids III	There is no benefit of using steroids in patients with mild symptoms, not needing oxygen support.[4] Treatment should stop if discharged from hospital within the 10 days, although gradual weaning off from steroid therapy might be required in patients with severe infection or prolonged hospital stay.[1]	**Dexamethasone**: Dose: 6mg PO/IV Once a Day for up to 10-days or **Hydrocortisone**: Dose 50mg IV TDS for 7-10 days or Prednisolone: Dose 40 mg Once a Day for up to 10-day, or Methylprednisolone: Dose 32 mg once a Day for up to 10-days[2] Cautions: Monitor blood glucose every 6 hours, target levels 108-180mg/dl. If blood glucose levels high, consider starting insulin therapy
Proning	Prone positioning improves outcomes in hypoxic and mechanically ventilated patients with severe infection. [4–6]	
Thromboprophylaxis	Current guidance suggests prophylactic doses of LMWH in patients with no evidence of venous thromboembolism. There is No benefit of full anticoagulation in patients with no evidence of VTE.[7,8]	(VTE)- 0.5mg Enoxaparin s/c once a day
Convalescent plasma	Convalescent Plasma has NOT provided any benefit in the treatment of patients with SARS CoV2 infection.[4,9]	The RECOVERY [10] and REMAP- CAP trials[11], as well as a large trial conducted in India – the PLACID Trial[12] – provided evidence that convalescent plasma did not improve outcomes.
Other drugs	In patients hospitalised with COVID-19, the RECOVERY trial has demonstrated no benefit of: a) Hydroxychloroquine[13] b) Azithromycin[14,15]	

	Test/Agent	Details
	c) Lopinavir-Ritonavir[16,17]	
IL-6 Inhibitors	Interleukin 6 inhibitors: Tocilizumab/ Sarilumab. The RECOVERY and REMAP CAP Trials [18] found that tocilizumab significantly improved survival and other clinical outcomes in patients with hypoxaemia and systemic inflammation.	Please refer to the SPC for tocilizumab.[19] Please refer to the SPC for sarilumab.[18,20]
Ivermectin	Current evidence does not support the use of Ivermectin for treatment or prophylaxis.[21,22]	
Vaccination	Vaccination against SARS-CoV-2 is the most effective tool for protecting individuals as well as protecting public health. [23,24]	Vaccination reduces the risk of hospitalisation by 80% and risk of mortality by 90%. This, along with the self- isolation of cases and close contacts, contact tracing and appropriate case management are the most important control measures.*

*Transmission risk reduction averages between 50-70% across different data sets. Neutralising protection against infection after a first dose starts between 14-21 days for the different licensed vaccines. The adverse effects differ between different vaccines, but the benefits of vaccination in reducing risk of severe infection far outweighs the side effects (majority of which are minor and self-limited). It is important to maintain a COVID 19 safe environment at vaccination centres.

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