How to use these guidelines?

- SARS-CoV-2 infection can result in diverse clinical conditions in children. These guidelines are intended to assist providers in the evaluation and management of the most severe conditions.

- Acute COVID-19 in children can begin as fever and very non-specific “viral” symptoms within different organ systems (e.g. anosmia, rhinorrhea, diarrhea, rash). Some children, especially those who are older with comorbidities like obesity, progress to develop severe lower respiratory tract disease like that seen commonly in adults. The guidance in the Acute COVID-19 section is based primarily on data and principles from the treatment of the respiratory disease in adults.

- Multisystem inflammatory syndrome of children (MIS-C) is a severe syndrome of inflammatory dysregulation that generally occurs weeks after a primary symptomatic or even asymptomatic infection. MIS-C also represents a spectrum of diseases, with younger children often experiencing a vasculitis like that of Kawasaki Disease and older children and adolescents presenting with severe myocarditis and shock.

- How do you decide which pathway to follow?
  - This table summarizes characteristics that can be used to distinguish the pathways.
  - The timing from exposure may yield a clue. MIS-C classically comes weeks after exposure compared to the shorter incubation period (~ 4-14 days) for acute infection; but note the time windows do overlap.
  - Children with mild disease can always be monitored, following symptoms +/- select lab values based on the presentation; but remain alert for acute decline in children with MIS-C.
  - Some children can have a mix of features from the pathways (e.g. MIS-C and lower respiratory disease). The evaluation and management of children with severe and mixed features should be based on principles of these guidelines and consultation with subspecialties.
  - Many children in our care have multiple and complicated chronic medical conditions; their management may fall outside of these guidelines, and should be tailored based on discussion with the relevant subspecialties.

These guidelines were developed by the Pediatric COVID Clinical Working Group, with input from pediatric critical care, hospital medicine, rheumatology, cardiology, gastroenterology, infectious disease, and hematology at Benioff Children’s Hospitals San Francisco and Oakland. These are clinical guidelines only and should not replace clinical judgement. Data about SARS-CoV-2 infection in children continues to evolve; versions of these guidelines will be date stamped and updated. If you have suggestions or questions about these guidelines please email maude.dull@ucsf.edu or theodore.ruel@ucsf.edu.
Distinguishing Acute COVID-19 from MIS-C

Acute COVID-19 and MIS-C have overlapping features. These findings may help to differentiate between them.

**Acute COVID-19**
- COVID exposure within ~2 weeks
- Less likely +COVID antibodies
- More likely +COVID PCR
- Prominent upper and/or lower respiratory symptoms
- Acute loss of taste and/or smell

**MIS-C**
- Onset of symptoms 2-6 weeks after infection or exposure
- More likely +COVID antibodies
- Less likely +COVID PCR
- Oral mucosal changes
- Swollen hands / feet
- Erythema of palms or soles
- Extremely elevated ferritin (>10K)
- Coronary artery aneurysms
- Elevated BNP OR
- Evidence of cardiac dysfunction
### Acute COVID-19 Guidelines

#### MIS-C Symptoms

#### Acute COVID-19 Symptoms

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASYMPTOMATIC</strong></td>
<td>No symptoms ascribed to COVID</td>
</tr>
<tr>
<td><strong>MILD</strong></td>
<td>Respiratory or other symptoms <em>not</em> requiring healthcare without a new or increased supplemental oxygen requirement</td>
</tr>
<tr>
<td><strong>MODERATE</strong></td>
<td>Respiratory or other symptoms requiring healthcare <em>without</em> a new or increased supplemental oxygen requirement</td>
</tr>
<tr>
<td><strong>SEVERE</strong></td>
<td>New or increased requirement for supplemental oxygen (Oxygen saturation &lt; 94% or below patient baseline)</td>
</tr>
<tr>
<td><strong>CRITICAL</strong></td>
<td>New or increased requirement for invasive or noninvasive mechanical ventilation, sepsis, multiorgan failure, or rapidly worsening clinical trajectory that does not yet meet these criteria</td>
</tr>
</tbody>
</table>
ASYMPTOMATIC

No symptoms ascribed to COVID

If patient meets criteria for HIGH RISK COVID:

- Severe obesity (BMI > 99th percentile for age)
- Severe immunocompromise as defined by the attached antiviral guidance (not mild-moderate)
  - Patient dependent on home trach/vent, Bipap, or HFNC
  - Severe lung disease
  - Severe cardiac disease
- Patients without the above but with multiple EUA-defined risk factors will also be considered

Consider holding immunosuppression if it can be avoided. Specific COVID treatment is not recommended.
MILD

Respiratory or other symptoms not requiring healthcare without a new or increased supplemental oxygen requirement

If patient meets criteria for HIGH RISK COVID:

- Severe obesity (BMI > 99th percentile for age)
- Severe immunocompromise as defined by the attached antiviral guidance (not mild-moderate)
- Patient dependent on home trach/vent, Bipap, or HFNC
- Severe lung disease
- Severe cardiac disease

Patients without the above but with multiple EUA-defined risk factors will also be considered

Consider holding immunosuppression if it can be avoided. Specific COVID treatment is not recommended.

Monoclonal antibody therapy is not recommended routinely, but may be considered on a case-by-case basis per EUA

ID consultation recommended for any treatment questions in patients hospitalized with COVID-19

Go back to Acute COVID-19 Guidelines Page

If patient develops oxygen requirement proceed to SEVERE COVID guidelines
Respiratory or other symptoms requiring healthcare **without** a new or increased supplemental oxygen requirement

**MODERATE**

**LABS**

- BNP
- Troponin
- D-dimer
- Ferritin
- Fibrinogen
- INR/PT/PTT

**Consider based on clinical presentation:**

- Specimen storage (red, freeze)
- COVID IgG
- Blood Culture if indicated

**Recommended if not already done:**

- CBC with differential
- C-reactive protein
- Erythrocyte Sedimentation Rate
- Basic Metabolic Panel
- Albumin

**Supportive care is recommended for all patients.**

**Antiviral therapy may be considered on a case-by-case basis as outlined in pediatric multicenter guidance.**

- Monoclonal antibody therapy is not recommended routinely, but may be considered on a case-by-case basis per EUA

ID consultation recommended for any treatment questions in patients hospitalized with COVID-19

Go back to **Acute COVID-19 Guidelines Page**

- Anticoagulation may be indicated in hospitalized patients
- If patient develops oxygen requirement proceed to **SEVERE COVID guidelines**
SEVERE

New or increased requirement for supplemental oxygen (Oxygen saturation < 94% or below patient baseline)

LABS

- CBC with differential
- C-reactive protein
- Erythrocyte Sedimentation Rate
- Basic Metabolic Panel
- Albumin
- BNP
- Troponin
- D-dimer
- Ferritin
- Fibrinogen
- INR/PT/PTT
- Specimen storage (red, freeze)
- COVID IgG
- Blood Culture if indicated

Remdesivir is indicated
ID Consult required for antivirals

Consider adding Dexamethasone

Duration of Therapy:
Remdesivir: 5 days in severe illness
Dexamethasone: 10 days

**Therapy can be discontinued if patient is well enough for discharge**

Remdesivir: Dosage is determined by age and weight of patient

Monitoring for Remdesivir:
Monitor hepatic panel at baseline and during therapy
Discontinue remdesivir
ALT elevation > 10X ULN and/or signs or symptoms of liver inflammation:

Dexamethasone:
0.15 mg/kg/dose (max 6 mg/dose) IV/enterally once daily
Consider risks vs. benefits of dexamethasone in relationship to underlying conditions (e.g. prior immunosuppression, metabolic disease, etc.) especially in patients with less severe respiratory illness

Antiviral treatment recommendations are based on UCSF IDMP Pediatric Guidelines

Anticoagulation may be indicated in hospitalized patients

At point of hemodynamic instability, revisit MIS-C recommendations

Go back to Acute COVID-19 Guidelines Page
New or increased requirement for invasive or noninvasive mechanical ventilation, sepsis, multiorgan failure, or rapidly worsening clinical trajectory that does not yet meet these criteria.

**CRITICAL**

**LABS**
- CBC with differential
- C-reactive protein
- Erythrocyte Sedimentation Rate
- Basic Metabolic Panel
- Albumin
- BNP
- Troponin
- D-dimer
- Ferritin
- Fibrinogen
- INR/PT/PTT
- Specimen storage (red, freeze)
- COVID IgG
- Blood Culture if indicated

**Recommended if not already done:**
- ID Consult required for antivirals
- Remdesivir is indicated
- Consider adding Dexamethasone
- Duration of Therapy:
  - Remdesivir: 5 - 10 days in critical illness, guided by clinical course
  - Dexamethasone: 10 days or until discharge

**Remdesivir:**
- Dosage is determined by age and weight of patient
- Click here for remdesivir dosing and EUA requirements

**Monitoring for Remdesivir:**
- Monitor hepatic panel at baseline and during therapy
- Discontinue remdesivir
- ALT elevation > 10X ULN and/or signs or symptoms of liver inflammation:

**Dexamethasone:**
- 0.15 mg/kg/dose (max 6 mg/dose) IV/enterally once daily
- Consider risks vs. benefits of dexamethasone in relationship to underlying conditions (e.g. prior immunosuppression, metabolic disease, etc.) especially in patients with less severe respiratory illness

**Antiviral treatment recommendations are based on UCSF IDMP Pediatric Guidelines**

**Anticoagulation may be indicated in hospitalized patients**

**At point of hemodynamic instability, revisit MIS-C recommendations**

Go back to Acute COVID-19 Guidelines Page  Go back to Main Page
Remdesivir Therapy
Indicated for Severe and Critical disease
ID Consult required for antivirals

Age < 12 years and/or weight < 40 kg

Remdesivir
Lyophilized powder only

Wt 3.5 - 40 kg:
5 mg/kg/dose IV on day 1,
then 2.5 mg/kg/dose IV q24h

Wt > 40 kg:
200 mg/dose IV on day 1,
then 100 mg/dose IV q24h

Obtain informed consent from caregiver including discussion that medication is not yet FDA approved for patients < 12 years or <40 kg

Age ≥ 12 years and weight > 40 kg

Remdesivir
Lyophilized powder only

Wt >= 40 kg:
200 mg/dose IV on day 1,
then 100 mg/dose IV q24h

Remdesivir is FDA approved for treatment of hospitalized patients ≥ 12 years and ≥ 40kg

Go back to Acute COVID-19 Guidelines Page
Antiviral treatment recommendations are based on UCSF IDMP Pediatric Guidelines

At point of hemodynamic instability, revisit MIS-C recommendations
MIS-C Evaluation

Consider MIS-C if...

Refer to CDC & WHO case definitions

Fever AND Critically Ill

OR

Persistent fever ≥3 days

AND clinical or lab features of MIS-C

AND ill-appearing

OR

Persistent unexplained fever for ≥5 days

Initial Evaluation

Clinical Features

Treatment

Anticoagulation

Suspected MIS-C

Ongoing fever, lab evidence of inflammation, multi-system involvement, seriously ill, no alternate diagnosis

Confirmed MIS-C

Above plus +COVID PCR or IgG, or known exposure
# Initial Evaluation

## Step 1: Diagnosis

<table>
<thead>
<tr>
<th>Evidence of Shock</th>
<th>High Suspicion for MIS-C</th>
<th>Low Suspicion for MIS-C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate sepsis evaluation</td>
<td>No evidence of shock</td>
<td>No evidence of shock</td>
</tr>
<tr>
<td>Initial Labs + Additional Labs CXR, EKG, POCUS/ECHO</td>
<td>Initial Labs + Additional Labs</td>
<td>Initial Labs +/- CXR if indicated</td>
</tr>
<tr>
<td>Careful fluid resuscitation if high suspicion for cardiac dysfunction</td>
<td>+/- CXR if indicated</td>
<td>If lab evidence of MIS-C, obtain EKG, cardiology consult for possible ECHO</td>
</tr>
<tr>
<td></td>
<td>If lab evidence of MIS-C, obtain EKG, cardiology consult for possible ECHO</td>
<td>If clinically stable AND no lab evidence of MIS-C</td>
</tr>
</tbody>
</table>

## Step 2: Treatment

<table>
<thead>
<tr>
<th>Meets CDC or WHO case definitions for MIS-C</th>
<th>Meets criteria for Complete or Incomplete KD AND Negative or pending COVID PCR/IgG No known COVID-19 contacts within the past 2 - 4 weeks</th>
<th>If clinically stable AND no lab evidence of MIS-C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage per MIS-C treatment protocol</td>
<td>Standard KD management Monitor for signs of shock If COVID PCR or IgG becomes positive, manage per MIS-C treatment protocol</td>
<td>Consider discharge with close PCP follow-up</td>
</tr>
</tbody>
</table>

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Go back to MIS-C Evaluation

Consider alternate diagnoses
Clinical Features of MIS-C

- Evidence of current or recent SARS-CoV-2 infection by RT-PCR, serology, or antigen test, **OR**
- Exposure to a suspected or confirmed COVID-19 case within the 4 weeks prior to the onset of symptoms, **AND**
- ≥ 2 organ system involvement:

  **GI** : diarrhea, abdominal pain, appendicitis, pancreatitis, hepatitis, gallbladder hydrops or edema
  
  **CV** : hypotension or shock, dysrhythmia/arrhythmia, EF <55%, pulmonary edema due to left heart failure, coronary artery dilation (z-score ≥2.5) and/or aneurysm, pericarditis, pericardial effusion, valvulitis, BNP > 400, elevated troponin

  **Heme** : WBC <4K, anemia, platelets <150K, DVT, PE, hemolysis, bleeding, prolonged PT/PTT, extremity ischemia

  **MSK** : arthritis, arthralgias, myositis, myalgias

  **Mucocutaneous** : bilateral conjunctival injection, oral mucosal changes, rash or skin ulcers, “COVID toes,” swollen/red/cracked lips, erythema of palms or soles, edema of hands or feet, periungual desquamation

  **Respiratory** : supplemental O2 or mechanical ventilation, severe bronchospasm requiring continuous bronchodilators, pulmonary infiltrates on CXR, lower respiratory infection, PE, pneumothorax, pulmonary hemorrhage, need for chest tube

  **Neuro** : stroke, seizure, encephalitis, aseptic meningitis, demyelinating disorder, AMS, suspected meningitis with negative culture

  **Renal** : acute kidney failure
**Initial Labs:**
- CBC with Differential
- CRP
- ESR
- BMP
- ALT
- Albumin
- UA with Micro
- SARS-CoV2-PCR (or NAAT as part of RVP)
- COVID IgG
- RVP

**Additional Labs:**
- BNP
- Troponin
- Ferritin
- D-dimer
- PT
- PTT
- Fibrinogen
- LDH
- Blood Culture
- Red top to hold prior to IVIG

**Labs to be Considered with Consultation:**
- Quantitative Immunoglobins (IgG/IgA/IgM)
- Lymphocyte Subsets
- Antiphospholipid Antibodies
- Cytokine Panel
- Soluble IL-2R

Go back to *MIS-C Evaluation*
Differential Diagnosis

Kawasaki Disease
- More common in younger children
- COVID testing negative
- Less likely shock/cardiac dysfunction

Drug Hypersensitivity Reactions
- Consider SJS, DRESS or serum sickness like reaction
- History of recent or semi-recent exposure to drug
- Arthralgias and diffuse mucositis

Myocarditis:
- May overlap with MIS-C or have alternate cause

Bacterial infection/Sepsis:
- Obtain cultures and evaluate for source
- Consider meningitis

Staphylococcal and streptococcal toxin-mediated diseases
- Diffuse rash and hypotension
- Obtain cultures and evaluate for source, including gynecology or scarlet fever

Staph Scalded Skin Syndrome (SSSS):
- Increasing erythema and bullae
- Younger children
- Obtain cultures

Tick-Borne Illnesses:
- With epidemiologic risk factors
- Rocky Mountain Spotted Fever or Leptospirosis

Viral Infections:
- Active COVID infection, measles, adenovirus, enterovirus

Main Page

Go back to MIS-C Evaluation
MIS-C Treatment

**Initial Management**
- ECHO if not already done
- Admit to ICU if shock, hypotension, concern for cardiac dysfunction/dysrhythmia
- Consult ID, Rheumatology, Cardiology
- Patients with mild disease may receive supportive care only, monitor until clearly improving.
  (Mild = normal vital signs apart from fever, only reason for hospitalization is for mild dehydration and/or monitoring).

**First-Line Treatment**
- IVIG 2 g/kg/dose (use ideal body weight) IV X1 dose per infusion protocol
- Methylprednisolone 1 mg/kg/dose (max 30 mg/dose) IV q12h
- Anti-platelet: ASA 3-5 mg/kg/dose (max 81 mg) enterally qday, if platelets > 80K
- Histamine-2 receptor antagonist (H2RA) or Proton pump inhibitors (PPI) while on high-dose steroids

  Consider IVIG without steroids if Kawasaki Disease features present (e.g. mucositis, swollen hands and feet) and not critically ill
  Consider holding corticosteroids if significant ongoing concern for bacterial sepsis

  If concern for MAS or critically ill, consider pulse-dose methylprednisolone 30 mg/kg/dose (max 1000 mg/dose) IV q24h for 1-3 days
  (in consultation with rheumatology)

  Consider high-dose methylprednisolone 10 mg/kg/dose IV q24h for patients with severely depressed cardiac function
  (in consultation with heart failure team)

  Consider transitioning to enteral corticosteroid equivalent as patient improves and continue until CRP normalized

**Second-Line Treatment**
- Anakinra IV if not improving with first-line treatment OR concern for MAS
  Initial dose 2-4 mg/kg/dose (max 100 mg/dose) IV q24h, may increase dose in consultation with rheumatology

Click here for **Post-Discharge Follow-up**

Anticoagulation may be indicated in hospitalized patients
Follow-Up

**Rheumatology follow-up:**
Labs and medication management
Once CRP normalized, taper steroids over 15 days in 5-day steps (2 mg/kg/day for 5 days, 1 mg/kg/day for 5 days, then 0.5 mg/kg/day for 5 days, then off), per KD RAISE protocol

**Cardiology follow up:**
ECG & ECHO at 7-14 days and again at 4-6 weeks after presentation or sooner if clinically indicated
Continue ASA until 4-6 week ECHO confirms normal coronary arteries and LV systolic function + normal inflammatory markers + normal platelets
Anticoagulation in Patients with COVID-19 and MIS-C

Infection with SARS-CoV-2 is associated with thrombotic complications, particularly in children over the age of 12.

It is recommended that patients > 12 years old hospitalized with COVID-19 or MIS-C be placed on prophylactic dose anticoagulation therapy with LMWH or UFH, provided that there are no bleeding contraindications to anticoagulation. Prophylactic anticoagulation should be considered in younger children (≤ 12 years old).

Therapeutic dose anticoagulation may be indicated in some cases (see below). In addition, use mechanical thromboprophylaxis with sequential compression devices, if possible.

- Please see MIS-C for use of aspirin and other therapies in children with MIS-C
- Consult Hematology for LMWH/UFH anticoagulation treatment recommendations (with ideally a multidisciplinary treatment meeting/plan)

Relative contraindications to anticoagulation:
- Platelet count <50,000
- Fibrinogen <100mg/dL
- Receiving ASA > 5 mg/kg/day
- Underlying bleeding disorder

Active bleeding is a contraindication to anticoagulation

When to use prophylactic (low dose) anticoagulation
(LMWH goal ~0.2-0.4 units/mL or UFH goal ~0.1-0.3 units/mL)

When to use therapeutic (full dose) anticoagulation
( LMWH goal ~0.5-1 units/mL or UFH goal ~0.3-0.6 units/mL)

Duration of Anticoagulation

Anticoagulant Drug Doses
When to use prophylactic (low dose) anticoagulation
LMWH goal ~0.2-0.4 units/mL or UFH goal ~0.1-0.3 units/mL

Suggested in patients who are hospitalized with MIS-C or symptomatic COVID-19 AND one or more of the following risk factors:

- ICU admission (including need for mechanical ventilation, inotropic infusion support)
  - Central venous catheter (including PICC line)
    - D-dimer > 2.5 mcg/mL
  - Age > 12 years or post-pubertal
    - Obesity (> 95th percentile)
  - Concomitant estrogen-containing oral contraceptive use
    - First degree family history of unprovoked VTE
  - History of thrombosis or acquired or inherited thrombophilia
  - Sedated and muscle-relaxed or complete immobility
  - Active malignancy, nephrotic syndrome, flare of underlying inflammatory disease, sickle cell VOC
  - Congenital or acquired heart disease with venous stasis or impaired venous return (consult cardiology)
    - Any rhythm abnormalities, heart block, etc. (consult cardiology)
When to use therapeutic (full dose) anticoagulation
(LMWH goal ~0.5 - 1 units/mL or UFH goal ~0.3 - 0.6 units/mL)

Suggested in patients hospitalized with MIS-C or symptomatic COVID-19
AND one or more of the following:

- Documented thrombosis (Consult Hematology)
- Moderate to severe ventricular dysfunction per Cardiology
- Coronary aneurysm Z score > 10, per Cardiology
- Consider therapeutic anticoagulation for active malignancy, nephrotic syndrome, flare of underlying inflammatory disease state, heart disease with venous stasis or impaired venous return, personal history of thrombosis, or multiple risk factors. (No high quality evidence for therapeutic dosing for these indications).

Discuss with specialist managing underlying condition and/or hematology.
Duration of Anticoagulation

Prophylactic Anticoagulation

- Discontinue prophylactic anticoagulation at discharge in most patients
- Discontinue earlier if patients are improved and risk factors have resolved
- Consider continuation of prophylactic anticoagulation post-discharge for ongoing severe inflammation with other risk factors.

Duration: 30 days post-discharge or when risk factor(s) resolve, whichever is sooner

Therapeutic Anticoagulation

- Continue therapeutic dosing while indicated and formulate outpatient plan with consultants (cardiology, rheumatology and/or hematology)
**Anticoagulant Drug Doses**

<table>
<thead>
<tr>
<th>PROPHYLACTIC DOSING</th>
<th>THERAPEUTIC DOSING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LMWH</strong> (clinically stable patients)</td>
<td><strong>LMWH</strong></td>
</tr>
<tr>
<td>Age &gt; 2 months:</td>
<td>Enoxaparin 1 mg/kg/dose SubQ q12h</td>
</tr>
<tr>
<td>Enoxaparin 0.5 mg/kg/dose SubQ q12h</td>
<td></td>
</tr>
<tr>
<td><strong>UFH</strong> (unstable patients)</td>
<td><strong>UFH</strong></td>
</tr>
<tr>
<td>Heparin: 10-15 units/kg/hour IV</td>
<td>Children &gt; 1 yr:</td>
</tr>
<tr>
<td>No loading dose needed</td>
<td>Loading dose 75 units/kg IV over 10 minutes</td>
</tr>
<tr>
<td></td>
<td>(range 50-100 units/kg),</td>
</tr>
<tr>
<td></td>
<td>followed by 20 units/kg/hr IV</td>
</tr>
<tr>
<td></td>
<td>(range 15-25 units/kg/hr).</td>
</tr>
</tbody>
</table>

**Direct oral anticoagulants**
(e.g., rivaroxaban and apixaban)
Not recommended for inpatient VTE prophylaxis because of possible drug interactions with some medications used to treat COVID-19
Publications:


Other resources:

American College of Rheumatology COVID-19 Guidelines
CDC Case Definition for MIS-C
COVID-19 Pathway - Seattle Children’s
Fact Sheet for Health Care Providers: Emergency Use Authorization (EUA) of Casirivimab and Imdevimab
Fact Sheet for Healthcare Providers: Emergency Use Authorization (EUA) of Bamlanivimab
Infectious Disease Society of America COVID-19 Guidelines
Multisystem inflammatory syndrome in children and adolescents temporally related to COVID-19 - World Health Organization
UCSF IMDP Pediatric COVID-19 Guidelines
UCSF Adult COVID-19 Management Guidelines
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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AKI</td>
<td>Acute Kidney Injury</td>
</tr>
<tr>
<td>ALT</td>
<td>Alanine Aminotransferease</td>
</tr>
<tr>
<td>AMS</td>
<td>Altered Mental Status</td>
</tr>
<tr>
<td>ASA</td>
<td>Aspirin</td>
</tr>
<tr>
<td>BiPAP</td>
<td>Bilevel Positive Airway Pressure</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
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<tr>
<td>BMP</td>
<td>Basic Metabolic Panel</td>
</tr>
<tr>
<td>BNP</td>
<td>B-type Natriuretic Peptide</td>
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<tr>
<td>CBC</td>
<td>Complete Blood Count</td>
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<tr>
<td>COVID-19</td>
<td>Coronavirus Disease 19</td>
</tr>
<tr>
<td>CRP</td>
<td>C-Reactive Protein</td>
</tr>
<tr>
<td>CXR</td>
<td>Chest XRay</td>
</tr>
<tr>
<td>DVT</td>
<td>Deep Vein Thrombosis</td>
</tr>
<tr>
<td>DRESS</td>
<td>Drug Reaction with Eosinophilia and Systemic Symptoms</td>
</tr>
<tr>
<td>ECG</td>
<td>Electrocardiography</td>
</tr>
<tr>
<td>ECHO</td>
<td>Echocardiogram</td>
</tr>
<tr>
<td>EF</td>
<td>Ejection Fraction</td>
</tr>
<tr>
<td>ESR</td>
<td>Erythrocyte Sedimentation Rate</td>
</tr>
<tr>
<td>EUA</td>
<td>Emergency Use Authorization</td>
</tr>
<tr>
<td>HFNC</td>
<td>High Flow Nasal Cannula</td>
</tr>
<tr>
<td>ID</td>
<td>Infectious Diseases</td>
</tr>
<tr>
<td>IgA</td>
<td>Immunoglobulin A</td>
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<td>IgG</td>
<td>Immunoglobulin G</td>
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<tr>
<td>IgM</td>
<td>Immunoglobulin M</td>
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<td>IL-2R</td>
<td>Interleukin-2R</td>
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<tr>
<td>INR</td>
<td>International Normalized Ratio</td>
</tr>
<tr>
<td>IVIG</td>
<td>Intravenous Immune Globulin</td>
</tr>
<tr>
<td>KD</td>
<td>Kawasaki Disease</td>
</tr>
<tr>
<td>LDH</td>
<td>Lactate Dehydrogenase</td>
</tr>
<tr>
<td>LMWH</td>
<td>Low Molecular Weight Heparin</td>
</tr>
<tr>
<td>MAS</td>
<td>Macrophage Activate Syndrome</td>
</tr>
<tr>
<td>MIS-C</td>
<td>Multisystem Inflammatory Syndrome</td>
</tr>
<tr>
<td>NAAT</td>
<td>Nucleic-acid Amplification Test</td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Physician</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PICC</td>
<td>Peripherally Inserted Central Catheter</td>
</tr>
<tr>
<td>PE</td>
<td>Pulmonary Embolism</td>
</tr>
<tr>
<td>POCUS</td>
<td>Point-of-Care Ultrasound</td>
</tr>
<tr>
<td>PT</td>
<td>Prothrombin Time</td>
</tr>
<tr>
<td>PTT</td>
<td>Partial Thromboplastin Time</td>
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<tr>
<td>SJS</td>
<td>Steven-Johnson Syndrome</td>
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<tr>
<td>RT-PCR</td>
<td>Reverse Transcriptase PCR</td>
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<tr>
<td>RVP</td>
<td>Respiratory Viral Panel</td>
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<td>SubQ</td>
<td>Subcutaneous Route</td>
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<tr>
<td>UA</td>
<td>Urinalysis</td>
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<td>UFH</td>
<td>Unfractionated Heparin</td>
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<tr>
<td>ULN</td>
<td>Upper Limits of Normal</td>
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<tr>
<td>VOC</td>
<td>Vaso-Occlusive Disease</td>
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<tr>
<td>VTE</td>
<td>Venous Thromboembolism</td>
</tr>
<tr>
<td>WBC</td>
<td>White Blood Count</td>
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