

COVID-19 has Gone Quiet. Should We Calm Down?

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2019 was characterized by the appearance of a new COVID-19 virus infection [30]. Human coronaviruses were first isolated by D. Tyrrell and M. Bynoe in 1965 with seasonal infection [25]. But, at the beginning of the XXI century, we were faced with its different variants: severe acute respiratory syndrome (SARS), which first appeared in November 2002 in the Chinese province of Guangdong [15]. At that time, 8098 cases with a mortality rate of 9.6% were registered [21]. The next was Middle East Respiratory Syndrome (MERS, MERS-CoV). The first cases of which were registered in the eastern part of Saudi Arabia in September 2012. As of December 2019, 2,484 cases were confirmed, of which 857 (34.5%) were fatal [10].

The last outbreak of coronavirus infection in December 2019 led to the COVID-19 pandemic. From the beginning of the pandemic to its extinction, a large number of works devoted to the study of this disease have been published. Thus, age, gender, comorbidity [8], ethnic [17] and national [20] affiliation, weigh down its course. In the works analyzing mortality and lethality from COVID-19, despite the criteria legalized by WHO [2], there is sometimes confusion with these concepts and terms due to differences in their interpretation in different countries, for example in the USA [16], in England [5], in Italy [7], in The Republic of Belarus [26]. Therefore, when talking about COVID-19, we must compare and operate with the following terms: mortality (from SARS-CoV-2 infection), hospital letalis (in covid-hospital) and community-acquired letalis in outpatient medical organizations (from SARS-CoV-2 infection) [19].

Unfortunately, much remains unclear about the cause, etiology, pathogenesis, clinical manifestations and treatment of this category of patients. Thus, hyperglycemia is a frequent disorder detected in patients with COVID-19. At the same time, it was found that patients with hyperglycemia have longer hospitalization periods and an increased risk of an unfavorable outcome [27]. Several possible causes of hyperglycemia in COVID-19 are currently being considered: stress hyperglycemia [28]; direct damage to the pancreas by the SARS-CoV-2 virus [29]; undiagnosed type 2 diabetes [4]; prediabetes [22]; diabetes mellitus, first detected against the background of COVID-19 [23]; administration of glucose solutions [9]; administration of glucocorticosteroids [3].

The issues with fluctuations in the blood of D-dimers have not been finally resolved [24], because these patients rarely have pulmonary embolism [31]. The mechanism of the growth of ferritin levels [18] is not very clear, especially in COVID-19, occurring with iron deficiency anemia, where it is initially reduced. Whether its intensive synthesis is *de novo*, or it comes out of other organs. There are questions about the mechanism of growth of C reactive protein in the blood [12], because it increases mainly with bacterial infection.

MERS-CoV-2 infection is widespread all over the world and has devastating effects on people's health and lives. Why? Firstly, it spread very quickly. Thus, the first case of the disease in Brazil was registered just 3 months after the outbreak in Wuhan in December 2019 (China) [11], and in the Netherlands - on February 27, 2020 [6]. Secondly, in many regions of the world it appeared in several waves [1]. Thirdly, the rapid appearance of new mutations of this virus, for example, "centaur" [13] and "deltacron" [14], require a very serious attitude to the risk factors of mortality in this disease. Fourth, it is necessary to take into account the occurrence of the bridge syndrome.

There are a lot of questions left and they need to be solved gradually. It is necessary to do this with the joint efforts of colleagues from different countries in order to be ready to meet a new infection.

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