Damage of Kidney by Covid-19

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Betacorona RNAS is related to SARS in 2002, with MERS in 2012. Cardiovascular and renal patients are at risk of death. Kidney patients are at higher risk because of their morbidity. The patient in dialysis, the post-transplant patient, the immunosuppressed patient, with cancer, hypertension, diabetes, cardio kidney syndrome, hematooncological syndromes, and the one who uses drugs with nephrotoxic potency there are to follow up by telemedicine.

The biopsies performed showed curiously tubular necrosis without glomerulopathy different from that of the United States, Italy and Spain. It appears that there is no renal tropism but other work suggests this infection 3.9%, in severe cases and presence of proteinuria, elevated area, by 63%.

Cheng reports seven serious hospitalized patients who died 12.3%. Patients with acute renal impairment admitted to UCI ranges from 0.1% to 12% and this increases mortality to 91% in cases of respiratory distress the damage in acute renal patient by Covid-19. Probably will not leave sequels but in chronic diabetic or Comorbidity it will be possible to wait if the damage is reversible.

We have to wait 3 to 6 months. The patient on dialysis requires special care especially if the dialysis is at home, in the hospital with biosecurity protocol in both, washing hands, avoiding visits, avoiding leaving home, wearing masks, continue treatment with a minimum of medicines at home of 3 months, being in contact by telemedicine with Fresenius dialysis companies, with the national kidney foundation, avoid undue feeding with high load of potassium and sulfates, as well as avoid contacts with suspects who have the Covid-19, or who have it, strict social estrangement and having an emergency to announce to the doctor in the car of their arrival for safety protocol as there may be rooms with sick people who must be isolated for security protocol as there may be rooms with sick people who must be isolated.

The patient in UCI must be aware of the patient in shock, since these patients can receive potentially nephrotoxic drugs; this patient is hypo-infused in poor conditions in prone position or in mechanical ventilation and dialysis. In the transplanted patient or receptor, their immune system is weak and susceptible to infection. CDC protocols must be followed and in cases of likely to postpone it if you have been exposed.

This virus produces renal injury, with decreased renal flow, rhabdomyolysis, inflammation and direct attack of the virus, worsening the situation of the kidney with diarrhea, vomiting in patients those with infarctions that have to be subjected to catheterization the contrast should be measured and the dialysis should be performed after the procedure, just as if it is contrast used for a skull untac, urotac, or in case of massive pulmonary embolism use of rtpa combined with balloon and acolysis as pulmonary thrombosis is used non-ionic contrast iso-osmolar but is nephrotoxic.

Metabolic acidosis should be monitored for acute renal failure by Covid-19. In new publications we have seen proteinuria 63%, 35% nephrotic syndrome what tells us unlike Chinese literature attack on glomeruli and hematuria 20%, uremia 27, creatinine 19 in conclusion covid-19 attacks the kidney through the ace2 receptor, cytokines producing tubulopathies, glomerulopathy, interstitial infiltrate, and presence of the virus by histochemical immune post mortem and rhabdomyolysis. These patients should follow the criteria I say and the fraction of renal.

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