

CARE IN HOSPITAL FOR CHILDREN AND ADOLESCENTS WITH SEVERE TO CRITICAL COVID-19



NATIONAL CLINICAL EVIDENCE TASKFORCE

COVID-19

VERSION 2.1

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FORMS OF GUIDANCE

Evidence-Based Recommendation (EBR)
Consensus Recommendation
Good Practice Point

Types of EBRs

RECOMMENDATION FOR USE

RECOMMENDATION AGAINST USE

CONDITIONAL RECOMMENDATION FOR USE

CONDITIONAL RECOMMENDATION AGAINST USE

General

PATIENTS

- This flowchart applies to children in hospital because of COVID-19.
- This flowchart applies to children under 16 years of age.
- Depending on the physical size and/or developmental status of the patient, either the paediatric or adult flowcharts can be applied.

FLUID MANAGEMENT

GOOD PRACTICE POINT

In all patients with confirmed or presumed moderate to severe COVID-19, undertake fluid management as per usual considerations for severe illness, which may include restrictive fluids.

VTE PROPHYLAXIS

CONSENSUS RECOMMENDATION

Thromboprophylaxis

For all children and adolescents hospitalised for COVID-19, the following are recommended to prevent thrombosis, based on age and risk assessment.

- In children and adolescents aged **12 years and over** who are hospitalised specifically for COVID-19 treatment and with no contraindications to anticoagulants[#], use prophylactic doses of LMWH* and mechanical thromboprophylaxis (TED stockings or calf compressors) until discharge from hospital.
- In children **less than 12 years old** who are hospitalised specifically for COVID-19 treatment and **with either D-dimer levels > 5 x upper limit normal, or additional thrombosis risk factors*** (including hospital associated VTE), use prophylactic doses of LMWH* and mechanical thromboprophylaxis (TED stockings or calf compressors) where suitable based on size and mobility until discharge from hospital.

DRUG TREATMENTS

Consider eligibility for drug treatments, depending on time since symptom onset and lab features (e.g. CRP).

There are limited data on the efficacy of drug treatment in children and adolescents.

Refer to:

- Summary of recommendations in [DRUG TREATMENTS FOR CHILDREN AND ADOLESCENTS WITH COVID-19 Clinical Flowchart](#)

Supportive care

Definition of disease severity

SEVERE ILLNESS

Any one of:

Respiratory/vital signs

- Moderate-severe work of breathing
- Abnormal vital signs for age (tachycardia, tachypnoea) with breaches of Early Warning Criteria (e.g. Medical Emergency Team [MET])
- Apnoea needing support / stimulation (infants)

Oxygen requirement

- Requires high-flow oxygen or non-invasive ventilation

Feeding/hydration

- Poor feeding, unable to maintain hydration without nasogastric or IV fluids

Conscious state

- Drowsy / tired but easily rousable

CRITICAL ILLNESS

Any one of:

Respiratory/vital signs

- Unable to maintain breathing or prevent apnoea without advanced modes of support
- Abnormal vital signs for age with persistent breaches of Early Warning Criteria (e.g. MET)
- Haemodynamically unstable without inotropic or vasopressor support
- Other organ failure

Oxygen requirement

- Requires advanced modes of support to maintain oxygenation
- Intubation and mechanical ventilation
- Extracorporeal membrane oxygenation (ECMO)

Feeding/hydration

- Poor feeding, unable to maintain hydration without nasogastric or IV fluids

Conscious state

- Altered conscious state / unconscious

Respiratory support

NON-INVASIVE

CONSENSUS RECOMMENDATION

HFNO or NIV

Consider using high-flow nasal oxygen (HFNO) or non-invasive ventilation (NIV) therapy for neonates, children and adolescents with hypoxaemia or respiratory distress associated with COVID-19 and not responding to low-flow oxygen. Use it with caution and pay strict attention to staff safety, including the use of appropriate PPE.

CONSENSUS RECOMMENDATION

Prone positioning

For neonates, children and adolescents with COVID-19 and respiratory symptoms who are receiving non-invasive respiratory support, consider prone positioning if patient co-operation is possible. When positioning a patient prone, ensure it is used with caution and close monitoring of the patient.

CONSENSUS RECOMMENDATION

Respiratory management of deteriorating child

Consider endotracheal intubation and mechanical ventilation in neonates, children and adolescents with COVID-19 who are deteriorating despite optimised, non-invasive respiratory support.

CONDITIONAL RECOMMENDATION FOR

Videolaryngoscopy

In neonates, children and adolescents with COVID-19 undergoing endotracheal intubation, consider using videolaryngoscopy over direct laryngoscopy if available and the operator is trained in its use.

MECHANICAL VENTILATION

CONSENSUS RECOMMENDATION

Prone positioning

For mechanically ventilated neonates, children and adolescents with COVID-19 and hypoxaemia despite optimising ventilation, consider prone positioning if there are no contraindications.

CONSENSUS RECOMMENDATION

Positive end-expiratory pressure

For mechanically ventilated neonates, children and adolescents with COVID-19 and moderate to severe ARDS with atelectasis, consider using a higher PEEP strategy over a lower PEEP strategy. The absolute PEEP values that constitute a high and low PEEP strategy will depend on age and patient size.

CONSENSUS RECOMMENDATION

Recruitment manoeuvres

For mechanically ventilated neonates, children and adolescents with COVID-19 and hypoxic respiratory failure characterised by severe atelectasis unresponsive to other ventilation strategies, consider using recruitment manoeuvres.

GOOD PRACTICE POINT

In neonates and infants, staircase or stepwise incremental recruitment manoeuvres should only be performed using mean airway pressure in a high-frequency oscillatory ventilation mode. Staircase or stepwise (incremental PEEP) recruitment manoeuvres should not be performed during conventional ventilation.

ECMO

CONSENSUS RECOMMENDATION

Extracorporeal membrane oxygenation

Consider early referral to an ECMO centre for venovenous or venoarterial ECMO in mechanically ventilated neonates, children and adolescents with COVID-19 with refractory respiratory or cardiovascular failure despite optimising other critical care interventions.

CONSENSUS RECOMMENDATION AGAINST

Neuromuscular blockers

For intubated neonates, children and adolescents with COVID-19, do not routinely use continuous infusions of neuromuscular blocking agents (NMBAs).

However, if effective lung-protective ventilation cannot be achieved, consider targeted intermittent use of NMBAs. If indicated, the choice of NMBA should be guided by the age group and regional practice.

CONSENSUS RECOMMENDATION

High-frequency oscillatory ventilation

Do not routinely use HFOV as a first line mode of mechanical ventilation in neonates, children and adolescents with severe COVID-19. HFOV should be limited to a rescue therapy in neonates and children not responding to conventional mechanical ventilation in a specialist centre with experience with HFOV.

HFOV delivers gas at very high flow rates. This may increase the aerosol-generating potential compared to other forms of respiratory support used in intensive care.

Key source

[National COVID-19 Clinical Evidence Taskforce](#) – Australian guidelines for the clinical care of people with COVID-19.

Contraindications to thromboprophylaxis

- Stroke / intracranial haemorrhage
- Any bleeding from any site / uncontrolled bleeding
- Likely to need surgery in <24 hours
- Congenital bleeding disorder (e.g. Von Willebrand Disease, haemophilia)
- Platelets <50x10⁹/L and/or INR >1.8
- Uncontrolled hypertension

Consider unfractionated heparin (UFH)

* Dose of low molecular weight heparin (LMWH)

- ≥3 months old – enoxaparin 0.5 mg/kg BD (max 60 mg BD)
- <3 months old – enoxaparin 0.75 mg/kg BD
- UFH is an alternative to LMWH and can be considered if there is potential for surgical intervention, renal impairment or other clinical factors that would normally favour UFH over LMWH. Dosing should be advised by paediatric haematology.

Where eGFR is <30 mL/min/1.73 m², UFH or clearance-adjusted doses of LMWH may be used (discuss with paediatric haematologist).

^ Thrombosis risk factors

- Admission to PICU
- Obesity (BMI >95th centile)
- Central venous catheter
- Length of stay anticipated >3 days
- Immobility that is not longstanding
- Personal history of VTE
- Known thrombophilia
- First degree relative with VTE
- Active malignancy
- Recent surgery / trauma
- Severe dehydration
- Underlying medical condition: nephrotic syndrome, cystic fibrosis, sickle cell disease, cardiac disease, chronic inflammatory disorder (juvenile idiopathic arthritis, inflammatory bowel disease), post splenectomy