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COVID-19: A Case with Community-Acquired Pneumonia

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Abstract

In 2019 in Wuhan, China, a novel coronavirus (COVID-19) was identified, this is a new coronavirus, which has not been identified in humans before. This paper reports a suspected COVID-19 case with resolving Community-Acquired Pneumonia.

Keywords: COVID-19, Nigeria, case report, WHO, Community-Acquired Pneumonia.

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1. Introduction

Coronaviruses are a large family of viruses that are known to cause illness ranging from common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS). Coronavirus disease (COVID-19) is a recently discovered coronavirus-caused infectious disease. Most people infected with the COVID-19 virus will experience mild to moderate respiratory disease and recover without any special treatment being required. Older people and those with underlying health conditions such as cardiovascular disease, diabetes, chronic respiratory disease and cancer are more likely to experience significant illness.

2. The Case

A 65 year old male patient with generalized body weakness, excessive urination, poor appetite, tremor, fever, difficulty in breathing, and cough was admitted on 13th June, 2020 at 5:00 p.m. Past medical record indicates that the patient has been treated in a peripheral hospital for community-acquired pneumonia with relief of symptoms, the records identified him as a known hypertensive, diabetic, and osteoarthritis patient managed with polyneuritis and bronchopneumonia. He was immediately referred for COVID-19 screening, neurologist review and expert management. Random blood sugar (RBS) on admission was 269 mg/dl. Patient was in severe respiratory distress with fever and desaturation. An urgent brain MRI/Neurology review was conducted, and an anesthetist was invited to make significant input. Glucose Potassium Insulin (GKI); a four hourly blood glucose, oxygen via face mask, and antibiotics was administered.

Observed from patient's monitor that the patient was not making spontaneous respiratory effect, domed immediately and rushed in to reassess his condition and commenced resuscitation.

3. Vital Signs

Table 1: Patient's observation record for vital signs

Date	Temp (^{0}C)	Pulse. R (bpm)	Resp. R (cpm)	B.P (mmHg)	SPO_2 (%)
13/06/2020	36.3	80	28	137/78	99
14/06/2020	38.9	115.6	30	154/89	90
15//06/2020	39.1	116	36	164/133	80

4. Drug Chart

Table 2: Drugs administered to patient

Date	Time	Drug	Dose	Route
13/06/2020	8 p.m.	Azithromycin Levofloxacin Insulin Daily FBS/Evening RBS	500 mg 500 mg 6 I.U	Oral I.V SC
14/06/2020	10 a.m.	Azithromycin Levofloxacin Insulin Paracetamol	500 mg 500 mg 8 I.U 600 mg	Oral Oral SC I.V
	8 p.m.	Recephin Levofloxacin	2g 750 mg	I.V I.V
15/06/2020	9 a.m.	Paracetamol Insulin	600 mg 8 I.U	I.V I.V
	7:45 p.m.	Recephin Levofloxacin	2g 750 mg	I.V I.V

5. Conclusion

The patient did not restore spontaneous respiration, despite the attempt to resuscitate. No heart rate was detected, no heart pulse was felt, no respiratory effort was detected and no breath pulse was heard. On 16/6/2020, the patient was clinically certified dead at 6:15 a.m. The result on COVID-19, RT-PCT returned POSITIVE on 18/06/2020.

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