

**Australian guidelines for the clinical care of people with COVID-19**

**Public consultation comments received via MAGIC and email**

Updated 07 December 2020

Standard response in MAGIC: “Many thanks for your feedback. We’re updating the guideline regularly and your comments will be considered by the guidelines team.”

Date and Name	Comment	Standard response given	Action
4 Apr 2020 Benjamin Crowe Via MAGIC v1.0	In the preamble where it's stated 'preliminary results suggest that their use may be effective in improving the symptoms and prognosis of people with COVID-19' - I feel the evidence is currently AGAINST use of corticosteroids, and that the best available evidence for lopinavir-ritonavir is that there is no benefit.	Yes	Text has been changed in v1.1 publication date 8 April 2020 to reflect that the benefit is uncertain: “The majority of early national and international guidelines do not support the use of disease-modifying therapies in treating people with COVID-19 due to a paucity of evidence. However, many promote their use in the context of clinical trials. Consequently, numerous clinical trials are underway to determine which, if any, should be used as a treatment for this disease.”

<p>8 Apr 2020 Felix Oberender Via MAGIC</p> <p>v1.0</p>	<p>"...we therefore recommend that antiviral and disease-modifying treatments should only be administered in the context of clinical trials with appropriate ethical approval."</p> <p>While I share the panel's concern, may I recommend adding that careful and considered case-based exceptions may be made in some circumstances.</p> <p>Rationale: The statement otherwise risks discriminating against children.</p> <ul style="list-style-type: none"> <li>- Paediatric trials are generally very few and specifically so in paediatric CoV-19 disease.</li> <li>- Due to low numbers, paediatric trials take significantly longer and are less likely to generate high-quality evidence.</li> </ul>	<p>Yes</p>	<p>Text has been added in v2.0 publication date 16 April 2020 to highlight that we will update this recommendation for special populations:</p> <p>"As evidence accumulates regarding the use of hydroxychloroquine in the treatment of COVID-19, the Taskforce will continue to review and update this recommendation, including in special populations (e.g. children, pregnant women, people with immunosuppression or chronic disease)."</p>
<p>20 Apr 2020 Kevin Lai via MAGIC</p> <p>v2.0</p>	<p><b>Section: 2 Introduction</b></p> <p>The name of College of Emergency Medicine is "Australasian College for Emergency Medicine", please check and correct</p>	<p>Yes</p>	<p>Name corrected in v2.1 publication date 23 April 2020.</p>
<p>20 Apr 2020 Kevin Lai via MAGIC</p> <p>v2.0</p>	<p><b>Section: 6.3 Monitoring</b></p> <p>There is an increasingly strong signal that early intubation may not be required for some hypoxic COVID patients. Indeed, it may even be harmful. (Gattinoni 2020: COVID-19 pneumonia: different respiratory treatment for different phenotypes?) Granted these are all experiences only, although invaluable, they carry a lot of biases. However, these experiences should be considered and discussed, as we are dealing with a brand new disease.</p>	<p>Yes</p>	<p>No action apart from standard response as we are still awaiting evidence to inform any change in this recommendation.</p>

<p>24 Apr 2020 anand at edguidelines.com via MAGIC v2.1</p>	<p><b>Section: 6.2 Non-invasive ventilation</b></p> <p>I believe this recommendation needs to be modified for several reasons:</p> <ul style="list-style-type: none"> <li>- during this pandemic, where guidelines have been notoriously conflicting, I don't think it is reasonable to make a "Consensus Recommendation" based on a single guideline (ANZICS) which at 6 weeks old is already outdated due to the rapid progression of information. International guidelines from areas that are actually seeing large numbers of COVID patients are arguably more relevant in forming a consensus than our local Australian guidelines based on minimal local COVID experience.</li> <li>- Both NHS and the very recent NIH guidelines are recommending a trial of NIV(the NIH guideline recommends a trial of high flow nasal oxygen preferentially).</li> <li>- Early intubation from the experience in the pandemic epicentres appears to have resulted in very high mortality. The recommendation was based on very weak evidence and was contrary to usual practice in hypoxaemic patients and therefore the low level evidence that has emerged against it should be considered very strongly. Further this recent large cohort from new york found mortality in intubated patients to be 88% and the dates of patient admissions suggests this was probably when the early intubation paradigm was likely the prominent mode of care.</li> </ul> <p><a href="https://jamanetwork.com/journals/jama/fullarticle/2765184">https://jamanetwork.com/journals/jama/fullarticle/2765184</a></p> <ul style="list-style-type: none"> <li>- CPAP should not be conflated with BiPAP in recommendations re "NIV".</li> </ul>	<p>Yes</p>	<p>The recommendation was updated in v3.0 publication date 30 April 2020 to account for different settings and info box was added for clarity.</p>
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	<p>A nuanced recommendation supporting a trial of CPAP would be appropriate and a recommendation to proceed to intubation if the CPAP trial did not achieve target patient outcomes (e.g. reducing work of breathing with maintained normal mentation).</p> <p>It may also be reasonable to suggest as the NIH guideline did, that High Flow Nasal Oxygenation be considered first before CPAP if available, the patient wears a surgical mask and hospital oxygen stores are sufficient.</p> <p>Thank you for considering my feedback.</p>		
<p>13 May 2020 Sandra Fitzgerald via MAGIC v4.0</p>	<p><b>Section: 8.1 Venous thromboembolism (VTE) prophylaxis</b></p> <p>Can I please clarify that this means that all adults who are COVID-19 positive with moderate symptoms should be on an anticoagulant?</p>	Yes	<p>Answer given on 18 June 2020 No, the choice of treatment will always depend on the clinical situation, but if there are no contraindications, prophylactic doses of anticoagulants are appropriate in adults with moderate COVID-19 or other indications.</p>
<p>15 May 2020 James Bartlett via MAGIC v.5.0</p>	<p><b>Section: 6.1 High-flow nasal oxygen therapy</b> <b>Info box:</b> <i>High-flow nasal oxygen (HFNO) therapy is a form of respiratory support where oxygen is delivered, often in conjunction with compressed air and humidification. It delivers high flow oxygen via large diameter nasal cannula that is humidified and heated. Flow rates can be given up to 60 L/min in adults and 25 L/min in children with an oxygen/air blender supplying oxygen at 21-100%. High-flow humidified oxygen should be considered when unable to maintain SaO2 ≥ 92% with standard oxygen</i></p>	Yes	<p>Text updated in v9 publication date 18 June 2020: “High-flow humidified oxygen should be considered when unable to maintain SaO2 ≥ 92% despite conventional oxygen delivery at &gt; 6 L/min or an FiO2 0.4.”</p>

	<p><i>delivery despite conventional oxygen delivery at FiO2 &gt; 6 L/min or an FiO2 0.4.</i></p> <p>Comment: Flow &gt;6L/min</p>		
<p>15 May 2020 James Bartlett via MAGIC v5.0</p>	<p><b>Section: 6.2 NIV</b> <b>Recommendation:</b> <i>In patients with COVID-19 for whom NIV is appropriate for an alternate clinical presentation (e.g. concomitant COPD with type 2 respiratory failure and hypercapnoea, APO), ensure airborne and other infection control precautions are optimised.</i></p> <p><b>Rationale:</b> <i>Routine use of non-invasive ventilation (NIV) is not recommended as it may be associated with a high failure rate, delayed intubation, and possibly increased risk of aerosolisation with poor mask fit.</i></p> <p>The rationale is discordant with the recommendation.</p>	Yes	<p>Text updated in v16 publication date 6 August 2020 Updated so that the rationale is no longer discordant with the recommendation.</p>
<p>18 May 2020 Peter Thomas via MAGIC v5.1</p>	<p><b>Section: 6.1 High-flow nasal oxygen therapy</b> <b>Recommendation:</b> <i>In shared wards or emergency department cubicles do not use high-flow nasal oxygen (HFNO) therapy for patients with hypoxaemia associated with COVID-19.</i></p> <p>The double negative in the "Not Recommended" and the "Do not use" make the interpretation of this murky. Literally - it is not recommended not to use high flow in shared wards or ED cubicles</p>	Yes	<p>No action taken This reflects how recommendations are written and labelled in MAGIC. This is standard practice across all guidelines that use the MAGIC platform.</p> <p>The use of different recommendation labels within sections (in this case high-flow nasal oxygen therapy) alerts the reader to particular scenarios when it should or should not be considered. The text below the label elaborates on and clarifies how the recommendation should be interpreted.</p>
<p>18 May 2020</p>	<p><b>Section: 6.1 High-flow nasal oxygen therapy</b> <b>Recommendation:</b> <i>During inter-hospital patient transfer/retrieval do not use high-flow nasal oxygen (HFNO)</i></p>	Yes	<p>No action taken. See above.</p>

Peter Thomas via MAGIC v5.1	<p><i>therapy for patients with hypoxaemia associated with COVID-19.</i></p> <p>The double negative in the "Not Recommended" and the "Do not use" make the interpretation of this murky.</p>		
13 Jun 2020 Ian Whyte via MAGIC v8.1	<p>Section: Definition of disease severity adults (critical illness)</p> <p>It is a tautology to say "PaO<sub>2</sub>/FiO<sub>2</sub> ratio &lt; 200" as PaO<sub>2</sub>/FiO<sub>2</sub> is written as a ratio. Simply "PaO<sub>2</sub>/FiO<sub>2</sub> &lt; 200" would suffice.</p>	Yes	Text updated in v9 publication date 18 June 2020.
As above	<p>Section: Disease-modifying treatments (Hydroxychloroquine)</p> <p>The Rationale for hydroxychloroquine is very generic and appears preliminary. It needs to be recast along the lines of other agents.</p>	Yes	Text updated in v16 publication date 6 August 2020 "Based on the available evidence, hydroxychloroquine is potentially harmful and no more effective than standard care in treating patients with COVID-19. We therefore recommend that hydroxychloroquine should not be used."
As above	<p>Section: Disease-modifying treatments (Lopinavir/Ritonavir)</p> <p>To say that "Chronic harms include: haemophilia" is incorrect. Lopinavir/ritonavir does not cause the inherited disease of haemophilia. It is associated with increased bleeding in patients with haemophilia.</p>	Yes	Text updated in v9 publication date 18 June 2020 "Chronic harms include: increased risk of bleeding in patients with haemophilia, ..."
As above	<p>Section: Disease-modifying treatments (Lopinavir/Ritonavir)</p>	Yes	The rationale will be revisited in connection with the next update of the recommendation.

	The Rationale for lopinavir/ritonavir is very generic and preliminary. It needs to be recast along the lines of other agents.		
As above	Section: Respiratory support (HFNO recommendation)  There are incorrect units here, the statement "oxygen delivery at FiO2 > 6 L/min" should be "oxygen delivery at > 6 L/min". FiO2 is always a fraction (as at the end of the sentence).	Yes	Text updated in v9 publication date 18 June 2020 "High-flow humidified oxygen should be considered when unable to maintain SaO2 ≥ 92% despite conventional oxygen delivery at > 6 L/min or an FiO2 0.4."
As above	Section: Respiratory support (most interventions)  There is no information in the Key info section.	Yes	Many of the consensus recommendations in this section of the guideline do not have completed Key info sections. These recommendations were drafted in the first weeks of the Taskforce and were based primarily on consideration of recommendations from other national and international guidelines. At the time the panels did not consider the components in the Key info section.  The Key info sections will be completed as and when new evidence becomes available and is considered by the panels.
As above	Section: Anticoagulants (Increased-dose VTE recommendation)  The use of an undifferentiated "creatinine clearance < 30 mL/min" is poor. Is this supposed to be Cockcroft-Gault (and if so is it total body weight or ideal body weight) or the most common value clinicians will be faced with which is the body surface area normalised estimated glomerular filtration rate in which case the phrase should be eGFR < 30 mL/min/1.73 m2.	Yes	Text updated in v16 publication date 6 August 2020

As above	Section: Definition of disease severity children/adolescents  The use of superscript for the footnotes to the recommendation has led to a potential confusion about units where "Requires high-flow oxygen at 2 L/kg/min <sup>3</sup> to maintain SpO <sub>2</sub> > 92%" reads at first glance as though the units are minutes cubed. Consider alternative ways of indicating footnotes such as [3].	Yes	Text updated in v9 publication date 18 June 2020 Added [ ] around superscripts to avoid ambiguity.
As above	All sections:  The correct spelling for "enroled" is "enrolled". There are multiple examples of this misspelling in the document.	Yes	Text updated in v9 publication date 18 June 2020 Corrected misspelling
As above	All sections:  Long-term and short-term, when used as adjectives, must always have a hyphen. There are numerous cases where this is not so.	Yes	Text updated in v9 publication date 18 June 2020 Added hyphen when long term and short term used as adjectives.
As above	Section: Disease-modifying treatments (Key info Lopinavir/Ritonavir)  "Gastrointestinal" is so spelt, not "gastrointestinal".	Yes	Text updated in v9 publication date 18 June 2020 Typo corrected
As above	Section: Respiratory support (ECMO)  The Surviving Sepsis Campaign reference is incorrectly numbered in the Adaptation section as [8] instead of [44].	Yes	Text updated in v9 publication date 18 June 2020 Reference numbering corrected
17 Jun 2020 Matthew	Section: <b>Respiratory Support NIV - In single rooms or shared ward spaces</b> with cohorting of confirmed COVID-19 patients only	Yes	Answer given on 18 June 2020 This recommendation is a consensus recommendation. This means that, at the moment, we do not have enough evidence to



Durie via MAGIC v8.1	Should this say "conditional recommendation" as with HFNP?		make an evidence-based recommendation. To differentiate recommendations that are solely based on consensus from evidence-based recommendations, we make sure to label them as such.
17 Jun 2020 Matthew Durie via MAGIC v8.1	Section: <b>Respiratory Support NIV - In shared wards or emergency department cubicles</b>  Should this say "Not Recommended"?	Yes	See above
17 Jun 2020 Matthew Durie via MAGIC v8.1	Section: <b>Respiratory Support NIV - During inter-hospital patient transfer/retrieval</b>  Should this say "Not Recommended"?	Yes	See above
5 Jul 2020 Takayuki Murayama via MAGIC v11	Section: <b>Disease-modifying treatments (Remdesivir - adults)</b>  In the outcome of "Time to recovery", it is displayed with "Placebo 11 days, Remdesivir 15 days". However, I think that "Placebo 15 days, Remdesivir 11 days" is right. This is because Beigel et al. wrote "Patients in the remdesivir group had a shorter time to recovery than patients in the placebo group (median, 11 days, as compared with 15 days; rate ratio for recovery, 1.32)".	Yes	Response via MAGIC 6 July 2020  "Thanks for your feedback. You are absolutely correct, the numbers are displayed in reverse in the evidence profile. We will correct the error in the next version of the guideline, which we will publish later this week."  Corrected in v12 publication date 9 July 2020

	I have a similar question about the outcome of "Time to improvement".		
14 Jul 2020 Morio Aihara via MAGIC  v12	Section: <b>Disease-modifying treatments (Remdesivir - adults)</b>  Question about the All-cause mortality (Day 14): In the Beigel ACTT-1 study, only 14-day mortality has been analyzed using HR (time-to-event). In contrast, the Wang trial reported 28-day total mortality using a dichotomous variable. As published in IDSA COVID-19, therefore, I think that these two studies cannot be combined due to the difference in both the measurement scale used and the observation period.	Yes	Response via MAGIC 16 Jul 2020 (v12)  "Thank you for your interest in our living COVID-19 treatment guideline and for your feedback.  In regard to your question about mortality, we have checked the studies and can confirm that both studies reported crude mortality rates at 14 days. The crude mortality rates can be found in Table 2 in Beigel et al and in Table 3 in Wang et al. We used these crude rates to calculate the risk ratio that is presented in the guideline.  We are very grateful for the close review of our guidelines by yourself and others in the GRADE Working Group, and welcome further comments."
6 Aug 2020 @David_F_Priest via MAGIC v16	Section: <b>Hydroxychloroquine</b> This post was removed by the moderators as it contained offensive material.	Yes	This post has been removed by the moderators as it contained offensive material.
17 Sept 2020 Olivia Smibert MAGIC v22.0	<b>Chapter 4.1 Definition of disease severity for adults.</b> May I ask about the incorporation of disease severity definitions including that used in the ACTT-1 trials and that outlined by the NIH? What is the evidence regarding saturation of 92 or 94% to be the threshold in change of disease severity as there seems to be some debate between different trials regarding what cut off is the best to use? Is there sufficient evidence to include biochemical parameters in any of the definitions now? May I also ask	Yes	Response via MAGIC 24 Sept 2020  The 92% cut off was derived from the SpO2/FiO2 ratio in the determination of ARDS. Sats of 92% on room air is the point at which a person would be classified as mild ARDS. The more oxygen someone requires to keep their sats at 92%, the more severe they are classified as. It was felt that the definition of

	about having local hospital protocols for defining disease severity, especially when they are not accessible to view?		“moderate“ COVID-19 neatly sits within those parameters and generally identify someone who requires oxygen support.
Nov 16th Linda Xu MAGIC v28.1	<b>Regarding flowchart 10-</b> the BSL for adults in the community, does the grey box “Is there public health advice to wear a mask in the local area” referring to clinical setting or generally. Eg in NSW where it is at amber alert, would the answer to that question be yes or no?	Yes	Response via email Dear Linda, Thank you for your query. Flowchart 10 is designed for adults in the community during the COVID-19 pandemic. As such, it really would depend where you are likely to be commencing basic life support. For example, in a clinical setting such as a GP clinic where it is usually BLS until the emergency services arrive, the wearing of masks may be required, whereas out in a park, it may not be. As the wearing of masks is at the direction of local authorities, even if not mandatory, the wearing of masks is at the discretion of the individual. It is important to note that this guidance is for members of the public who are trained first responders.
Nov 4th WA Chief Health Officer’s office	Suggestion of minor change to 8.3 - Respiratory management of the deteriorating patient.  <i>The goals of patient care need to balance the preferences and values of the patient, based on discussion and an advanced care directive or plan if available and the likelihood of survival and return to an acceptable level of independence or function.</i>	No, came via NHMRC council meeting	Response via MAGIC This was taken to the consumer panel, care of older people and palliative care panel and the guidelines leadership group and the following edits were made: <i>The goals of patient care need to balance the preferences and values of the patient, based on discussion and an advance care directive or plan if available, and consideration of the patient’s expected short and long-term responses to more invasive forms of treatment.</i>
3rd Dec 2020 ikawooya	Question regarding Paediatric Inflammatory Multisystem Syndrome (PIMS-TS)	Yes	Response via MAGIC 4 Dec 2020 Thanks for your comment. There are specific recommendations on the use of corticosteroids and remdesivir for children and

<p>@acres.org MAGIC v30.0</p>	<p>Does this guideline have specific recommendations e.g. the benefit of corticosteroids or remdesivir in this age group besides the multidisciplinary team.</p>		<p>adolescents for the treatment of acute COVID-19 under the section: Disease-modifying treatments&gt;Corticosteroids&gt;Corticosteroids for children and adolescents. <a href="https://app.magicapp.org/#/guideline/L4Q5An/rec/j2d4bn">https://app.magicapp.org/#/guideline/L4Q5An/rec/j2d4bn</a>  and Disease-modifying treatments&gt;Remdesivir&gt;Remdesivir for children and adolescents <a href="https://app.magicapp.org/#/guideline/L4Q5An/rec/jz9PeE">https://app.magicapp.org/#/guideline/L4Q5An/rec/jz9PeE</a></p>
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