MIS-C Inpatient Algorithm

Children's Mercy KANSAS CITY | Evidence Based Practice

Admit pt to Inpt Unit
(Follow "Initial Assessment" per *MIS-C Evaluation and Treatment* algorithm if pt admitted from outside facility)

Is MIS-C suspected from "Initial Assessment"?

No → Provide routine inpt management for diagnosis
OR
Discharge home with:
- PCP follow up in 24-48 hrs
AND
- Return to ED for fever ≥ 5 days and/or new signs/symptoms

Yes

Compensated shock: persistent tachycardia despite antipyretics, BP may be normal or have wide pulse pressure, intact peripheral perfusion or brisk cap refill
Hypotensive shock: tachycardia, hypotension and/or wide pulse pressure, delayed or flash peripheral perfusion

Does the pt have either compensated or hypotensive shock?

Yes → Suspect MIS-C with Compensated or Hypotensive Shock

Transfer to PICU
(DO NOT delay transfer while initiating following therapies):
- Initiate Sepsis Inpt PowerPlan
- Initiate MIS-C Inpt PowerPlan
- Administer 20 ml/kg NS bolus, reassess after each bolus to avoid fluid overload
- Obtain VBG, Tier 1 and Tier 2 labs, CXR, ECG, ECHO (urgent) if not already obtained
- Antibiotics per MIS-C Inpt PowerPlan (cefepime, vancomycin, doxycycline)
- Consult:
  - Infectious Diseases
  - Rheumatology
  - Cardiology
  - Coag: If Tier 2 labs abnormal OR clinical suspicion for MIS-C

Is pt stable for transfer to Medical Unit?

Yes → *Initiate MIS-C Inpt PowerPlan*

No → *Initiate MIS-C Inpt PowerPlan*

No

Suspect MIS-C without Shock

Initiate MIS-C Inpt PowerPlan

Labs:
- Draw Tier 1/Tier 2 labs per *MIS-C Evaluation and Treatment* algorithm if not already obtained

Diagnostic Studies:
- Obtain ECG, ECHO* (non-urgent)
  *consider PICU transfer if moderate or severe cardiac dysfunction on ECHO

Consult:
- Infectious Diseases
- Rheumatology
- Cardiology
- Coag: If Tier 2 labs abnormal OR clinical suspicion for MIS-C

Medications:
- PPI for GI Prophylaxis
- Fluid resuscitation as clinically indicated
- VTE Prophylaxis per COVID-19 VTE Prophylaxis Guidelines
- Additional treatment per consultant recommendations

Does pt meet discharge criteria?

No → *Initiate MIS-C Inpt PowerPlan*

Yes

Discharge Criteria:
- Minimum observation for 24 hours is recommended
- Hemodynamically stable ≥48 hours
- Improved or normal cardiac function
- Afebrile≥48 hours
- Down-trending inflammatory markers
- Improving or stable end organ involvement

Discharge pt after Outpt Follow-Up/Issues determined:
- Discuss need for Aspirin therapy at discharge with consulting teams
- Follow-up with PCP in 24-48 hours
- Follow-up with Rheumatology if pt received steroids, anakinra, immune modulation beyond IVIG, concern for MAS, or provider discretion
- Follow-up with Infectious Diseases if ongoing treatment for infection or treated with IVIG alone
- Follow-up with cardiology at 2 weeks and 6 weeks following discharge
- Follow-up with Coag if thrombus identified or pt continuing on prophylactic anticoagulation at the time of discharge
- Return to ED for fever ≥5 days and/or new signs/symptoms

Abbreviations (laboratory & radiology excluded):
pt = patient
MIS-C = Multisystem inflammatory syndrome in children
ED = Emergency Department
PICU = Pediatric Intensive Care Unit

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