

Preventive Health Care in Liver Disease

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Description

Although there has been more focus on measures to improve the quality of end-of-life care for patients with end-stage liver disease, there have been few studies of patient care experiences during terminal hospitalizations. We looked at data from a big national database to learn more about palliative care and how people with end-stage liver disease used health care. The pandemic of coronavirus disease 2019 (COVID-19) poses a significant challenge to healthcare systems in impacted areas. Patients over the age of 65 and those with pre-existing medical issues have been identified as groups at risk of developing a serious disease [1].

Due to a lack of adequate studies, it is unclear to what degree chronic liver illnesses should be regarded risk factors at this time. Patients with advanced liver disease and those who have had a liver transplant, on the other hand, are at a higher risk of infection and/or a severe COVID-19 course. Furthermore, the current epidemic necessitates an atypical allocation of healthcare resources, which could have a severe influence on the care of people with chronic liver disease who require ongoing medical attention. The newly found coronavirus, severe acute respiratory syndrome coronavirus 2, causes Coronavirus Disease 2019 (COVID-19) (SARS-CoV-2) [2].

Fever, fatigue, and a dry cough are the most common COVID-19 symptoms. Shortness of breath, pains, nasal congestion, sore throat, anosmia, and ageusia are all symptoms that some people experience. Nausea, vomiting, and diarrhoea are less common. While the majority of patients' symptoms stay mild throughout the infection, older patients were shown to be at increased risk of a fatal illness course, with hypertension, diabetes, and coronary heart disease being the most common comorbidities in these groups [3].

Systemic viral infections, on the other hand, are frequently linked with temporary transaminase increases that may represent general immunological activation or inflammation generated by circulating cytokines without impairing liver function, a situation known as bystander hepatitis. This could even be the case in people with COVID-19 who haven't been diagnosed with liver failure, even in the most severe and deadly cases. However, as discussed in, symptoms of liver impairment can emerge in critically ill COVID-19 patients. It's unclear whether patients with cirrhosis and COVID-19 are more likely to decompensate or develop acute-on-chronic liver failure (ACLF), as has been

found with influenza infection. As the virus's receptor, angiotensin-converting enzyme, SARS-CoV-2 may also infect liver cells directly.

To prevent the spread of SARS-CoV-2, physical separation has been advised and/or adopted in a number of nations throughout the world. This method attempts to avoid a rapid increase in SARS-CoV-2 infections in the general community, with the overall goal of reducing the number of patients with a severe COVID-19 course at any given moment, allowing healthcare personnel to continue to offer medical/intensive care to these patients. At the same time, vulnerable patient groups should be protected from individuals who may have been exposed to or infected with SARS-CoV-2. As a result, the benefits of maintaining patient care must be evaluated against the risk of infection in these individuals. These factors necessitate the adaptation of normal operating procedures for outpatient care, such as the remodelling of waiting spaces to allow adequate spacing between patients, and the lowering of staffing levels [4,5].

Conflict of Interest

None.

References

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