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CASE REPORT

COVID 19: Is the Curse Still Haunting us or a New One Arriving?

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Abstract

COVID 19 started as an epidemic in the country of China which later became a pandemic taking many lives around the globe during the later half of 2020 to 2022. Our combined efforts to eliminate the pandemic were successful to an extent till the end of 2022 when the cases started declining. But the recent increasing trend of COVID like illness even though RT PCR is negative raises a question whether we are really living in a COVID free world?

Keywords: COVID 19, ARDS – acute respiratory distress syndrome, RT PCR negative, non invasive ventilation, respiratory failure

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Introduction

CORONA virus was first identified in Wuhan, China on December 2019. The quick spread of the disease made it a global pandemic. Symptoms range from mild fever, runny nose to severe ARDS and death. WHO declared it as a global pandemic on March 11, 2020. It covered whole world at a devastating rate with two waves, the later being the worse than the former. After vaccination and all precautionary measures COVID cases are at a declining trend in India since the later part of 2021. But the real question is “IS COVID 19 REALLY OVER”

Many experts stated that this Covid virus may reach an endemic stage in India rather than disappearing completely. So the people should learn to live with virus.

Cases

We are discussing a series of 6 cases in the span of about 2 months which presented with COVID like illness but are RTPCR negative for COVID 19.

Initially all the cases with similar complaints like dry cough, low grade fever, shortness of breath (MMRC 2 – 4), malaise. All the patients initially have some existing comorbidities. HRCT chest findings include ground glass opacities and reticular thickening in bilateral diffuse lung fields, submetacentric mediastinal nodes. These reports conclude possible infective aetiology. All the patients are vaccinated for COVID 19 at various timelines in the past.

All patients were initially admitted into ICU. Treatment has been started with

iv antibiotics (beta lactams + macrolide), antivirals (oseltamivir), nasal oxygen, proton pump inhibitors, anticoagulants (Xa inhibitors, low molecular weight heparins), vitamin supplements, iv fluids and continuing the previous medication of patients according their comorbidities. Remdesivir was not given as RT-PCR turned out to be negative. Initially saturations maintained by nasal oxygen. But gradually by the third day most patients needed non-invasive ventilation due continuous fall in saturations up-to 50–60%. Patients were even tried with newer drugs like i.v Aivaptadil in escalating dose for up to 3 days. Fresh frozen plasmas transfused. Bronchodilators, mucolytics, nebulization's, glucocorticoids and continuous oxygen supply has been provided to the patient. Repeat ABG are done to check the metabolic and respiratory status of the patient. Monitoring of fluid intake, urine output, nutrition, vitals has been done every two hours.

Despite aggressive treatment by the end of a week stay in ICU most patients condition deteriorated gradually. Nasal oxygen was changed to non-invasive ventilation and then subsequently on machinal ventilation due to severe respiratory failure. Tachypnea and tachycardia gradually increased. Saturation levels kept on declining despite ventilatory support and finally patient landed in cardio respiratory arrest (Table 1 and Figures 1 to 2).

Table 1. Insights into Presentations, Histories and outcome for patients

	AGE	SEX	PRESENTING COMPLAINTS	CO-MORBIDITIES	HRCT FINDINGS	NO OF DAYS STAY IN ICU	TYPE OF VENTILATION	OUTCOME
Patient no 1	33Yrs	F	S/P LSCS with High grade fever with dry cough with shortness of breath for 2 days	No co-morbidities	<ul style="list-style-type: none"> - Segmental lower lobe consolidation with air bronchogram and ground glass haze opacities seen in both lungs mainly in b/l lower lobes with patchy reticular bands noted - Few subcentric mediastinal nodes noted - s/o infective aetiology? 	10 days	NIV ventilation for 10 days Mechanical Ventilation for 2 hrs	DEATH
patient no 2	55Yrs	M	Severe respiratory distress with dry cough with SOB with chest pain with fever for 3 days	No co-morbidities	<ul style="list-style-type: none"> - both lungs show patchy confluent ground glass haze opacities with superimposed reticular thickening and focal air bronchogram mainly in subpleural region - mild b/l pleural thickening noted - mild borderline cardiomegaly - few sub centric mediastinal node noted - s/o ARDS- infective aetiology 	4 days	NIV ventilation for 4 days	Recovered
Patient no 3	59 Yrs	M	Acute respiratory distress for 2 days with dry cough with fever with severe headache for 8 days	No co-morbidities	<ul style="list-style-type: none"> - Patchy and confluent ground glass opacities with lobar consolidation and air bronchogram seen in both lungs involving all segments with patchy reticular thickening - b/l pleural effusion with pleural thickening noted 	12 days	NIV ventilation for 11 days Mechanical ventilation for 1 day	DEATH

					<ul style="list-style-type: none"> - few sub centric mediastinal nodes noted - s/o infective aetiology 			
Patient no 4	65 Yrs	M	SOB with dry cough with fever for 7 days	Type 2 DM	<ul style="list-style-type: none"> - ground glass attenuation seen in b/l upper, right middle, b/l lower lobes - s/o infective aetiology - atypical or viral pneumonia 	11 days	NIV Ventilation for 11 days	DEATH
Patient no 5	67Yrs	F	SOB (1 day) with dry cough (4-5 days) with multiple oral ulcers (1 month)	No co-morbidities	<ul style="list-style-type: none"> - Both lungs show diffuse ground glass opacities with smooth interlobular and interseptal reticular thickening noted with upper to lower lobe gradient and subpleural region. - Mild bronchiectatic changes with peri bronchial wall thickening in both lungs - Few sub centric mediastinal nodes noted - Mild b/l pleural thickening noted - s/o ILD? 	7 days	3 days – nasal o2 and BIPAP with NIV ventilation 4 days – mechanical ventilation (SIMV)	DEATH
Patient no 6	75Yrs	F	SOB with Dry cough with Fever for 2 days	HTN with Type 2 DM	<ul style="list-style-type: none"> - large confluent areas of alveolar space opacifications seen in both lungs predominantly at bases s/o bronchopneumonia - moderate right and mild left pleural effusion 	2 days	NIV ventilation 1 day Mechanical ventilation 2 hrs	DEATH

All the above cases are negative for RT-PCR COVID

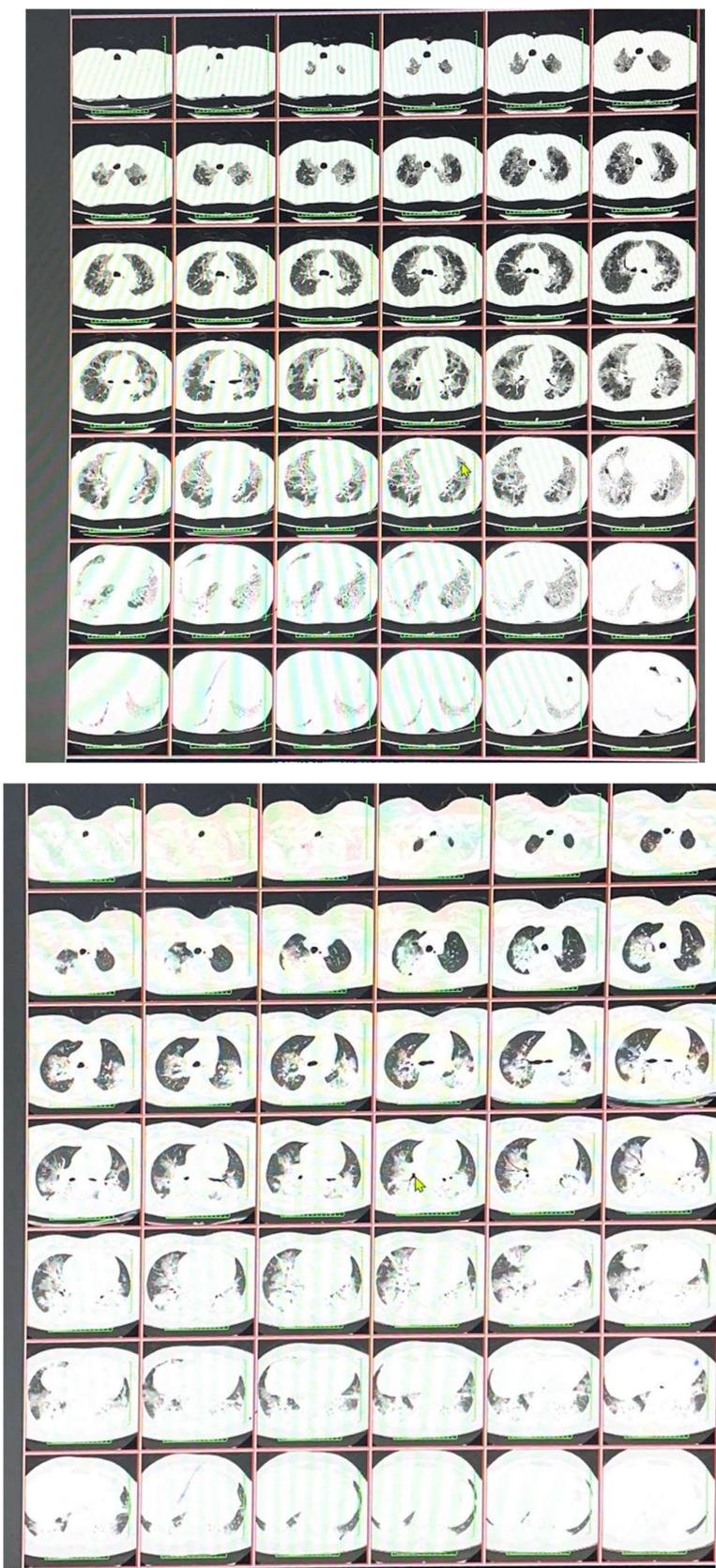


Figure 1. HRCT chest

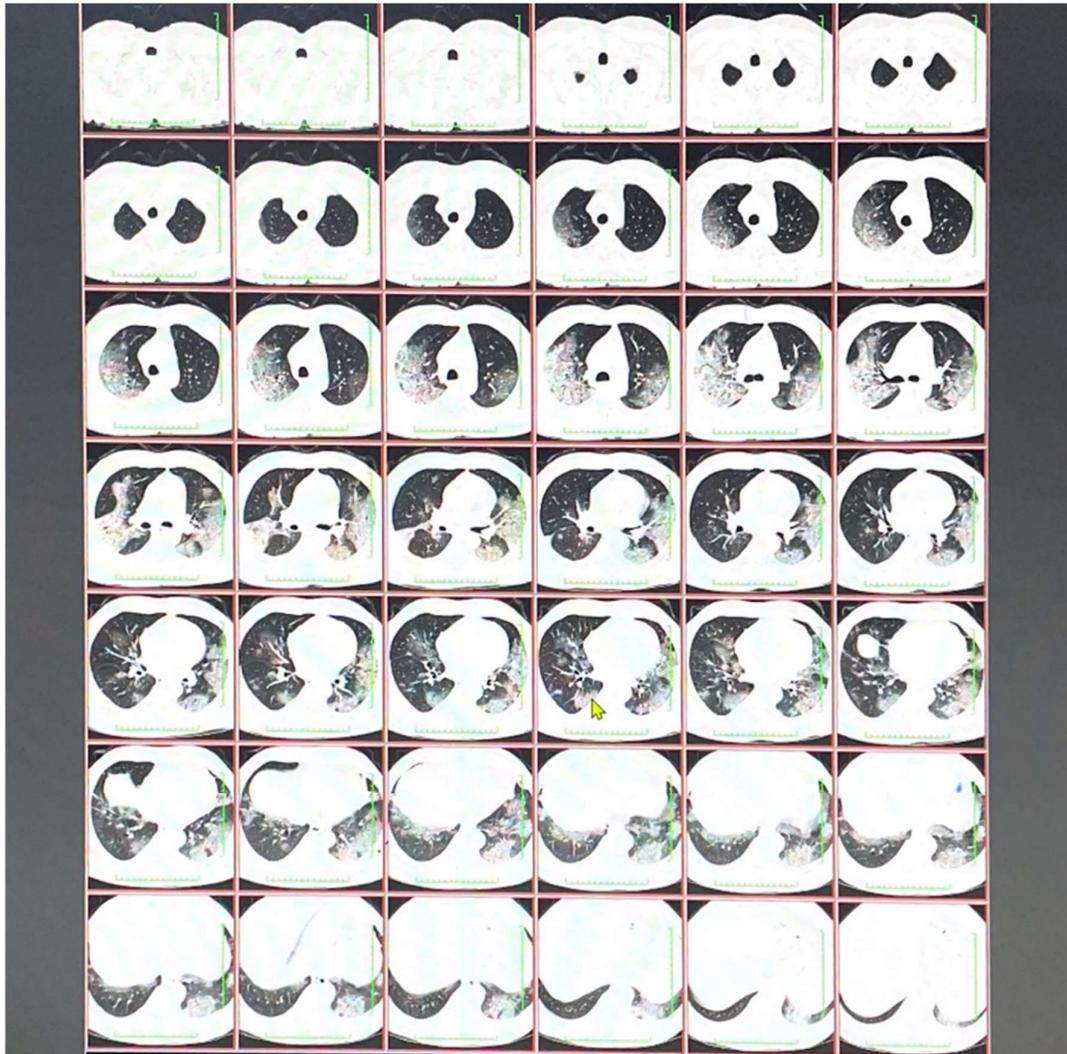


Figure 2. HRCT CHEST - Both lungs show diffuse ground glass opacities with smooth interlobular and interseptal reticular thickening noted with upper to lower lobe gradient and subpleural region. Mild bronchiectatic changes with peri bronchial wall thickening in both lungs

Discussion

The first case of COVID 19 in India was reported on January 30th, 2020. Subsequently in the next month two more cases have been reported from India. Major number of cases were reported from Maharashtra, Tamil Nadu, Delhi, Gujarat [1]. ICMR mentioned the cases reported from India are mostly asymptomatic or mild [2]. About 80–85% of deaths in COVID 19 are reported in patients with

comorbidities like hypertension, diabetes mellites, renal and cardiovascular diseases. The mortalities differ from nation to nation ranging from 0.7 to 10% [3].

Treatment include use of remdesivir, molnupiravir, ritonavir. The use of dexamethasone therapy is also recommended. Bronchodilators, mucolytics and airway supportive measures like NIV ventilation, invasive ventilation if needed. Convalescent plasma can be tried.

Monitoring D - dimer levels and prophylactic anticoagulation is recommended [4].

Total deaths due to covid can never be determined. Studies stated that total deaths due to COVID 19 are about 7 times more than that were reported officially [5].

Many adoptive mutations are now recently found in COVID 19 making it more deadly and resistant to newer therapeutic agents [6]. Many researchers even stated that Covid will be never be completely disappearing and people must learn to live with it [6].

Conclusion

We present a series of cases that presented and complicated like COVID 19 even though they are RT – PCR negative for the same. Despite the popular assumption that COVID 19 has been ended, we doubt that COVID 19 is still existing among us. Cases that present as pneumonitis with the classical radiological features on HRCT - chest which require ICU admission must be tested for covid and managed aggressively. Preventive measures should be taken to decrease transmission among the contacts. Public should be educated regarding the existence of Covid among us.

Statements and declarations

Conflicts of interest

The authors declares that they do not have conflict of interest.

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