

Response to COVID-19 in Japan (with a focus on clinical research)

日本におけるCOVID-19への対応(臨床研究を中心に)



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Dr. Ohmagari has completed his clinical fellowship in Infectious Diseases at University of Texas-Houston. After serving as chief of the Division of Infectious Diseases at the Shizuoka Cancer Center, in 2011 Dr. Ohmagari moved to NCGM which is one of six national medical centers in Japan with infectious diseases as main objective. At NCGM, Dr. Ohmagari has been acting as Director of the Disease Control and Prevention Center since 2012. He also serves as the director of AMR Clinical Reference Center, which is commissioned by Ministry of Health, Labor and Welfare, Japan.

Dr. Ohmagari is engaged in the care, prevention and research of infectious diseases from a global perspective. As a physician, Dr. Ohmagari is directly involved in the clinical management of patients with infectious diseases. At the same time, Dr. Ohmagari is working on the on-site response in infectious disease crisis management in Japan.

新型コロナウイルス感染症は、2019年12月に中国の武漢市で初めて患者が報告された。

WHOは本ウイルスによる感染症の呼称をCoronavirus Disease 2019 (COVID-19)と決定した。

WHOは2020年1月30日に国際的に懸念される公衆衛生上の緊急事態(Public Health Emergency of International Concern: PHEIC)を宣言した。

当日は日本におけるCOVID-19への臨床対応を紹介する。

The new coronavirus infection was first reported in December 2019 in the city of Wuhan, China.WHO has decided to designate the infection caused by this virus as Coronavirus Disease 2019 (COVID-19).WHO announced on January 30, 2020 that it is a public health concern of international concern A Public Health Emergency of International Concern (PHEIC) has been declared. At the event, the clinical response to COVID-19 in Japan will be introduced.

Clinical response to COVID-19 in Japan

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Co Morbidities and severity of COVID-19

	All (n=2638)	No Oxygen (n=1629)	Oxygen Tx (n=784)	Intubation (n=223)
Congestive heart failure	96 (3.6%)	24 (1.5%)	64 (8.2%)	8 (3.6%)
Peripheral vascular diseases	47 (1.8%)	18 (1.1%)	17 (2.2%)	12 (5.4%)
Cerebrovascular accidents	145 (5.5%)	52 (3.2%)	77 (9.8%)	16 (7.2%)
COPD	44 (1.7%)	9 (0.6%)	26 (3.3%)	9 (4%)
Pulmonary diseases non-COPD	66 (2.5%)	14 (0.9%)	40 (5.1%)	12 (5.4%)
Hypertension	396 (15%)	153 (9.4%)	181 (23.1%)	62 (27.8%)
Hyperlipidemia	216 (8.2%)	98 (6%)	82 (10.5%)	36 (16.1%)
Mild DM	374 (14.2%)	143 (8.8%)	157 (20%)	74 (33.2%)
Severe DM	67 (2.5%)	23 (1.4%)	36 (4.6%)	8 (3.6%)
Obesity	146 (5.5%)	59 (3.6%)	65 (8.3%)	22 (9.9%)
Cancer	103 (3.9%)	39 (2.4%)	49 (6.2%)	15 (6.7%)

The prevalence of comorbidities such as diabetes and obesity is lower in Japanese patients.

Wiersinga WJ, et al. JAMA. 2020; Gang S, et al. MMWR. 2020; Zhou F, et al. Lancet. 2020; Doeherty AB, et al. BMJ. 2020; Petrilli CM, et al. BMJ. 2020

COVIREGI-JP
NCGM

Proportion of post-hospitalization deaths in hospitalized cases

The rate of death after hospitalization was higher in the elderly and in cases of serious illness*1 at the time of admission. The rate of post-hospitalization deaths was lower in all age groups for patients admitted in June and later than in those admitted before June.

	Cases of serious illness on admission*2	
	Cases admitted before June 5	Cases admitted after June 6
0-29yo	5.6% (1/18)	0.0% (0/11)
30-49yo	2.2% (3/139)	0.0% (0/31)
50-69yo	10.9% (45/411)	1.4% (1/74)
70yo-	31.2% (162/519)	20.8% (21/101)
∑†	19.4% (211/1087)	10.1% (22/217)

*1 The patient is classified as critically ill on admission if any of the following conditions is met: oxygen administration, ventilator management, SpO2 of 94% or less, or respiratory rate of 24 breaths/minute or more.

THE NEW ENGLAND JOURNAL OF MEDICINE

ORIGINAL ARTICLE

Remdesivir for the Treatment of Covid-19 — Preliminary Report

J.H. Beigel, K.M. Tomashek, L.E. Dodd, A.K. Mehta, B.S. Zingman, A.C. Kalil, E. Hohmann, H.Y. Chu, A. Luetkemeyer, S. Kline, D. Lopez de Castilla, R.W. Finberg, K. Dierberg, V. Tapson, L. Hsieh, T.F. Patterson, R. Paredes, D.A. Sweeney, W.R. Short, G. Touloumi, D.C. Lye, N. Ohmagari, M. Oh, G.M. Ruiz-Palacios, T. Benfield, G. Fatkenheuer, M.G. Kortepeter, R.L. Atmar, C.B. Creech, J. Lundgren, A.G. Babiker, S. Peit, J.D. Neaton, T.H. Burgess, T. Bonnett, M. Green, M. Makowski, A. Osinusi, S. Nayak, and H.C. Lane, for the ACTT-1 Study Group Members*

DOI: 10.1056/NEJMoa2007784

Patients with high urinary L-FABP and urinary β2 microglobulin tended to be more severe after one week.

Progression of severity and urinary biomarkers on admission

Shape of symbols: Severity at 1 week after admission
 • Severe • Moderate ▼ Mild

Color of symbols: Severity at each time point
 • Severe • Moderate • Mild

Cut-off value to detect: — Severe class — Mild class

Crit Care Expl 2020; 2:e0170
 DOI: 10.1097/CCX.0000000000000170

Serum CCL17 level becomes a predictive marker to distinguish between mild/moderate and severe/critical disease in patients with COVID-19

Highlights

- CCL17 were showed strong association with the development of severe pneumonia.
- The downregulation of CCL17 could be unique in COVID-19.
- A flare-up of IFN- γ , IL-3, IL-6, IP-10, and CXCL9 were a trigger for severe symptom.

https://doi.org/10.1016/j.gene.2020.145145

開催にあたって
プログラム
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第二部
第三部セッション1
第三部セッション2

Greetings
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Part 1 Session 2
Part 2
Part 3 Session 1
Part 3 Session 2