Annals of Clinical Nephrology

Open access Opinion

Close Monitoring and Early Intervention to Prevent Progression of AKI maybe Important to Reduce Mortality in Covid-19 Patients

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INTRODUCTION

Ongoing investigations reveal that the incidence of AKI in coronavirus patients with significantly increased clinical mortality is normal, even after adjusting for possible mixed factors. Also, patients with stage 2 or 3 her AKI experienced a double risk of death compared with patients without AKI. Another important finding is that age, history of heart disease, elevated white blood cell count, C-relatives protein, fibrinogen, and severity of pneumonia were identified as risk factors associated with the progression of AKI. This finding has important implications not only for the hospitalized population, but also for those at risk of contracting this infection. Several ongoing studies have reported that her AKI rate in coronavirus patients varied from her 2.3% to 42%. In an early study of coronaviruses from China, Guan et al. found a frequency of AKI in 2.4% of patients found to be infected with the coronavirus, with a fatality rate of 1.2% for all patients. In another concentrate by Cheng et al., 5.1% of all patients developed her AKI, and he had a case fatality rate of 16.1% in patients without AKI. Nevertheless, this mortality rate increased to 33% when he developed AKI. Instead of these studies, our review found a high incidence of AKI. This may make sense, as there are several variables that distinguish our review from previous studies.

DESCRIPTION

The more significant levels of C-reactive protein and leukocyte counts suggest that cytopathic effects may play an important role in the progression of AKI. Another important gambling variable for AKI is previous history of heart disease as a free gambling component of AKI in the model. This finding may be made meaningful by recent evidence that SARS-CoV-2 can fully bind the angiotensin-switching protein to the (ACE2) receptor in human cells. It is widely transmitted in both the heart and kidney. In addition, in our review, higher fibrinogen was recognized as a free gambling factor partner for AKI. This is a credible finding among the various experts who have described coagulopathy as one of the usual complications of coronavirus patients. However, further research is awaited to better understand this dynamics. By the way, there was a clear pattern when looking at the number of days until emergency hospitalization and the degree of improvement in AKI. A possible justification for this is the difficulty in distinguishing evidence for AKI at early stages. Scr rise is often delayed and inconsistent with KDIGO creatinine measurements in AKI. Previous research has found that checking only the Scr standard can actually delay the detection of AKI.

CONCLUSION

Findings suggest that there is likely to be significant error in the incidence of AKI in coronavirus patients using the KDIGO Scr model alone. Our concentrate further tended toward AKI as a stand-alone well-being factor that was firmly associated with increased mortality. Mortality in patients analyzed was >90%. Several variables were associated with her higher mortality from AKI in this review. First, the dataset for this study was collected early in this coronavirus pandemic when clinical assets had not been diverted. The lack of early detection and status of derivation methods for such patients likely contributed to the higher mortality rates observed. Second, as the Chinese coronavirus shows.

ACKNOWLEDGEMENT

None.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

Received:	30-November-2022	**Manuscript No:**	ipacn-22-15401
Editor assigned:	02-December-2022	**PreQC No:**	ipacn-22-15401 (PQ)
Reviewed:	16-December-2022	**QC No:**	ipacn-22-15401
Revised:	21-December-2022	**Manuscript No:**	ipacn-22-15401 (R)
Published:	28-December-2022	**DOI:**	10.35248/2471-8505-6.6.131

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Citation Vieira RSR (2022) Close Monitoring and Early Intervention to Prevent Progression of AKI maybe Important to Reduce Mortality in Covid-19 Patients. Ann Clin Nephrol. 6:131.