

पाचार्य का कार्यालय OFFICE OF THE PRINCIPAL

वर्धमान महावीर मेडिकल कॉलेज एवं सफ़दरजंग अस्पताल

VARDHMAN MAHAVIR MEDICAL COLLEGE & SAFDARJUNG HOSPITAL

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NEW DELHI - 110029

स्वास्थ्य सेवा महानिदेशालय, स्वास्थ्य एवं परिवार कल्याण मंत्रालय, भारत सरकार गुरु गोबिंद सिंह इंद्रप्रस्थ विश्वविद्यालय, दिल्ली से संबद्ध

Directorate General of Health Services, Ministry of Health & Family Welfare, Govt of India Affiliated to Guru Gobind Singh Indraprastha University, Delhi

Ref.No 1-11/06, VMMC

General instructions and mandatory guidelines for MBBS students

- 1. All students must wear a mask.
- 2. Respiratory etiquettes are to be strictly followed. This involves strict practice of covering one's mouth and nose while coughing/sneezing with a tissue/handkerchief/flexed elbow and disposing off used tissues properly. Spitting shall be strictly prohibited.
- 3. Physical distancing to be followed as far as feasible.
- 4. Practice frequent hand washing with soap (for at least 30-40 seconds) even when hands are not visibly dirty.
- 5. Use alcohol-based hand sanitizers (for at least 20 seconds).
- 6. Self-monitoring of health and reporting any illness at the earliest to the Warden/ Designated Nodal Officer.
- 7. Students with any symptoms of INFLUENZA LIKE ILLNESS (fever, cough, sore throat, malaise & diarrhea) will immediately report to the Nodal Officer/Warden/ UG Incharge.
- 8. Dr. Nishanth Dev, Associate Professor & Dr. Shivani Sharma, Asst. Prof., Dept. of Medicine will be designated as Nodal Officers for coordination.
- 9. Contact persons: Dr. Manish Kumath (Boys Hostel warden-9868984826), Dr. Rekha Bharti (Girls Hostel Warden-9871394999), Dr. Nishanth Dev (M: 9717283133) and Dr. Shivani Sharma (8447569303).
- 10. All students are advised to refer to the COVID-19 guidelines issued by MOHFW available on college & MOHFW website.



AIIMS/ ICMR-COVID-19 National Task Force/ Joint Monitoring Group (Dte.GHS)

Ministry of Health & Family Welfare, Government of India CLINICAL GUIDANCE FOR MANAGEMENT OF ADULT COVID-19 PATIENTS

Revised on 05/01/2023 Adult patient diagnosed with COVID-19

Mild disease

Upper respiratory tract symptoms and/or fever WITHOUT shortness of breath or hypoxia

Home Isolation & Care (Refer to relevant guideline)

MUST DOS

- Physical distancing, indoor mask use, hand hygiene
- Symptomatic management (hydration, anti-pyretics, antitussive)
- Monitor temperature and oxygen saturation (by applying a SpO probe to fingers)
- Stay in contact with treating physician

Seek immediate medical attention if:

- Difficulty in breathing or 5pO₂ ≤ 93%
- High grade fever/severe cough, particularly if lasting for >5 days
- A low threshold to be kept for those with any of the high-risk features*

*High-risk for severe disease or mortality

- Age > 60 years
- Cardiovascular disease and CAD
- Diabetes mellitus and other immunocompromised states (such
- Active tuberculosis
- Chronic lung/kidney/liver disease
- Cerebrovascular disease
- Obesity
- ✓ Unvaccinated
- Antibiotics should not be used unless there is clinical suspicion of bacterial
- Possibility of coinfection of COVID-19 with other endemic infections must
- be considered Systemic corticosteroids are not indicated in mild disease

DO NOT USE IN COVID-19

- Lopinavir-ritonavir Hydroxychloroquine Ivermectin Neutralizing monoclonal antibody
- Convalescent plasma Molnupiravir Favipiravir

Moderate disease

Any one of:

- 1. Respiratory rate ≥ 24/min, breathlessness
- 2.SpQ : 90% to ≤ 93% on room air

Severe disease

Any one of:

- Respiratory rate >30/min, breathlessness
- 2.SpO2 < 90% on room air

ADMIT IN WARD

Oxygen Support:

- Target SpO : 94-96% (88-92% in patients with COPD)
- Preferred devices for oxygenation: non-rebreathing face mask
- Awake proning encouraged in all patients requiring supplemental oxygen therapy (sequential position changes every 2 hours)

Anti-inflammatory or immunomodulatory therapy:

- Dexamethasone 6 mg/day or equivalent dose of methylprednisolone (32 mg in 4 divided doses) usually for 5 to 10 days or until discharge, whichever is earlier.
- Patients may be initiated or switched to oral route if stable and/or improving
- There is no evidence for benefit for systemic steroids in those NOT requiring oxygen supplementation, or on continuation after discharge
- Anti-inflammatory or immunomodulatory therapy (such as steroids) can have risk of secondary infection such as invasive mucormycosis when used at higher dose or for longer than required

Anticoagulation:

Prophylactic dose of unfractionated heparin or Low Molecular Weight Heparin (weight based e.g. enoxaparin 0.5mg/kg per day SC). There should be no contraindication or high risk of bleeding

Monitoring:

- Clinical Monitoring: Respiratory rate, Hemodynamic instability, Change in oxygen requirement
- Serial CXR; HRCT chest to be done ONLY if there is worsening
- Lab monitoring: CRP, D-dimer, blood sugar 48 to 72 hrly; CBC, KFT, LFT 24 to 48 hrly

ADMIT IN HDU/ICU

Respiratory & Cardiovascular Support:

- Consider use of NIV (Helmet or face mask interface depending on availability) in patients with increasing oxygen requirement, if work of breathing is LOW
- Consider use of HFNC in patients with increasing oxygen requirement
- Intubation should be prioritized in patients with high work of breathing /if NIV is not tolerated
- Use institutional protocol for ventilatory management when required
- Need for vasopressors to be considered based on clinical situation

Anti-inflammatory or immunomodulatory therapy:

- Dexamethasone 6 mg/day or equivalent dose of methylprednisolone (32 mg in 4 divided doses) usually for 5 to 10 days or until discharge, whichever is earlier. No evidence for benefit in higher doses.
- Anti-inflammatory or immunomodulatory therapy (such as steroids) can have risk of secondary infection such as invasive mucormycosis when used at higher dose or for longer than required

Anticoagulation:

Prophylactic dose of unfractionated heparin or Low Molecular Weight Heparin (weight based e.g., enoxaparin 0.5mg/kg per day SC). There should be no contraindication or high risk of bleeding

Supportive measures:

- Maintain euvolemia (if available, use dynamic measures for assessing fluid résponsiveness)
- If sepsis/septic shock: manage as per existing protocol and local antibiogram

Monitoring:

- Clinical Monitoring: Work of breathing, Hemodynamic instability, Change in oxygen requirement
- Serial CXR; HRCT chest to be done ONLY if there is worsening
- Lab monitoring: CRP, D-dimer, blood sugar 48 to 72 hrly; CBC, KFT, LFT 24 to 48 hrly

After clinical improvement, discharge as per revised discharge criteria

Additionally in moderate or severe disease at high risk of progression

Consider Remdesivir for up to 5 days (200 mg IV on day 1

- followed by 100 mg IV OD for next 4 days)

 To be started within 10 days of onset of symptoms, in those having moderate to severe disease with high risk of progression (requiring supplemental oxygen), but who are NOT on IMV or ECMO
- No evidence of benefit for treatment more than 5 days NOT to be used in patients who are NOT on oxygen support or in
- home setting
 Monitor for RFT and LFT (remdesivir not recommended if eGFR
 <30 ml/min/m2; AST/ALT >5 times UNL) (not an absolute
 contraindication)

Additionally in rapidly progressing moderate or severe disease

Consider Tocilizumab preferably within 24-48 hours of onset of severe disease/ ICU admission [4 to 6 mg/kg (400 mg in 60 kg adult) in 100 ml NS over 1 hour] if the following conditions

- Rapidly progressing COVID-19 not responding adequately to steroids and needing oxygen supplementation or IMV Preferably to be given with steroids Significantly raised inflammatory markers (CRP and/or IL-6) Rule out active TB, fungal, systemic bacterial infection Long term follow up for secondary infections (such as reactivation of TB, flaring of Herpes)