### Summary Recommendations

#### Hemodynamics
- For adults with COVID-19 and shock, the COVID-19 Treatment Guidelines Panel (the Panel) recommends using dynamic parameters, skin temperature, capillary refilling time, and/or lactate levels over static parameters to assess fluid responsiveness (BIIa).
- For the acute resuscitation of adults with COVID-19 and shock, the Panel recommends using buffered/balanced crystalloids over unbalanced crystalloids (BIIa).
- For the acute resuscitation of adults with COVID-19 and shock, the Panel recommends against the initial use of albumin for resuscitation (BI).
- For adults with COVID-19 and shock, the Panel recommends norepinephrine as the first-line vasopressor (AI).
- For adults with COVID-19 and shock, the Panel recommends titrating vasoactive agents to target a mean arterial pressure (MAP) of 60 to 65 mm Hg over higher MAP targets (BI).
- The Panel recommends against using hydroxyethyl starches for intravascular volume replacement in adult patients with COVID-19 and sepsis or septic shock (AI).
- When norepinephrine is available, the Panel recommends against using dopamine for adult patients with COVID-19 and shock (AI).
- As a second-line vasopressor, the Panel recommends adding either vasopressin (up to 0.03 units/min) (BIIa) or epinephrine (BIIb) to norepinephrine to raise MAP to target or adding vasopressin (up to 0.03 units/min) (BIIa) to decrease norepinephrine dosage.
- The Panel recommends against using low-dose dopamine for renal protection (AI).
- The Panel recommends using dobutamine in adult patients with COVID-19 who show evidence of cardiac dysfunction and persistent hypoperfusion despite adequate fluid loading and the use of vasopressor agents (BIII).
- The Panel recommends that all adult patients with COVID-19 who require vasopressors have an arterial catheter placed as soon as practical, if the resources to do so are available (BIII).
- For adult patients with refractory septic shock who have completed a course of corticosteroids to treat COVID-19, the Panel recommends using low-dose corticosteroid therapy ("shock-reversal") over no corticosteroid therapy (BIIa).

#### Oxygenation and Ventilation
- For adults with COVID-19 and acute hypoxemic respiratory failure despite conventional oxygen therapy, the Panel recommends starting therapy with high-flow nasal cannula (HFNC) oxygen; if patients fail to respond, noninvasive ventilation (NIV) or intubation and mechanical ventilation should be initiated (BIIa).
- For adults with COVID-19 and acute hypoxemic respiratory failure who do not have an indication for endotracheal intubation and for whom HFNC oxygen is not available, the Panel recommends performing a closely monitored trial of NIV (BIIa).
- For adults with persistent hypoxemia who require HFNC oxygen and for whom endotracheal intubation is not indicated, the Panel recommends a trial of awake prone positioning (BIIa).
- The Panel recommends against the use of awake prone positioning as a rescue therapy for refractory hypoxemia to avoid intubation in patients who otherwise meet the indications for intubation and mechanical ventilation (AIII).
- If intubation becomes necessary, the procedure should be performed by an experienced practitioner in a controlled setting due to the enhanced risk of exposing health care practitioners to SARS-CoV-2 during intubation (AIII).
- For mechanically ventilated adults with COVID-19 and acute respiratory distress syndrome (ARDS):
  - The Panel recommends using low tidal volume (VT) ventilation (VT 4–8 mL/kg of predicted body weight) over higher VT ventilation (VT >8 mL/kg) (AI).
  - The Panel recommends targeting plateau pressures of <30 cm H$_2$O (Alla).
  - The Panel recommends using a conservative fluid strategy over a liberal fluid strategy (BIIa).
  - The Panel recommends against the routine use of inhaled nitric oxide (Alla).
Summary Recommendations, continued

- For mechanically ventilated adults with COVID-19 and moderate to severe ARDS:
  - The Panel recommends using a higher positive end-expiratory pressure (PEEP) strategy over a lower PEEP strategy (BIIa).
  - For mechanically ventilated adults with COVID-19 and refractory hypoxemia despite optimized ventilation, the Panel recommends prone ventilation for 12 to 16 hours per day over no prone ventilation (BIIa).
  - The Panel recommends using, as needed, intermittent boluses of neuromuscular blocking agents (NMBAs) or a continuous NMBA infusion to facilitate protective lung ventilation (BIIa).
  - In the event of persistent patient-ventilator dyssynchrony, or in cases where a patient requires ongoing deep sedation, prone ventilation, or persistently high plateau pressures, the Panel recommends using a continuous NMBA infusion for up to 48 hours, as long as the patient’s anxiety and pain can be adequately monitored and controlled (BIII).
- For mechanically ventilated adults with COVID-19, severe ARDS, and hypoxemia despite optimized ventilation and other rescue strategies:
  - The Panel recommends using recruitment maneuvers rather than not using recruitment maneuvers (CIIa).
  - If recruitment maneuvers are used, the Panel recommends against using staircase (incremental PEEP) recruitment maneuvers (AIIa).
  - The Panel recommends using an inhaled pulmonary vasodilator as a rescue therapy; if no rapid improvement in oxygenation is observed, the treatment should be tapered off (CIII).

Pharmacologic Interventions

- In the absence of a proven or suspected bacterial infection, the Panel recommends against the use of empiric broad-spectrum antibiotics in adult patients with severe or critical COVID-19 (BIII).
- As with any hospitalized patient, adult patients with COVID-19 who receive antibiotics should be reassessed daily to minimize the adverse consequences of unnecessary antimicrobial therapy (AIII).

Extracorporeal Membrane Oxygenation

- There is insufficient evidence for the Panel to recommend either for or against the use of extracorporeal membrane oxygenation in adults with COVID-19 and refractory hypoxemia.

Rating of Recommendations: A = Strong; B = Moderate; C = Weak
Rating of Evidence: I = One or more randomized trials without major limitations; IIa = Other randomized trials or subgroup analyses of randomized trials; IIb = Nonrandomized trials or observational cohort studies; III = Expert opinion