COVID-19 patients: Anticoagulation Management at UNC – Regular floor or ICU

a) Initial labs in all COVID patients: CBC with diff, retic, DIC panel*, AT3, ferritin, LDH, CMP
b) Repeat labs: Daily CBC and DIC panel*

* DIC panel at UNC = PT, aPTT, fibrinogen, D-dimer

<u>All patients</u> receive anticoagulation, unless bleeding contraindications - **thoroughly consider and factor into the decision-making a patient's bleeding risk factors**

Group A

Full-intensity

- Confirmed DVT or PE or other established reason for therapeutic anticoagulation (AF, mechanical heart valves replacement, etc.);
- High suspicion of DVT/PE, but objective documentation cannot be obtained.
- Renal failure patient on dialysis with repetitive clotting of dialysis tubing.

1. **<u>Either Enoxaparin</u> 1 mg/kg q 12** hr (attn: renal fx)

or

2. **<u>UFH</u>** 80 U/kg bolus, then 18 U/kg/hr
   - Target "hep correlation" or anti-Xa: 0.3-0.7 U/ml (preferably 0.5-0.7 U/mL)

Group B

Intermediate-intensity

- Patient with very high D-dimer (> 2,500 ng/mL [i.e. ca. 10x upper limit of normal] with UNC assay)[1]

1. **Either <u>Enoxaparin</u>** 0.5 mg/kg q 12 hr (attn: renal fx)

or

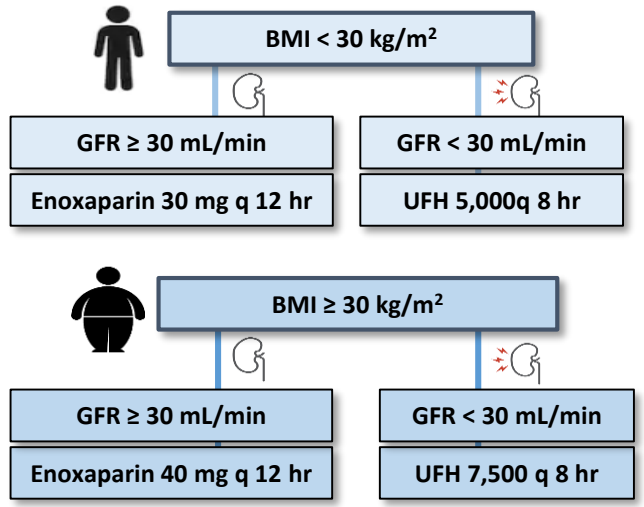
2. **<u>UFH</u>** 60 U/kg bolus, then 12 U/kg/hr
   - Target "hep correlation" or anti-Xa: 0.3-0.7 U/ml (preferably 0.3-0.5 U/mL)

3. If patient's bleeding risk too high, move patient to Group C.

Group C

Lower-intensity

- All patients who do NOT have a clear indication for full-dose anticoagulation (= Group A), and are not in Group B.
- Patients in Group C have D-dimer < 2,500 ng/mL (i.e. < ca. 10x upper limit of normal) with UNC assay)[2].



UFH monitoring:

- Test both, aPTT and "Heparin-unfractionated" (anti-Xa) test for first 48 hrs
- assess how well these two tests correlate
- If good correlation, then use aPTT; if poor correlation: use "Heparin-unfractionated" (anti-Xa) test.

After hospital discharge

(applies to Groups B and C)

- ***Patients who were sick with COVID-19***: Give **<u>Eliquis</u>®** (Apixaban) 2.5 mg bid or **<u>Xarelto</u>®** (Rivaroxaban) 10 mg once daily **for 30 days and until the patient is mobile**.
- ***Patients admitted to UNC for non-COVID reasons*** (but found to be infected with the SARS-CoV-2 virus): Consider **<u>Eliquis</u>** 2.5 mg bid or **<u>Xarelto</u>** 10 mg once daily **for up to 30 days,** particularly if they are > 75 year of age, had hospital admission > 2 days, were in the ICU, have cancer or previous h/o VTE, are obese, or have a D-dimer before d/c home of > 2x normal (i.e. > 500 ng/mL with UNC assay).
- Any patient with COVID-19 discharged from the hospital should be <u>educated about the 4 main symptoms</u> of DVT (swelling, pain, redness, warmth) and PE (SOB, CP, tachycardia, cough/hemoptysis).

[1] If a Group B patient's D-dimer on daily f/u testing falls to ≤ 2,500 ng/mL, consider keeping patient at intermediate-intensity dosing.
[2] If a Group C patient's D-dimer on daily f/u testing increases to > 2,500 ng/mL, consider repeat testing to determine a trend and moving to intermediate-intensity dosing.
If there are management concerns, a hematology consult can be obtained.

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