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[ijirset@gmail.com](mailto:ijirset@gmail.com)

[www.ijirset.com](http://www.ijirset.com)

# Management of Patients with Confirmed Coronavirus Disease

<sup>1</sup>Dr. Neha Varshneya, <sup>2</sup>Aakanksha Tarunnum, <sup>3</sup>Dr. Suresh Kumar Singh

<sup>1</sup>Lecturer, Dept. of Commerce, SS Jain Subodh PG Mahila Mahavidyalaya, Jaipur, India

<sup>2</sup>Research Scholar (Ph.D), Dept. of Botany, MJRP University, Jaipur, India

<sup>3</sup>Head & Asst. Professor, Dept of Botany, VA Govt. Degree College Atrauli (Aligarh), India

**ABSTRACT:** The emergence of a new virus means that understanding transmission patterns, immunity, severity, clinical unity studies features, and risk factors for infection are still limited. To address these unknowns, WHO has launched a global initiative which aims to enable any countries, in any resource setting, to gather rapidly robust data on key epidemiological parameters to understand, respond and control the COVID-19 pandemic. WHO, in collaboration with technical partners, has developed several generic investigation protocols, branded the WHO Unity Studies. These protocols use a combination of molecular and serologic testing.

These protocols are designed to rapidly and systematically collect and share data in a format that facilitates aggregation, tabulation and analysis across different settings globally.

The widespread adoption of the Unity protocols in more than 90 countries, underlines their usefulness to support countries' decision-making to implement or lift appropriate public health and social measures to prevent and control the COVID-19 infection.

## I.INTRODUCTION

Recommendations are made for the use of chest imaging in acute care of adult patients with suspected, probable or confirmed COVID-19. Imaging modalities considered are radiography, computed tomography and ultrasound. This guide addresses the care pathway from presentation of the patient to a health facility to patient discharge. It considers different levels of disease severity, from asymptomatic individuals to critically ill patients. Accounting for variations in the benefits and harms of chest imaging in different situations, remarks are provided to describe the circumstances under which each recommendation would benefit patients. The guide also includes implementation considerations for different settings, provides suggestions for impact monitoring and evaluation and identifies knowledge gaps meriting further research.

Toolkit is intended for clinicians working in acute care hospitals in low- and middle-income countries, managing adult and paediatric patients with acute respiratory infection, including severe pneumonia, acute respiratory distress syndrome, sepsis and septic shock. The main objective is to provide some of the necessary tools that can be used to care for the critically ill patient from hospital entry to hospital discharge.[1]

Emergency Medical Service (EMS) preparedness and response to COVID-19 and is directed to EMS providers. Prehospital workers, including EMS personnel and other emergency responders, may potentially be exposed to the disease through patient contact or through contaminated environments. It is paramount that providers follow specific practice guidelines to mitigate the effects of an escalating pandemic.

Guidance should be given to Member States on quarantine measures for individuals in the context of COVID-19. It is intended for those responsible for establishing local or national policy for quarantine of individuals, and adherence to infection prevention and control measures.

WHO has developed this rapid advice note to meet the need for recommendations on the safe home care for patients with suspected novel coronavirus (2019-nCoV) infection presenting with mild symptoms and public health measures related to management of asymptomatic contacts.

Interim guidance on the management of the blood supply in response to the pandemic outbreak of coronavirus disease (COVID-19). It emphasizes the importance of being prepared and responding quickly and outlines key actions and measures that the blood services should take to mitigate the potential risk to the safety and sufficiency of the blood supplies during the pandemic.

It should be read in conjunction with WHO Guidance for National Blood Services on Protecting the Blood Supply During Infectious Disease Outbreaks, which provides general guidance on the development of national plans to respond to any emerging infectious threats to the sufficiency or safety of the blood supply.

WHO therefore invites Member States, health facilities and other entities to participate in a global effort to collect anonymized clinical data related to hospitalized suspected or confirmed cases of COVID-19 and contribute data to the Global COVID-19 Clinical Data Platform. The platform is a secure, limited-access, password-protected platform hosted on OpenClinica.

To harmonize data collection across diverse global settings, WHO has developed standard case report forms (CRFs) which contains a minimum set of key variables and forms the basis of three types of CRFs:

- (1) core rapid CRF for adults and children;
- (2) CRF for pregnant women; and
- (3) CRF for multisystem inflammatory syndrome (MIS) in children and adolescents temporally related to COVID-19.[2]

## II.DISCUSSION

The clinical characterization case record form (clinical CRF) is intended to provide member states with a standardized approach to collect clinical data in order to better understand the natural history of disease and describe clinical phenotypes and treatment interventions (i.e. clinical characterization). By using one standardized clinical data tool, there is potential for clinical data from around the world to be aggregated; in order to learn more to inform the public health response and prepare for large scale clinical trials.

The WHO COVID-19 Essential Supplies Forecasting Tool (ESFT) is designed to help governments, partners, and other stakeholders to estimate potential requirements for essential supplies to respond to the current pandemic of COVID-19. Although it gives users with an estimation of the number of cases, this calculator is not an epidemiological calculator.

The focus of this tool is to forecast essential supplies: it includes estimation of personal protective equipment, diagnostic equipment, biomedical equipment for case management, essential drugs for supportive care, and consumable medical supplies.[3]

The COVID-19 ESFT tool is intended to be complimentary to the Health Workforce tools (Adaptt and the Workforce Estimator). Both tools use the same base clinical attack rate ranges and classify health workforce using ILO ISCO codes, but their outputs are intentionally different due to their primary focus.

## III.RESULTS AND CONCLUSION

The primary objectives are to provide descriptions or estimates of :

- clinical presentation of COVID-19 infection and course of associated disease;
- secondary infection rate (SIR) and secondary clinical attack rate of COVID-19 infection among close contacts (overall, and by key factors such as setting, age and sex, for various end-points);[4]
- serial interval of COVID-19 infection;
- symptomatic proportion of COVID-19 cases (through contact tracing and laboratory testing); and identification of possible routes of transmission.
- identification of possible routes of transmission[5,6]

The secondary objectives are to support the estimation of:

- the basic reproduction number (R0) of COVID-19 virus;
- the incubation period of COVID-19; and
- the preliminary COVID-19 infection and disease-severity ratios (for example, case-hospitalization ratio [CHR] and case-fatality ratio [CFR])[7]

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