

Minutes - Covid ICU Skype meeting 4/8/2020

Issue: Self extubations

Discussion started with the issue of several self extubations have occurred with the thought that increased sedation is needed. The heavy sedation protocol for covid-19 vented patients is completed, and the Order set is to be going live soon. Name of order set is pending but will be distributed to the group. The new order set has for heavy sedation is a recipe list with multiple options including methadone and ketamine.

Issue: Constipation

Require a more aggressive bowel regimen. Concern for better bowel regimen since using heavy sedation. Need for more aggressive bowel regimen was agreed upon.

Issue: Use of benzodiazepine for anxiety related to SOB

Some people are having success with Ativan and Xanax po only q8. Avoiding iv benzodiazepine and some success with Ketamine.

Issue: Proning

The questions raised were how much sedation, paralytics for the process of proning. The other questions is who should be proned. The thoughts expressed where paralyze with pushes for the proning process, then heavy sedation but not continuous infusions of paralytics.

Issue Xray prior to first proning; is a recommendation to evaluate ETT placement since RT must change securing device and no xray obtained after intubation

Issue Manpower for proning if proning everyone: On gpu patients are self proning.

Issue when to prone:

if patients have been self proning on the gpu admitted to the ICU should continue with proning. Also looking a the P/F ratio < 150 since moving to low peep tables.

Issue Data: Discussed making sure the date gathered and documented is clean. Please use proning order set and nurses are documenting in EPIC.

Issue: Nutrition

Some felt patients are not getting feed while proned and that they nutritional needs are not being met. Discussion involved using the order set allows for volume goal to catchup. It also holds feeds for 50 minutes prior to proning. Concern are we taking propofol into account in kilocalories delivered.

Other nutrition issues; do we have ability to feed post pyloric and should we move forward with this? Also lack of pumps and bags to do feedings

Issue: Handoff

It was asked about the ICU handoff report in epic that was in the process of being being revised and would be helpful or not helpful to move forward with this at this time.

Issue: Stethoscope use

New templates available to document clinical exam which does not involve use of stethoscope.

Issue: Unit specific Iphone and Ipads to communicate with family

Is this secure? We are currently allowed to use face time

Issue: appropriate mask use

Discussion of N95 vs surgical masks and how to deal with people's discomfort of when to use which mask.

Issue : MSOfa score incorrect on EPIC

Meeting today at 1pm to see if need to go to manual over epic. Other issue if a MSOFA improves does that change the designation. Defer to clinical decision based on patients overall status was discussed.

Minutes - Covid ICU Skype meeting 4/1/2020

Please excuse omissions due to occasional loss of connectivity and ambient noise. Names of commenters are included unless not identified at beginning of comment.

13 Covid pods in 4 different ICUs
Doubled ICU capacity with currently only 3 beds open

Use of steroids – Ackerman

Unidentified: Concern that the short course of steroids are not working. Extending these out up to 7 days potentially seeing improvement.

Unidentified: Comment on possibly higher doses of steroids

Rivers: Reviewed study from Lancet regarding steroids that confirms some of the findings we're seeing.

Coba: Asked to discuss possible steroid taper. Agreement that there would be no steroid taper.

How are patients dying? – Khoshbin

Hurst: Two main etiologies: 1)acute distributive shock possibly 2/2 cytokine storm; have not been given Tocilizumab; all were on Plaquenil and steroids; 2)Renal failure; 2 patients had dialysis catheters clot off and could not receive treatment.

Peruzzi: Patients recovering from respiratory issues observed dying from myocarditis

Cowger: Observed patients arriving with high troponins and minimal respiratory symptoms. Outcomes with VA ECMO have not been great. In NY, WA did not use much VA ECMO; potentially suggesting cardiomyopathy not as severe as respiratory issues

Have people been anticoagulating these patients? – Yeldo

Yeldo: Are they prothrombotic? Is there a standard practice? Heparin gttts?

Hegab: Patients do seem to be hypercoagulable. D-Dimers are elevated. Small study out of China showed AC improved mortality with D dimer > 6x normal. D-dimer > 1 associated with increased mortality.

We are not currently incorporating anticoagulation due to heparin shortage, blood shortage; in the process of pushing through clinical trial of anticoagulation

Based on limited data, Hegab is selectively anticoagulating. Using Enoxaparin. 1mg/kg, q12

Renal Failure – what is threshold to dialyze? - Stagner

J Uduman: No standardized approach, patient specific. Controversial on optimal timing.

Is there a utility to switching to low PEEP table? – Abu Sayf

Hegab: Has not observed responsiveness to higher PEEPs. Proning much sooner; should be using low PEEP table.

J Uduman: Series from Italy; 5 patients – seems to validate low PEEP observation

Peruzzi: Some papers seem to support high peep tables; patients tend to be extubated to HFNC

Tatem: *Typed comment:* *I would agree with the low PEEP/high FiO2 strategy. We're not seeing issues with compliance that would require high PEEP. The severe hypoxemia that improves with proning is more consistent with shunt physiology.*

Derecruitment? – Unidentified

Hegab: Would expect patients to have compliance issues and thinks people are having cytokine storms instead post extubation.

Are we avoiding APRV? – Unidentified

Hegab: Yes. Several pneumothoraces. They need oxygen, not pressure.

Unidentified: Are hemoglobinopathies contributing to hypoxia which would make FiO2 more beneficial

Peruzzi: Hypoxia vs Hypoxemia – unclear signal

Peruzzi: Consider shunts in cases of hypoxemia especially since we are unable to get baseline echo on patients.

Cobra: Has found some benefit using high PEEP table. Dropping by one every 8 hours if signs of improvement as opposed to a higher rate of wean. Has used APRV with some improvement. Tries not to switch them until CPAP. Believes they are initially PEEP dependent.

Hegab: Concern about APRV – amount of nursing and RT involvement may limit the usefulness due to unnecessary exposures

Kelly: Is invasive CPAP a ventilatory option

Unidentified: Avoiding non-invasive ventilation 2/2 limited amount of negative pressure rooms. Trying to optimize more HFNC. Early in the course we're seeing hypoxic respiratory failure and responding to PEEP.

Eichenhorn: Going back to APRV – concern for using APRV unless there is a medical director present. Concerned that APRV has not shown benefit. Considering closing down APRV

Peruzzi: If careful and selective can help, but agrees not designed for epidemic.

Rubinfeld: Supports moratorium on APRV

Eichenhorn: Does not see any support for APRV in the literature. Supports a study of APRV, but not as a general mode of ventilation. Instructing RT to not use in this patient population.

Khoshbin: Agrees that there is not obvious progress with APRV.

Jayaprakash: Has been able to wean PEEP and has not seen de-recruitment.

Timing for repeat Covid testing for tracheostomy? - Jayaprakash

Peruzzi: Decision made not to proceed to tracheostomy on COVID patients

Johnson: Would not consider traching within 14 days and then case by case basis. Same should hold true for any aerosolizing procedures.

Do we have capacity for retesting? – Unidentified

Ramesh: Yes, we will be able to retest in the near future but not yet. Negative test does not guarantee that the patient is not shedding the virus.

Khoshbin: Concern for sickened physicians

Johnson: Is the reason the PEEP is effective because we are recruiting more alveoli to participate in gas exchange? *Cut out second half of statement...*

Peruzzi: Believes the PEEP is effective due to recruitment.

Johnson: Should we measure FRC? We should measure with the “old gas balloon”

Eichenhorn: says no old gas balloons. He seems serious about that.

Comments on protocols for cardiac arrest, nutrition, and transports - Coba

Pflaum: UK data suggests no longer than 10-15 min or single shock. Also comes down to provider judgement, if maxed on vasopressors may make no sense to code. Weigh risks and benefits of exposure to team. Seattle is using plastic sheeting over ETT to minimize exposure.

Eichenhorn: This decision must be transparent to family. Slow code is not ethically appropriate.

Swiderek: For transfers – can transfer to any GPU with transfer note and call.

Eichenhorn: Residents may not refuse. Staff makes these decisions. Any refusal should be reported to Eichenhorn.

Coba: Are we overfeeding with tube feeds and Propofol; what should caloric goals be?

Unidentified: Signal cut out but seems like a document was sent out discussing this topic.

Final Comments:

Swiderek: Will plan additional meetings like this one, possibly weekly.

Rivers: Would like to discuss research at next meeting.

Coba: If there is a good candidate for ECMO, we should consider transfer to another facility. HFH not currently offering ECMO, however.