

# Interpretation of data of case- sheets from COVID-19 ward

“Results? Why, man, I have gotten lots of results! If I find 10,000 ways something won’t work, I haven’t failed. I am not discouraged, because every wrong attempt discarded is often a step forward.” – Thomas Alva Edison (1847-1931), Inventor and Physicist.

Dear Editor,

Sharma *et al.*<sup>[1]</sup> conducted a drug utilization study in a COVID dedicated hospital in Northern India and assessed how comorbidities are managed in such patients. They conducted this retrospective study by calculating drug utilization pattern while some information gaps remain as the analysis was not conducted in real time. The study provides a useful insight into the pattern of admissions, severity- status and outcomes of the inpatient -facility when the humanity is facing one of the biggest challenges ever it did. For those health care workers who manage such illnesses, the study offers much sought after charts and tables by looking at which they can gather a lot of information in one go.

Nevertheless, there are certain discrepancies towards which we want to draw attention of the authors. Under a heading of Introduction, the authors state that case fatality ratio of (COVID-19) is 1.8%. But [Table 1]<sup>[1]</sup> of the study Results shows an overall mortality in this group to be 36.95%. Moreover, in mild/moderate group of patients, the mortality figure is 32.68%. What that means is that about every third patient at the COVID -dedicated hospital is dying when one has mild/moderate illness.

But this finding is contradictory to worldwide and Indian experience. What may have happened is that as residents and other junior staff members are posted at the frontline of reception and emergency departments, they may have been misclassifying patients in different groups. As mortality increases with age to a certain extent, senior staff members may not be always guiding the residents at the bedside and making necessary corrections in the medical- records only subsequently. Resultantly some incorrect entries may have been unintentionally seeping in the records and are visible here when data -analysis is made of this illness. Subsequently, if we draw some conclusion from such suboptimal information, there’d be no surprise when its results lie outside the normal range.

Treating team at the hospital prescribed antibiotics to a large number of patients there. The authors write that 36.52% of patients received antimicrobials. But this group of drugs does not have value in viral infections.<sup>[2]</sup> When a physician in private practice prescribes this class of drugs to visiting patients, insecurity and pressure to perform in a brutal and highly -competitive market economy are overriding factors in the decision- making process, although the reasoning does not justify the unethical practice. But why’d those working in a tertiary- care teaching hospitals go the downhill path of unnecessary prescriptions, I wonder.<sup>[3]</sup> Even before the pandemic arrived at the world- stage, antibiotic resistance was a pressing concern for medical society.<sup>[4]</sup> Hence why did the medical society not look at the elephant in the room, is a mystery we need to solve.

In the aftermath of the second wave, there was an epidemic of Mucormycosis. What was the contribution of the unnecessary and unjustifiable over- prescription of antibiotics, corticosteroid, PPIs and antacids for that catastrophe, we need to carefully explore now.<sup>[5]</sup>

Under a heading of Discussion, the authors discuss the guidelines of Ministry of Health and Family Welfare, Government of India which issued advisory for certain drugs and procedures. However we need to recall that as we gather more evidence at a breakneck speed, changing those ones becomes necessary at equal pace. And if delay occurs in regularly updating and issuing the circular, some patients may be harmed.<sup>[6]</sup>

Under a heading of Material and Methods, the authors state that they excluded those patients (from the study) who were initially non-diabetic but later developed hyperglycemia consequent to use of steroid. But hyperglycemia develops even otherwise as well in seriously ill patients.<sup>[7]</sup> What happened to those patients, I am curious to know.

### Financial support and sponsorship

Nil.

### Conflicts of interest

There are no conflicts of interest.

**Harish Gupta**

*Department of Medicine, KG’s Medical University, Lucknow, Uttar Pradesh, India*

**Address for correspondence:** Dr. Harish Gupta, Department of Medicine, KG’s Medical University, Lucknow - 226 003, Uttar Pradesh, India.  
E-mail: harishgupta@kgmcindia.edu

## References

1. Sharma A, Jain M, Yadav R, Rathi P. Managing comorbidities in COVID-19 patients: A drug utilization study in a COVID-19 dedicated hospital in Northern India. *J Family Med Prim Care* 2021;10:3387-94.
2. Garg SK. Antibiotic misuse during COVID-19 pandemic: A recipe for disaster. *Indian J Crit Care Med* 2021;25:617-9.
3. Arshad M, Mahmood SF, Khan M, Hasan R. Covid -19, misinformation, and antimicrobial resistance. *BMJ* 2020;371:m4501. doi: 10.1136/bmj.m4501.
4. US FDA. Combating antibiotic resistance. Updated on Oct 29, 2019. Available from: <https://www.fda.gov/consumers/consumer-updates/combating-antibiotic-resistance>.
5. Singh K, Kumar S, Shastri S, Sudershan A, Mansotra V. Black fungus immunosuppressive epidemic with COVID-19 associated mucormycosis (zygomycosis): A clinical and diagnostic perspective from India. *Immunogenetics* 2021. doi: 10.1007/s00251-021-01226-5.
6. Pulla P. COVID-19: India's slow moving treatment guidelines are misleading and harming patients. *BMJ* 2021;372:n278. doi: 10.1136/bmj.n278.
7. Marik PE, Bellomo R. Stress hyperglycemia: An essential survival response! *Crit Care* 2013;17:305.

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

**Received:** 03-10-2021

**Revised:** 27-11-2021

**Accepted:** 28-11-2021

**Published:** 18-03-2022

### Access this article online

#### Quick Response Code:



**Website:**  
[www.jfmprc.com](http://www.jfmprc.com)

**DOI:**  
10.4103/jfmprc.jfmprc\_1974\_21

**How to cite this article:** Gupta H. Interpretation of data of case- sheets from COVID-19 ward. *J Family Med Prim Care* 2022;11:1582-3.

© 2022 Journal of Family Medicine and Primary Care | Published by Wolters Kluwer - Medknow