

The Novel Coronavirus 2019 Epidemic and Kidneys

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Novel coronavirus disease (COVID-19) is a newly discovered contagious disease caused by SARS-CoV-2 virus, primarily manifesting as an acute respiratory illness with interstitial and alveolar pneumonia, but can affect multiple organs such as kidney, heart, digestive tract, blood and nervous system¹. The rapidly spreading outbreak which first emerged in Wuhan, Hubei Province in China in December 2019 has raised concerns about a global pandemic. To date (2 March 2020), 88,948 cases of COVID-19 have been reported worldwide in 65 countries (and a cruise ship) and 79,842 in mainland China, with 3,043 deaths worldwide (mainland China 2,915 deaths).²

SARS-CoV-2 has been identified as a bat-origin coronavirus (CoV). The full-length genome sequence of the COVID-19 virus showed a close relationship with the bat SARS-like coronavirus strain BatCov RaTG13 belonging to the Betacoronavirus genus.³

Previous coronavirus infections severe acute respiratory syndrome (SARS-CoV) and Middle East Respiratory Syndrome coronavirus (MERS-CoV), have infected more than 10,000 people in the past 2 decades, with mortality rates of 10% and 37% respectively^{4,5}. COVID-19 is more contagious than these illnesses, spreads by human-to-human transmission via droplets, fecal or direct contact, and has an incubation period estimated at 1 to 14 days (usually 3 to 7 days).

Infection has been reported in all ages, including children. The majority of infections are mild, presenting with a flu-like illness. The common clinical presentations of COVID-19 are fever (98%), cough (76%), and myalgia and fatigue (18% each)⁶, with accompanying leucopenia (25%) and lymphopenia (63%). Symptoms of upper respiratory infection with rhinorrhea and productive cough are uncommon, except in children. About 16-20% cases have been classified as 'severe' or 'critical'. Of the 41 patients described by Huang et al⁶, all had pneumonia with abnormalities on computerized tomographic examination of the chest (bilateral lobular and subsegmental areas of consolidation), and 32% required ICU care. Higher plasma cytokine levels (IL2, IL7, IL10, GSCF, IP10, MCP1, MIPIA, TNF α) were present in patients requiring ICU admission. Limited reports suggest that severe complications are uncommon in children.⁷

Diagnosis

The diagnosis is mainly based on epidemiological factors (history of contact), clinical manifestations, and laboratory examination (hemogram, chest CT and virological examination, etc)⁸. Of note, there are recent cases without any travel history or apparent contact with infected individuals. Several COVID-19 nucleic acid detection assays have been developed, both in-house and commercial. They use fluorescence PCR, and probe anchoring polymerization technique. Gene sequencing has also been utilized. The World Health Organization has appointed several referral laboratories in different countries.⁹ A serological test has been developed and allowed detection of a cluster of cases in Singapore¹⁰. More sensitive and convenient detection methods continue to be developed.

Kidney involvement in COVID-19 infection

In previous reports of SARS and MERS-CoV infections, acute kidney injury (AKI) developed in 5-15% cases and carried a high (60-90%) mortality. Early reports suggested a lower incidence (3-9%) of AKI in those with COVID-19 infection^{1,11-13}. Recent reports, however, have shown higher frequency of renal abnormalities. A study of 59 patients with COVID-19 found that 34% of patients developed massive albuminuria on the first day of admission, and 63% developed proteinuria during their stay in hospital¹⁴. BUN was elevated in 27% overall and two thirds of patients who died. CT scan of the kidneys showed reduced density, suggestive of inflammation and edema. Cheng et al¹³ recently reported that amongst 710 consecutive hospitalized patients with COVID-19, 44% had proteinuria and hematuria and 26.7% had hematuria on admission. The prevalence of elevated Scr and BUN were 15.5% and 14.1% respectively. AKI was an independent risk factor for patients' in-hospital mortality^{13,14}.

Pathogenesis of kidney injury

The exact mechanism of kidney involvement is unclear: postulated mechanisms include sepsis leading to cytokine storm syndrome or direct cellular injury due to the virus. Angiotensin converting enzyme and dipeptidyl peptidase 4, both expressed on renal tubular cells, were identified as binding partners for SARS-CoV and MERS-CoV respectively^{15,16}. Viral RNA has been identified in kidney tissue and urine in both infections^{17,18}. Recently, Zhong's lab in Guangzhou has successfully isolated SARS-CoV-2 from the urine sample of an infected patient, suggesting the kidney as the target of this novel coronavirus¹⁹.

Treatment

The current treatment of COVID-19 with AKI includes general and supportive management, and kidney replacement therapy. There is no effective anti-viral therapy available at present.

General management

All the patients with confirmed COVID-19 should be quarantined. A N-95 fit-tested respirator and protective clothes and equipment are essential. Early admission to ICUs in designated hospitals is recommended for severely ill patients.

Supportive care, namely bed rest, nutritional and fluid support, maintenance of blood pressure and oxygenation are important measures, as for all critically ill patients. Other measures include prevention and treatment of complications by providing organ support, maintaining hemodynamic stability and prevention of secondary infection.

Antiviral therapy

There is no specific effective antiviral drug for COVID-19 at present. The guidelines of the Chinese National Health Commission recommend aerosolized inhalation of interferon α , and Lopinavir/Ritonavir. The specific therapeutic value and safety of Lopinavir/Ritonavir in COVID-19 patients is under investigation (ChiCTR2000029308)²⁰. Successful treatment with remdesivir has been reported in a COVID-19 patient; a clinical trial on the efficacy of remdesivir in COVID-19 patients is currently underway in China (NCT0425266; NCT04257656) and is expected to be completed in April 2020. Chloroquine phosphate has been shown to have some efficacy against COVID-19 associated pneumonia in multicenter clinical trials conducted in China.²¹

Extracorporeal treatments

CRRT has been successfully applied in the treatment of SARS, MERS and sepsis^{22,23}. High-volume hemofiltration (HVHF) in a dose of 6L/hr removed inflammatory cytokines (IL-6) and improved the SOFA (Sequential Organ Failure Assessment) scores at day 7 in patients with sepsis²⁴. Therefore, CRRT may play a role in patients with COVID-19 and sepsis syndrome. The potential role of extracorporeal therapy techniques needs to be evaluated, however.

Glucocorticoids

In a retrospective study of patients with SARS-CoV and sepsis, steroids, in a mean daily dose of 105.3 +/- 86.1 mg in 147 of 249 noncritical patients (59.0%) reduced mortality and shortened duration of hospitalization, while 121 of 152 critical patients (79.6%) received corticosteroids at a mean daily dose of 133.5 +/- 102.3 mg, and 25 died²⁵. A subsequent retrospective observational study of 309 MERS patients showed that those who received high dose steroids were more likely to require mechanical ventilation, vasopressors and RRT²⁶. In a metanalysis of corticosteroid use in SARS patients, 4 studies provided conclusive evidence of harm (psychosis, diabetes, avascular necrosis and delayed viral clearance)²⁷. Therefore, the use of steroids is controversial and not recommended by WHO due to potential inhibition of viral clearance and prolongation of the duration of viremia²⁸.

Convalescent plasma

Preliminary clinical studies in China have shown that early application of convalescent plasma in patients with COVID-19 could accelerate clinical recovery⁶. Currently two trials: an open-label, non-randomized clinical trial (NCT04264858) and a multicenter, randomized and parallel controlled trial (ChiCTR2000029757) on the efficacy of convalescent plasma in patients with COVID-19 are underway in China.

Monoclonal antibody

Monoclonal antibody directed against the RBD domain of the S protein of MERS-CoV has been found to have neutralizing activities in plaque assays *in vitro*.²⁹ A monoclonal antibody against COVID-19 has not yet been developed. Trastuzumab, a monoclonal antibody against the IL-6 receptor, has achieved encouraging preliminary clinical results. The safety and efficacy of Trastuzumab in COVID-19 infection is undergoing evaluation by a multicenter randomized controlled trial (ChiCTR2000029765).

COVID-19 in patients with kidney disease

Pregnant women, newborn and the elderly, and patients with comorbidities like diabetes mellitus, hypertension, cardiovascular disease are susceptible to COVID-19 infection and likely to have more severe illness often requiring ICU care. The impact of COVID-19 on CKD has not been reported³⁰.

COVID-19 infection presents a special threat to patients on dialysis. There are 7184 hemodialysis (HD) patients in 61 treatment centers in Wuhan city. At a single HD center in

Renmin Hospital, Wuhan University, 37 HD out of 230 HD patients, and 4 of 33 staff members developed COVID-19 infection between 14 January and 17 February 2020³⁰. A total of 7 patients on HD died, of whom 6 had COVID-19 infection. HD patients with COVID-19 had less lymphopenia, lower serum levels of inflammatory cytokines and milder clinical disease than other patients with COVID-19 infection.

Management of patients on dialysis

COVID-19 infection presents particular challenges for patients on dialysis, in particular, in center hemodialysis. Uremic patients are particularly vulnerable to infection and may exhibit greater variations in clinical symptoms and infectivity. In center HD significantly increases the risk of transmission of infection, including to medical staff and facility workers, patients themselves and family members, and all others.

The Chinese Society of Nephrology³¹ and the Taiwan Society of Nephrology³² have recently developed guidelines for dialysis units during the COVID-19 outbreak. A summary of these guidelines is provided below:

1. A working team consisting of dialysis physicians, nursing staff and technologists should receive training in updated clinical knowledge of epidemic COVID-19, notification of infection at risk, epidemic prevention tools, and guidelines from the government, academic society, and hospital authority. The list of staff should be recorded and be retained by dialysis hospitals.
2. Information on travel, occupation, contacts, and clusters history (TOCC) of each medical staff, dialysis patient, their family members, residents of the same institution, and colleagues at work should be collected and updated regularly.
3. Latest care recommendations and epidemic information should be updated and delivered to all medical care personnel as needed. Training can be done peer to peer or online.
4. Group activities, including group rounds, group studies, and case discussions should be minimized.
5. It is recommended that staff members have meals at different time to avoid dining together. Goggles, masks, and hats should be removed before meals, and hands washed with flowing water. Talking during meals should be minimized to reduce the spread of droplets.
6. Staff should self-monitor their symptoms and should inform the team leader in case they or their family members develop symptom(s) suggestive of COVID-19 infection.

7. Entrance control, identification and shunting of people at risk of infection, body temperature measurement, hand washing, wearing proper (surgical or N95) masks throughout the process, machine disinfection, environmental cleanliness, good air conditioning and ventilation conditions, should be instituted.
8. Patients and accompanying persons should be given hands-free hand sanitizer while entering the dialysis room. Patients should wear medical masks and avoid meals during dialysis. They can bring convenience food such as candy to prevent hypoglycemia.
9. Patients with suspected or confirmed COVID-19 infection should be admitted to negative pressure isolation ward of specified hospitals. If the capacity of the isolation facility is overloaded, the "Fixed Dialysis Care Model" as below is recommended for dialysis patients under the 14-day period of quarantine for possible contact with COVID-19.
10. Place of dialysis treatment: patients should continue hemodialysis at the original hemodialysis center and not change to another center.
11. Dialysis shift and personnel: Do not change dialysis shifts and caregiver staff to avoid cross contamination and infection. Minimize the relevant contacts.
12. Patients who need vascular access surgery should be screened for novel coronavirus before the surgery. Operations on patients with confirmed or suspected novel coronavirus infection should be carried out in a designated room with necessary protection for medical staff.
13. Transportation: Public transport should not be used. Patients should arrange personal transportation and take fixed transportation routes. Transport personnel and escorts should wear surgical grade or N95 masks throughout.
14. All patients who have fever should be screened for novel coronavirus infection, and should be given dialysis in the last shift of the day until infection is excluded.
15. Pass route for entering hospital and dialysis unit: The pick-up and drop-off should not be shared with other dialysis patients. Entering and exiting with other patients at the same time should be avoided. The route, mode and time of transport of dialysis personnel should be fixed.
16. Precautions in dialysis unit: Patients should not be in close proximity; treatment and waiting areas should have good air conditioning and ventilation to remove droplet particles from the air.
17. Designated care personnel: All personnel involved in direct patient care should undertake full protection, including long-sleeved waterproof isolation clothing, hair caps, goggles,

gloves and medical masks (surgical mask grade or above). Hand hygiene should be strictly implemented.

18. Dialysis machine: Equipment that may come into contact with patients or potentially contaminated material should be disinfected according to standard protocols.
19. If a new confirmed or highly suspected case of novel coronavirus infection in dialysis centers is identified, disinfection should be carried out immediately. Areas in close contact with these patients should not be used for other patients until cleared.
20. The medical waste from confirmed or suspected patients with novel coronavirus infection should be considered as infectious medical wastes and disposed accordingly.

Operational strategies for family member and caregivers

1. All the family members living with dialysis patients must follow all the precautions and regulations given to patients to prevent person-to-person and within family transmission of the COVID-19, which include body temperature measurement, good personal hygiene, handwashing, and prompt reporting of potentially sick people.
2. Dialysis patients, who have a family member or caregiver subject to "basic quarantine", can have dialysis as usual in accordance during the 14-day period.
3. Once the family members or caregiver of dialysis patients have been converted to a confirmed case, the patient's identity should be upgraded and treated in accordance with the above-mentioned conditions.

In summary, COVID-19, a disease caused by a novel coronavirus, is a major global human threat with a potential to turn into a pandemic. Kidney involvement seems to be frequent in this infection and AKI is an independent predictor of mortality. The impact of this infection in those with CKD has not been studied, and the management of patients on dialysis who have been suspected to have been in contact with COVID-19 should be carried out according to strict protocols to minimize risk to other patients and healthcare personnel taking care of these patients.

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