

Pulmonology and COVID-19

Karunasree P*

GITAM University, Vishakhapatnam, Andhra Pradesh, India

Short Communication

Corona virus disease (COVID 19) is caused by SARS-VOC 2 virus. It was first detected in 2019 in Wuhan China. SARS-CoV-2, the virus that causes COVID-19, belongs to the COVID family.

When the virus infects the body and gets in it, it comes into contact with the mucous membranes lining the nose, mouth, and eyes. The virus enters the healthy cells of the body where new parts of the virus are developed using the healthy cell. It multiplies, and the new ones infect the cells nearby.

The new Coronavirus can infect the upper and lower part of your respiratory tract. It goes down your airways. The lining can become irritated and the inflammation starts in the body. The contamination can arrive all the way down into the alveoli.

Coronavirus is another condition, and researchers are learning all the more consistently about how it can deal with your lungs. They accept that the impacts on the body are like those of the other Covid diseases, severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS).

As the air sacs are harmed, there is an influx of fluid which is for the most part excited cells and protein and this liquid accumulation causes pneumonia. This further disables the oxygen consumption by the lungs and frustrates the oxygen trade.

It most likely to develop in old age people, people with medical problems like diabetes, cancer, lung infections, heart diseases. The first case was reported in November 2019. The first wave of this corona, the most prevailing clinical indication has been very serious and dangerous respiratory problem. Patients were moved to emergency wards with asthenia, heart pain, high temperatures, and severe dyspnea that often became difficult to control with conventional measures under 48 h, creating the need for ventilator support and obtrusive measures. During this period, pulmonologists provided ventilatory support to many patients because of their health problems and conditions precluded obtrusive measures, or essentially on the grounds that there were no ICU beds available due to increase in number of patients [1].

This has highlighted the importance of pulmonology in most countries and its relevance and impact on the control of the Covid-19 pandemic in recent months.

Performing aerosol generating procedures (AGPs) in the field of interventional pulmonology can prompt significant development of aerosols, prompting a high danger of disease among Health Care Workers (HCWs). So, in this situation, pulmonologists play a major role [2].

A pulmonologist is critical in evaluating the severity of such issues. Pulmonologists monitor the patient, initiate treatment and provide information to the patient's family to help them with their expectations during what can be a difficult illness [3].

The pneumonic infection caused by the COVID-19 attack, requires a fast diagnostic tool that supplements the demonstrative test by PCR and which is likewise valuable in assessing the movement of lung sores. Since the majority of these are peripheral, it is proposed that the utilization of thoracic ultrasound for early diagnosis and for the daily assessment of the movement of lung sores by a solitary wayfarer without the need to utilize the chest CT. It is also proposed to do a systematic ultrasound examination of the thorax separating it by quadrants and hence distinguishing the ultrasound signs that are identified with the kind of parenchymal or pleural gesture that the patient has: A lines, B lines, parenchymal build up, pleural line and pleural radiation [4].

Pulmonologists have played various roles during the pandemic: assessing patients with respiratory problems as an outpatient; assessing patients in the emergency wards; counselling and treating patients in the hospitals; observing and overseeing patients who basically need the intensive care unit; communicating with the patients and their families; and, giving virtual visit administrations to patients who are recuperating gradually yet are too wiped out to even think about coming into the workplace. By and large, pulmonologists have been accessible as an asset to the community to respond to questions, to console them and help them through their recuperation period.

References

1. Mendoza FJ, Ferradas, L. García del Barrio, and Gorka Bastarrika. "Extent and Quantification of Inflammation Burden in COVID-19 by Computed Tomography." *Arch Bronconeumol* (2020).
2. Gómez, César Cinesi, Óscar Peñuelas Rodríguez, Manel Luján Torné, and Carlos Egea Santaolalla, et al. "Clinical consensus recommendations regarding non-invasive respiratory support in the adult patient with acute respiratory failure secondary to SARS-CoV-2 infection." *Med Intensiva* 44 (2020): 429-438.
3. Cordovilla, Rosa, Susana Álvarez, Liliána Llanos, and Nuñez Ares, et al. "SEPAR and AEER consensus recommendations on the Use of Bronchoscopy and Airway Sampling in Patients with Suspected or Confirmed COVID-19 Infection." *Arch Bronconeumol* (2020).
4. Barreiro, Esther, Carlos Jiménez, Julia García de Pedro, and María Teresa Ramírez Prieto. "COVID-19 and Pulmonology in the XXI century: Challenge or Opportunity?." *Arch Bronconeumol* 56 (2020): 411.

How to cite this article: Karunasree P. "Pulmonology and COVID-19" *J Pulm Respir Med* 11 (2021): 553

*Address for Correspondence: Karunasree P, GITAM University, Vishakhapatnam, Andhra Pradesh, India, Tel: +919985642255, E-mail: karunasreepandiri@gmail.com

Copyright: © 2021 Karunasree P. This is an open-access article distributed under the terms of the creative commons attribution license which permits unrestricted use, distribution and reproduction in any medium, provided the original author and source are credited.

Received 07 July, 2021; Accepted 21 July, 2021; Published 28 July, 2021