## Acute COVID-19 Presentation excluding MIS-C

### Testing, Clinical Presentation and Diagnosis

**Identified Clinical Features**
- Signs and symptoms may be similar to those for common viral respiratory infections or other childhood illnesses
- Clinical presentation may include fever, cough, nasal congestion or rhinorrhea, sore throat, shortness of breath, diarrhea, nausea or vomiting, fatigue, headache, myalgia, poor feeding, or poor appetite
- There have been multiple reports to date of children with asymptomatic COVID-19 infection

**Diagnosis**
- Diagnosis of COVID-19 requires the detection of SARS-CoV-2 RNA by reverse transcription-polymerase chain reaction (RT-PCR) testing

### COVID-19 Treatment Summary

**Key Points to Consider**
- We recommend use of remdesivir for symptomatic patients following FDA labeling for indication or Emergency Use Authorization (EUA) criteria
- Dexamethasone 0.15 mg/kg daily (max 6 mg) may be considered for use for up to 10 days only in hospitalized patients receiving oxygen therapy or invasive mechanical ventilation
- Clinical trials on convalescent plasma and immunomodulatory therapy are ongoing
- Pharmacologic venous thromboembolism should be considered based upon recommendations outlined in [UW Health VTE Prophylaxis - Pediatric - Inpatient Guideline](#)

### Remdesivir (Veklury®)

- Currently, remdesivir is the only drug approved by the Food and Drug Administration (FDA) for the treatment of COVID-19 in hospitalized patients
- We recommend use of remdesivir for symptomatic patients as recommended under FDA-approval or meeting FDA emergency use authorization criteria
- SARS-CoV-2 nucleotide analog RNA polymerase inhibitor and is FDA approved for adults and pediatric patients (12 years of age and older and weighing at least 40 kg) for the treatment of (COVID-19) requiring hospitalization
- Dose is 200 mg IV for once, followed by remdesivir 100 mg IV once daily for 4 days or until hospital discharge, whichever comes first
- Available evidence does not show benefit of continuing remdesivir beyond 5 days
- Use is not recommended in patients with eGFR less than 30 mL/min due to the potential accumulation of the excipient betadex sulfobutyl ether sodium. However, other drugs using this excipient (e.g. IV voriconazole) have been used safely in renal insufficiency for short durations.2-4
- Obtain ALT at baseline and daily while on therapy and consider discontinuing if ALT levels increase to greater than 10 times the upper limit of normal or discontinue if ALT elevation is accompanied by signs or symptoms of liver inflammation

### Hospitalized Pharmacologic Management

- Summary of evidence available from the [NIH](#)
- Clinical drug-drug interaction studies of remdesivir have not been conducted. In vitro, remdesivir is a substrate of cytochrome P450 (CYP) 3A4 and of the drug transporters organic anion-transporting polypeptide (OATP) 1B1 and P-glycoprotein. It is also an inhibitor of CYP3A4, OATP1B1, OATP1B3, and MATE1.
- Also available through an FDA Emergency Use Authorization (EUA) for the treatment of COVID-19 in hospitalized pediatric patients weighing 3.5 kg to <40 kg or aged <12 years and weighing ≥3.5 kg with:
  - an oxygen saturation (SpO2) ≤94% on room air or requiring supplemental oxygen;
  - or requiring mechanical ventilation;
  - or requiring extracorporeal membrane oxygenation (ECMO)
  - Treatment teams should work with their pharmacist to facilitate the request process.
  - We recommend a treatment course of up to 5 days for patients not requiring or likely to require invasive mechanical ventilation and/or ECMO.
**Corticosteroids (CS)**

- The safety and effectiveness of dexamethasone or other corticosteroids for COVID-19 treatment have not been sufficiently evaluated in pediatric patients.
- Dexamethasone has been used safely in children in several respiratory conditions.
- We recommend consideration of dexamethasone 0.15 mg/kg (max 6 mg daily) for up to 10 days only in hospitalized patients requiring invasive ventilation unless dexamethasone is contraindicated in an individual patient.
- Use of dexamethasone in patients who require other forms of supplemental oxygen support should be considered on a case-by-case basis and is generally not recommended for pediatric patients who require only low levels of oxygen support (i.e., nasal cannula only).
- We do not recommend use in patients not receiving respiratory support. Recommendations extrapolated from results in adult patients reported 6 mg of dexamethasone daily for up to 10 days reduced 28-day mortality among hospitalized patients receiving invasive ventilation or oxygen supplementation at randomization. There was no difference in mortality for patients not requiring respiratory support at randomization.
- See (Influenza and COVID-19 Co-infection) for recommendations on the use of CS in co-infection
- If dexamethasone is not available, equivalent doses of other corticosteroids such as prednisone 1 mg/kg (max 40 mg daily), methylprednisolone 0.8 mg/kg (max 32 mg daily), or hydrocortisone 4 mg/kg (max 160 mg daily) may be used.
- Other corticosteroid regimens may be considered for the treatment of ARDS or septic shock, but benefit should be weighed against the risk of increased viral replication and shedding, secondary infection, and other steroid side effects.

**Venous thromboembolism prophylaxis and treatment**

- Pharmacologic venous thromboembolism should be considered based upon recommendations outlined in [UW Health VTE Prophylaxis - Pediatric - Inpatient Guideline](#).
- Coagulation dysfunction has been described in pediatric patients with critical COVID-19 infection.
- Consultation with Pediatric Hematology should be considered on a case-by-case basis.
- Consider pharmacologic prophylaxis in patients admitted to the PICU with critical COVID-19 unless contraindicated.
- Consider mechanical prophylaxis if chemoprophylaxis is contraindicated.
- DVT/PE treatment
  - Initiate full-dose anticoagulation when DVT/PE is confirmed OR if clinical suspicion for DVT/PE is high but confirmatory testing cannot be obtained.
  - If therapeutic anticoagulation is contraindicated, management should be determined on a case-by-case basis.

**Use of Consultants**

For symptomatic SARS-CoV-2 positive children, we recommend consultation with Pediatric Infectious Diseases.

**influenza and COVID-19 Co-infection**

- Oseltamivir: Begin empiric treatment for influenza with oseltamivir as soon as possible without waiting for influenza testing results Antiviral treatment of influenza can be stopped if influenza has been ruled out by nucleic acid detection assay performed on an upper respiratory tract specimen in non-intubated patients or on both upper and lower respiratory tract specimens in intubated patients
- Corticosteroids: To our knowledge, there are no studies investigating the use of corticosteroids (CS) in patients co-infected with COVID-19 and seasonal influenza. In co-infected patients, the potential benefits of CS for COVID-19 pneumonia in patients requiring some level of oxygen support (as shown in the RECOVERY trial) must be weighed against the potential harm of CS in the context of influenza infection. Non-randomized trials of CS in influenza have consistently shown increased mortality in patients receiving CS (with prolonged influenza virus replication being the postulated mechanism by which CS increase mortality). However, the CS doses in most of these studies have generally been higher than the more modest dose (0.15 mg/kg with max dose 6 mg/day dexamethasone) studied for COVID-19 in the RECOVERY trial. Thus,
  - In certain circumstances, based on provider clinical judgement, corticosteroids may be reasonable in hospitalized patients co-infected with COVID-19 and influenza who require supplemental oxygen.
  - If corticosteroids are used in co-infected patients, the corticosteroid equivalent dose should not exceed dexamethasone 0.15 mg/kg (max 6 mg/daily). Equivalent doses of other corticosteroids such as prednisone 1 mg/kg (max 40 mg daily), methylprednisolone 0.8 mg/kg (max 32 mg daily), or hydrocortisone 4 mg/kg (max 160 mg daily) may be used. Administration should not exceed 10 days.

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- We recommend a treatment course of up to 10 days for patients requiring invasive mechanical ventilation and/or ECMO.
- See [FDA Fact Sheet for Healthcare Providers](#) for additional details (e.g. dosing, contraindications, warnings).
- See [FDA Fact Sheet for Patients and Caregivers](#) for patient shared decision-making.

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- All patients with influenza should receive an inactivated influenza vaccine.

### Investigational Agents

#### Convalescent plasma

**Fact Sheet for Health Care Providers**

**Fact Sheet for Patients, Parents and Caregivers**

**FDA Convalescent Plasma Clinical Memorandum**

- **Place in therapy**
  - Clinical trials on convalescent plasma and immunomodulatory therapy are ongoing.
  - Clinical evidence supporting the convalescent plasma EUA is not derived from prospective, well-controlled randomized clinical trials (RCTs). Additional RCTs are needed. Thus, providers are encouraged to enroll patients in those ongoing clinical trials.
  - Ongoing clinical trials of convalescent plasma should not be amended based on the issuance of the EUA.
  - Convalescent plasma should not be considered the standard of care for the treatment of patients with COVID-19.

- **Regulatory Status**
  2. Ordering provider must provide recipients with the Fact Sheet for Patients/Caregivers and must communicate the following information to the recipients:
     - FDA has authorized emergency use of COVID-19 convalescent plasma, which is not an FDA-approved biological product.
     - The patient or caregiver has the option to accept or to refuse administration of COVID-19 convalescent plasma.
     - The potential risks and benefits of COVID-19 convalescent plasma are not entirely understood.
     - Information on available alternative treatments and the risks and benefits of those alternatives.
  3. If providing this information will delay the administration of COVID-19 convalescent plasma to a life-threatening extent, the information must be provided to the patients as soon as practicable after convalescent plasma is administered.

#### Anti-viral (spike protein) monoclonal antibody therapies

**Bamlanivimab FDA FAQ**

**Bamlanivimab Fact Sheet for Providers**

**Bamlanivimab Fact Sheet for Patients, Parents and Caregivers**

**Bamlanivimab + Etesevimab FDA FAQ**

**Bamlanivimab + Etesevimab Fact Sheet for Providers**

**Casirivimab + Imdevimab FDA FAQ**

- **Bamlanivimab (Eli Lilly), Bamlanivimab + Etesevimab (Eli Lilly), Casirivimab + Imdevimab (Regeneron)**
  - Neutralizing IgG1 monoclonal antibody that binds to the receptor binding domain of the spike protein of SARS-CoV-2.
  - Not authorized for use in patients:
    - who are hospitalized due to COVID-19, or
    - who require oxygen therapy due to COVID-19, or
    - who require an increase in baseline oxygen flow rate due to COVID-19 in those on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity.
  - Granted FDA emergency use authorization for the treatment of mild to moderate COVID-19 in adults and pediatric patients with positive results of direct SARS-CoV-2 viral testing who are 12 years of age and older weighing at least 40 kg, and who are at high risk for progressing to severe COVID-19 and/or hospitalization.
  - High risk for progressing to severe COVID-19 and/or hospitalization is defined as patients who meet at least one of the following criteria:
    - Have a body mass index (BMI) ≥35 kg/m²
    - Have chronic kidney disease
    - Have diabetes
    - Have immunosuppressive disease
    - Are currently receiving immunosuppressive treatment
    - Are 12-17 years of age AND have
      - BMI ≥85th percentile for their age and gender based on CDC growth charts, or
      - sickle cell disease, or
      - congenital or acquired heart disease, or
      - neurodevelopmental disorders, for example, cerebral palsy, or
      - a medical-related technological dependence, for example, tracheostomy, gastrostomy, or positive pressure ventilation (not related to COVID-19), or asthma, reactive airway or other chronic respiratory disease that requires daily medication for control.
### Cytokine modulation

#### Anti-cytokine Therapy (Baricitinib)\(^{13}\)
- Prior to using baricitinib or other anti-cytokine agents, consultation with Pediatric Rheumatology and Hematology should occur to discuss on a case by case basis pediatric patients who may benefit from immune modulation.
- There are insufficient data for the to recommend either for or against the use of the following immunomodulators for the treatment of COVID-19:
  - Interleukin (IL)-1 inhibitors (e.g., anakinra)
  - Interferon beta for the treatment of early (i.e. <7 days from symptom onset) mild and moderate COVID-19
- We recommend against the use of the following immunomodulators for the treatment of COVID-19, except in a clinical trial:
  - Anti-IL-6 receptor monoclonal antibodies (e.g., sarilumab, tocilizumab) or anti-IL-6 monoclonal antibody (siltuximab)
  - Interferons (alfa or beta) for the treatment of severely or critically ill patients with COVID-19
  - Bruton’s tyrosine kinase inhibitors (e.g., acalabrutinib, ibrutinib, zanubrutinib) and Janus kinase inhibitors (e.g., ruxolitinib, tofacitinib)

#### Other off-label “antiviral” agents
- We have reviewed the following agents and do not support the use outside of a clinical trial: lopinavir/ritonavir, hydroxychloroquine, chloroquine, azithromycin, darunavir/cobicistat, interferon, ivermectin, nitazoxanide, montelukast, ribavirin, zileuton, ruxolitinib.
- We cannot recommend for or against use of agents we have not reviewed.

### Laboratory and Imaging

| Screening for multisystem organ failure | CMP, Bilirubin-direct, CBC with differential, Prothrombin Time/INR, Fibrinogen, Troponin, BNP |
| Screening for hyperinflammation/CRS/shHLH | Ferritin, D-dimer, C-Reactive Protein, ESR, LD-Total, Triglycerides |
| Imaging | ECHO for cardiac function, evaluation of pericardial effusion and ventricular function |

### Pregnancy Considerations
- The decision to treat a pregnant woman should be done after shared decision-making between the patient, obstetrician, and hospital physician.
- UW Health Department of Obstetrics and Gynecology Guideline on COVID and Pregnancy Care is available on the COVID-19 Hub
- The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine (SMFM) have developed guidance to aid practitioners in assessing and managing pregnant women with suspected or confirmed COVID-19.
- Interim guidance is also available from the CDC for pregnant women who are diagnosed with COVID-19.

### Links to External Guidance
- NIH COVID-19 Treatment Guidelines - Special Considerations in Children
- CDC COVID-19 - Caring for Children
- CDC COVID-19 - Caring for Newborns

### Other drug considerations

| ACE inhibitors and ARBs | At present, there are no recommendations for or against the use of ACE inhibitors or ARBs when considered solely for the purposes of COVID-19 treatment.\(^{14}\) Barring contraindication, ACE inhibitor or ARB therapy should not be interrupted.\(^{15}\) |
| Ibuprofen and NSAIDs | For relief of fever or pain, preferential use of acetaminophen use is reasonable. NSAID use is not contraindicated in COVID-19.\(^ {16}\) |
Multisystem Inflammatory Syndrome in Children (MIS-C)\textsuperscript{17, 18}

**Case Definition for MIS-C\textsuperscript{19}**

As described in the Health Advisory, “Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 2019 (COVID-19),” the case definition for MIS-C is:

- An individual aged less than 21 years presenting with fever*, laboratory evidence of inflammation**, and evidence of clinically severe illness requiring hospitalization, with multisystem (>2) organ involvement (cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, or neurologic); \textbf{AND}
- No alternative plausible diagnoses; \textbf{AND}
- Positive for current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test; or exposure to a suspected or confirmed COVID-19 case within the 4 weeks prior to the onset of symptoms.

*Fever >38°C for ≥24 hours, or report of subjective fever lasting ≥24 hours

**Including, but not limited to, one or more of the following: an elevated C-reactive protein (CRP), erythrocyte sedimentation rate (ESR), fibrinogen, procalcitonin, d-dimer, ferritin, lactic acid dehydrogenase (LDH), or interleukin 6 (IL-6), elevated neutrophils, reduced lymphocytes, and low albumin

Additional comments:

Some individuals may fulfill full or partial criteria for Kawasaki disease but should be reported if they meet the case definition for MIS-C. Consider MIS-C in any pediatric death with evidence of SARS-CoV-2 infection.

**Clinical Presentation of MIS-C\textsuperscript{19}**

- Patients with MIS-C have presented with a persistent fever, fatigue, and a variety of signs and symptoms including multiorgan (e.g., cardiac, gastrointestinal, renal, hematologic, dermatologic, neurologic) involvement, and elevated inflammatory markers.
- Not all children will have the same signs and symptoms, and some children may have symptoms not listed here.
- In nearly half of the children, the clinical signs and symptoms are compatible with either complete or incomplete Kawasaki syndrome, with prominence of rash, conjunctivitis, and oral mucositis. In the remainder, the clinical presentation is more akin to toxic shock syndrome, with very prominent gastrointestinal symptoms of abdominal pain, vomiting and/or diarrhea and impressive cardiac dysfunction that often requires inotropic support.
- MIS-C may begin weeks after a child is infected with SARS-CoV-2.
- The child may have been infected from an asymptomatic contact and, in some cases, the child and their caregivers may not even know they had been infected.

**Evaluation of MIS-C\textsuperscript{19}**

- SARS-CoV-2 detection by RT-PCR or antigen test is indicated. Additionally, SARS-CoV-2 serology testing is suggested, even in the presence of positive RT-PCR or antigen.
- Per recommendations made by the American College of Rheumatology, a tiered approach to initial testing should be considered. See below for definitions of Tier 1 and Tier 2 testing.
  - Tier 1 evaluation:
    - For children with otherwise unexplainable fever >38°C, confirmed history of SARS-CoV-2 infection OR suspected exposure, and at least two suggestive clinical features (rash, edema of hands/feet, mucosal changes, GI symptoms, lymphadenopathy, neurological changes, or evidence of cardiovascular dysfunction) who are NOT in shock.
  - Tier 2 evaluation:
    - Should be completed if the patient is found to have a CRP >5 mg/dL or ESR >40 mm/hr AND at least one of the following:
      - Lymphopenia <1,000/μL, thrombocytopenia <150,000/μL, hyponatremia <135 mmol/L, neutrophilia, or hypoalbuminemia.
  - Tier 1 and Tier 2 evaluation:
    - If shock (inadequate perfusion to meet tissue demand) is also present
  - Tier 1 Screening
    - CBC w/differential
    - CMP
    - CRP and ESR
  - Tier 2/Complete Evaluation
    - BNP and troponin
    - EKG and Echocardiogram
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- Procalcitonin
- PT/INR, PTT, fibrinogen, von Willebrand Factor Antigen, and D-dimer
- Ferritin, LDH, and triglycerides
- Urinalysis
- CXR
- Cytokines (TNF alpha, IL-1, IL-6, and CXCL-9)
  - Order the TNF alpha, IL-1, IL-6 from ARUP (outside lab facility)
  - Order the CXCL-9 from Cincinnati Children’s Diagnostic Immunology Lab; use the Diagnostic Immunology Laboratory - Test Requisition Form
- Cytokine lab order and drawing information

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<thead>
<tr>
<th>Lab Order</th>
<th>Send to</th>
<th>Tube Color</th>
<th>Draw Volume</th>
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</thead>
<tbody>
<tr>
<td>Misc Test - Cytokine Panel, serum (includes IL-1, IL-6, IL-8, TNF alpha)</td>
<td>ARUP (0051524)</td>
<td>Red or SST</td>
<td>1.2 mL whole blood</td>
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<tr>
<td>Misc Test - IFN gamma, serum</td>
<td>ARUP (0051531)</td>
<td>Red or SST</td>
<td>1.2 mL whole blood</td>
</tr>
<tr>
<td>Misc Test - CXCL 9</td>
<td>Cincinnati Children’s (11709095)</td>
<td>Lavender EDTA</td>
<td>1.5 mL whole blood</td>
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</tbody>
</table>

- Any serology testing should be performed prior to administering IVIG or any other exogenous antibody treatments
- Other testing to evaluate multisystem involvement should be directed by patient signs or symptoms. Additionally, testing to evaluate for other potential diagnoses should be directed by patient signs or symptoms (i.e., blood cultures, abdominal imaging, etc.)

### Use of Consultants
- For all patients with features of MIS-C, we recommend consultation with Pediatric Infectious Diseases, Rheumatology, and Cardiology.
- Consult Dermatology for any MIS-C patient with skin finding
- Consult Hematology for an MIS-C patient with abnormal coagulation labs (PT/INR, PTT, D-dimer, vWF antigen) or concern for thrombosis

### Reporting of MIS-C
- Healthcare providers caring for patients who meet the case definition for MIS-C should notify UW Infection Control (Pager ID 2570).
- Infection Control can then report to the Wisconsin DPH and the CDC.
- A case of a patient with MIS-C should be reported to public health authorities within 48 hours of diagnosis.
- After hour phone numbers for health departments are available at the Council of State and Territorial Epidemiologists.
- For additional reporting questions, please contact CDC’s 24-hour Emergency Operations Center at 770-488-7100.

### Forms
- Instructions for Multisystem Inflammatory Syndrome Associated with COVID-19 Case Report Form
- Fillable Multisystem Inflammatory Syndrome Associated with COVID-19 Case Report Form
- Printable Multisystem Inflammatory Syndrome Associated with COVID-19 Case Report Form

### Treatment of MIS-C
- There are currently no published guidelines or CDC recommendations regarding treatment for MIS-C and no studies comparing efficacy of various treatment options. However, there have been published reports of the treatments that many institutions have been using. The most current guidance may be found at CDC website Information for Healthcare Providers about Multisystem Inflammatory Syndrome in Children
- Treatments have consisted primarily of supportive care and directed care against the underlying inflammatory process and multi-organ dysfunction syndrome. Supportive measures include but are not limited to:
  - fluid resuscitation
  - inotropic/pressor support
  - respiratory support
  - dialysis
  - extracorporeal membranous oxygenation (ECMO)
- Anti-inflammatory measures have included the frequent use of intravenous immunoglobulin (IVIG) and steroids. The use of other anti-inflammatory medications has been variable.
  - High-dose IVIG 2 g/kg (administered in 1 or 2 divided doses based on ideal bodyweight with a total max dose 100 g) is recommended for treatment of MIS-C with KD features, or moderate to severe disease without KD features (i.e. shock or...
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myocardial dysfunction). Cardiac function and fluid status should be assessed and monitored in MIS-C patients with shock before, during and after the IVIG treatment is provided. In some patients with cardiac dysfunction, IVIG may be given in divided doses (1 g/kg daily for 2 days).

- Low- to high-dose glucocorticoids with taper may be considered for treatment of MIS-C, especially in patients with features of KD who are persistently febrile despite IVIG and patients with moderate to severe features of MIS-C such as shock and myocardial dysfunction. Dosing regimens are variable across institutions and should be determined by the patient’s clinical presentation.
- For patients with KD features that require steroids per the KD treatment algorithm, or patients that have moderate to severe MIS-C with shock and myocardial dysfunction, we recommend treatment with low- to moderate-dose glucocorticoids. Low to moderate dosing regimen: methylprednisolone or prednisolone 2 mg/kg/day divided twice daily for 5 days (max 60 mg), followed by 1 mg/kg/day divided twice daily for 5 days (max 30 mg), and then 0.5 mg/kg/day DAILY for 5 days (max 15 mg).
- For patients with severe or life-threatening complications, such as severe shock requiring high dose inotropes and/or vasopressors or features of severe MAS, high dose, pulse IV methylprednisolone (30 mg/kg daily, max 1 g, for up to three days followed by taper) may be considered.
- For those failing to respond to therapies above (persistent fever, shock, etc.), anti-cytokine therapy with anakinra (>4 mg/kg/day IV or SQ) should be considered.

- Low-dose aspirin (3-5 mg/kg/day; max 81 mg/day) should be used in patients with MIS-C and KD-like features and/or thrombocytosis (platelet count ≥450,000/ul), coronary ectasia with coronary Z scores >2.5 and <10 and continued until normalization of platelet count and confirmed normal coronary arteries at ≥4 weeks after diagnosis. Treatment with aspirin should be avoided in patients with a platelet count ≤80,000/ul.
- Patients with documented thrombosis or an ejection fraction <35% should receive therapeutic anticoagulation with enoxaparin until at least 2 weeks after discharge from the hospital.24
- An American College of Rheumatology MIS-C and COVID-19 Related Hyperinflammation Task Force has developed guidance.20 Also available is UW Health Kawasaki Disease Diagnosis and Management Guideline.
- Antibiotics are routinely used to treat potential sepsis while awaiting bacterial cultures.
- Pharmacologic venous thromboembolism (VTE) prophylaxis should be considered based upon risk factors as per UW Health VTE Prophylaxis - Pediatric - Inpatient Clinical Practice Guideline in severe or critical COVID-19 related illness without a contraindication.
- Stress ulcer prophylaxis may be considered based upon risk factors per UW Health Stress Ulcer Prophylaxis in the Intensive Care Unit - Adult/Pediatric/Neonatal - Inpatient Clinical Practice Guideline

**Discharge and Follow-Up**

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<tr>
<th>Lab monitoring</th>
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<td>- Recommend weekly for 4 weeks: CBC, CRP, ESR, plus any of the specific labs that have not yet normalized: CMP, troponin, ferritin, or D-dimer</td>
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<tr>
<td>- Labs should be ordered with the comment “Please fax results to Rheumatology Clinic, American Family Children’s Hospital, 608-261-2961. If questions or critical results, call 608-263-6420 option 2.”</td>
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<tr>
<td>- Family should be informed to call Rheumatology when tests are done so Rheumatology can follow up with the family as to whether or not to continue getting them.</td>
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<tr>
<td>- Additional screening labs:</td>
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<td>- Only if patient or labs checked are worsening</td>
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<tbody>
<tr>
<td>- Follow up Cardiology visit with echocardiogram and ECG at about 7-10 days for all patients</td>
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<tr>
<td>- Exercise restriction for all until cleared by Cardiology</td>
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<tr>
<td>- Additional recommendation as per consultation with Cardiology</td>
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<tr>
<td>- Follow up with Rheumatology in 4-6 weeks; may be coordinated with Cardiology follow up</td>
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Disclaimer
Consensus care models assist clinicians by providing a framework for the evaluation and treatment of patients. This guideline outlines the preferred approach for most patients. It is not intended to replace a clinician’s judgment or to establish a protocol for all patients. It is understood that some patients will not fit the clinical condition contemplated by a guideline and that a guideline will rarely establish the only appropriate approach to a problem.

Disclosure
It is the policy of UW Health that all workgroup members and other persons who may influence content in this guideline disclose all relevant financial relationships with commercial interests. Any disclosure of a relationship listed is not intended to suggest bias in the information presented but rather to provide the reader with information that may be of importance in their evaluation of the information presented.

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Plan for review: This guideline will be reviewed as dictated and necessary given public health priorities and as clinical evidence evolves.
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Reference

1. Veklury (remdesivir) [prescribing information]. Foster City, CA: Gilead Sciences, Inc; February 2021.