COVID-19 Patient in ICU
Suggest D-Dimer and TEG on admission

Start DVT Prophylaxis
Heparin 5000 units three times daily or
LMWH 40 mg daily
Consult pharmacist for bariatric dosing

Start Therapeutic Anticoagulation
- Heparin drip (low intensity) or LMWH 1.5 mg/kg daily
  or 1 mg/kg twice daily
- Low intensity protocol goal AntiXa 0.4 – 0.5
- Assess treatment with anti Xa levels, D-Dimer, TEG.
- Assessment should be done per protocol on Heparin
drip or after 3 doses of LMWH
- Consider adjusting goal AntiXa based on TEG if available

Consider Therapeutic Anticoagulation
(above) with multiple TEG abnormalities
- May be used to adjust antiXa goals

When to switch back to prophylaxis?
- Confirm absence of DVT with LE ultrasounds
- Suggest monitoring TEG and D-dimer weekly and if remains elevated continue therapeutic anticoagulation.
- Anticoagulation could lower D-dimer and alter TEG so do not stop if these values return to normal
- Suggest continuing therapeutic anticoagulation as long as patient is critically ill in the ICU

Clinical evidence of persistent dead space ventilation - PaCO₂ greater than 40 mmHg despite respiratory rate greater than 25 breaths per minute with tidal volume of 6 mL/kg IBW or higher
AND
Shock defined as requiring vasopressor to maintain MAP > 65 mmHg

Renal Failure
- 30% of COVID-19 patients may develop renal failure
- Heparin first option for therapeutic anticoagulation

Consider compassionate use thrombolytics

Suggest all three:
- D Dimer >1000
- Elevation of D Dimer from baseline
- Evidence of clotting

TEG
- Think Rock Glass
- Reaction Time < 5 min
- TEG Angle > 75
- Maximum Amplitude > 70 mm
- Ly30 = 0

Consider compassionate use thrombolytics