

## A serious illness followed by post-intensive care syndrome belgian follow-up clinic cohort study COVID-19.

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### Abstract

All COVID-19 individuals who survived an ICU stay of 7 days and showed up for the M3 visit at our multidisciplinary follow-up clinic were included. The three main elements of post-intensive care syndrome—physical status, mental health issues, and cognitive impairment—and health-related quality of life were all addressed in the standardised examination that helped them. C-reactive protein and creatinine were referred to as biological parameters. A growing issue is the state of health of those who have survived a catastrophic disease. Survivors of a protracted stay in an intensive care unit may have mid- and long-term morbidities connected to the severe illness, the necessary support, and the environment, regardless of the initial sickness. The post-intensive care syndrome is defined by princeps as new or worsening physical, mental, and neurocognitive impairments that have an adverse impact on everyday functioning and quality of life in people who have survived serious illness. Recently, a broader definition that takes into account further elements such as osteopenia, metabolic problems, endocrine dysfunction, susceptibility, sleep issues, chronic pain, and exhaustion has been proposed.

**Keywords:** Osteopenia, Metabolic problems, Endocrine dysfunction, Sleep issues, chronic pain.

### Introduction

Acute respiratory distress syndrome, which can result in ICU admission and a lengthy stay, can be brought on by the COVID-19. After invasive ventilation is established, it has been shown that COVID-19 ARDS mimics the physiology of ARDS from different etiologies. The number of survival has increased dramatically as a result of recent improvements in COVID-19 ICU patient care, raising concerns about mid- and long-term outcomes. A variety of sequel that are connected to their critical condition or the SARS-CoV-2 infection may affect critical COVID-19 survivors [1]. Making accommodations may be challenging because symptoms may overlap. One month after being discharged from the hospital, a new cohort study looked at PICS in a small group of extremely ill COVID-19 survivors. During a telehealth follow-up, the clinical evaluation concentrated on a small number of outcomes. Over 90% of patients described symptoms that affected at least one significant PICS domain. More over one third of the patients developed acute stress problems or cognitive dysfunction within a month following discharge [2]. Survivors still reported having a poorer quality of life connected to their health three months after their severe illness. These outcomes are comparable to earlier ARDS groups as well. In contrast to mobility issues, pain, discomfort, anxiety,

or despair persisted six months after a crucial COVID-19. In this study, critically ill COVID-19 survivors referred to a face-to-face consultation in our post-ICU follow-up clinic at 3 months after a lengthy ICU stay were asked to characterise the mid-term outcomes and to assess the prevalence of the key PICS symptoms [3].

Since 2019, patients who have survived an ICU stay of less than 7 days have been routinely invited to our post-intensive care follow-up clinic at 1, 3, and 12 months after ICU discharge. At every stage, a multidisciplinary team is involved, including critical care doctors, nurses, physiotherapists, dieticians, and psychologists. This in-person follow-up is standardised and covers physical condition and functional abilities, dietary status and body composition, bone health, mental health issues, cognitive decline, sleep issues, and HRQoL. Additionally, a blood study is carried out with a focus on metabolic and inflammatory indicators. Our usual analysis includes measuring C-reactive protein and creatinine [4]. The consultations were open to any subsequent critically sick COVID-19 patients who had been admitted to the ICU during the initial wave. Patients who could not speak in the local language of French or who were still hospitalised in an inpatient rehabilitation institution were excluded from the study. Following attendance at the clinic three months after

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ICU discharge, clinical information on patients' physical, mental, and neurocognitive states as well as biological measures linked to kidney function and inflammatory status was prospectively gathered. Retrospectively, medical records were mined for demographic information as well as information about the patient's stay in the intensive care unit [5].

## Conclusion

The burden of a severe COVID-19 and an extended ICU stay was significant in the current group, affecting each patient's functional state and biological parameters in half and a quarter of them, respectively. Less than 10% of patients had no PICS symptoms and were completely well at M3. Similar findings were already made at one month in prior research, indicating very slow clinical status improvement without active and ongoing post-ICU treatment. Given the inherent bias of a follow-up clinic, where only the fittest patients accept or are able to attend the follow-up sessions, the actual effects on survivors may be understated. Up to 20% of the severely sick patients in the current first wave cohort of COVID-19 were still hospitalised in an inpatient rehabilitation centre and were not examined at M3.

The observations made in the current crucial COVID-19 cohort are comparable to the few published results that are comparable. Similar EQ-5D-3L scores were reported at M3 in

a small group of patients who had ICU LOS and mechanical ventilation that lasted slightly less time. Sleep disturbances and cognitive deficits were the two most common sequelae reported by survivors four months after release in a large sample of patients who spent around 10 days in the intensive care unit.

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