COVID-19 coronavirus: pathogenesis, clinical features, diagnostics, epidemiology, prevention and control

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ABSTRACT

Spreading of the diseases from country to country and from continent to another is one of the drawbacks of globalization. In December 2019, from Wuhan in China, COVID-19 was emerged as a new viral disease caused by a novel betacoronavirus which spread in more than 210 countries and 3 continents over 3 months. “SARS-CoV-2” is the name of the virus while “Coronavirus Disease 2019” (COVID-19) is the disease itself. Coronaviruses cause a variety of diseases in birds and mammals ranging from mild upper respiratory disease to severe acute respiratory distress which may lead to death. The aim of this review is to provide a brief introduction to coronaviruses, demonstrate and describe clinical features, epidemiological, transmission mode, treatment and vaccination trials of COVID-19 globally and in Egypt, and an attempt to review the rapid identification and diagnostic features of this virus as well as summarize history of pandemic and epidemic viral diseases. We hope our review will provide the global community and the literature with the wise steps for controlling and preventing the outbreak of this severe pathogenic virus.

Introduction

Coronaviruses are belonging to the subfamily Coronavirinae, family Coronaviridae, order Nidovirales. They are enveloped viruses with a single stranded positive-sense RNA. The name of corona means crown in which a characteristic club-like spikes project from surface of the virus, an unusually large RNA genome, and a unique replication strategy. Coronavirus are divided into four genotypes (alpha, beta, gamma and delta), alpha and beta are pathogenic to humans, with twenty-six different species featured by various antigenic cross-reactivity (Cleri et al. 2010; de Wilde et al. 2017). Coronaviruses have long been categorized as imperative veterinary viral pathogens, affecting numerous species of mammals and birds causing respiratory and enteric diseases. However, coronaviruses have been infecting humans for at least 500-800 years, and all are suggested to be originated in bats (Berry et al. 2015).

The first isolated coronavirus was the avian infection in 1937, which cause of devastating infections in chicken. After that, the first human coronavirus (HCoVs) was isolated in 1965 from infected patient and propagated in vitro by (Tyrrell et al. 1965) using human ciliated embryonic trachea cell line. HCoVs including HCoV-229E, OC43, NL63, and HKU1, cause mild respiratory diseases and have been considered negligible viral pathogens in healthy people.

In the 21st century, severe acute respiratory syndrome coronavirus (SARS-CoV) and middle east respiratory...
syndrome coronavirus (MERS-CoV) as two highly pathogenic strains of HCoVs, caused severe illness, the mortality rates were 10% and 37%, respectively, and more than 10,000 cumulative cases (Ksiazek et al. 2013). In December 2019, another novel pathogenic strain of HCoVs was discovered throughout a suspicious incidence of pneumonia in a Chinese city called Wuhan and has caused serious illness and death. SARS-CoV-2 is characterized by high transmission efficiency, and a rapidly increasing incidence of infections (Zhao et al. 2020) and its possibility of transmission by asymptomatic carriers (Biscayart et al. 2020). On 30 January 2020, the World Health Organization (WHO) declared the COVID-19 outbreak as the sixth public health emergency of international concern, following H1N1 (2009), polio (2014), Ebola in West Africa (2014), Zika (2016) and Ebola in the Democratic Republic of Congo (2019). In 11 March 2020, WHO declared COVID-19 a pandemic, when over 118,000 cases in over 110 countries around the world suffered from it. Therefore, special concern and global co-operation of the health workers, governments and public should be taken to prevent its spread.

Here we provide a brief discussion to the history of viral pandemics and coronaviruses reviewing their epidemiology and pathogenicity, and the methods of diagnosis of the highly pathogenic SARS-CoV2 (COVID-19). We will also discuss current treatment strategies, vaccination, prevention and control parameters of COVID-19.

Epidemiology of COVID-19 and history of pandemics of some viral diseases

SARS-CoV-2 was transmitted from China then propagates through Asia and spreaded through Europe mainly by starting in Italy and a huge wildfire spreading in the world occur. The incidence rate is growing enormously, as the mortality rate of COVID-19 in Wuhan was 4.9% (WHO-China Joint Mission on COVID-19 2020). The mortality rate of COVID-19 is differing between countries and it is very difficult to calculate the fatality rate while the pandemic is still ongoing.

The basic reproduction number (R0, R naught or R zero) is an indication of the transmissibility and the risk of a virus with respect to epidemic spread, representing the average number of new infections generated by an infectious person in a totally naive population. WHO estimated the mean of the R0 to be 1.95, while (Liu et al. 2020) review found that the R0 average to be 3.28 which exceed WHO estimates.

The problem in this disease is that people might be confused between the COVID-19 symptoms and the influenza virus symptoms and one of the major problems also within corona species is the high genetic variation and the high modification in the viral genomic structure. At the time of this manuscript 31/5/2020, 6,234,611 confirmed cases and 373,107 deaths and 2,781,605 recovery cases of COVID-19 were reported globally, in 215 countries and territories (European Centre for Disease Prevention and Control (ECDC), 2020).

The global daily cases and deaths illustrated in figure (1) and figure (2) represents the world population with COVID-19. The highest numbers of cases were found in United States of America, Brazil and Russia. While, the highest number of deaths were found in United States of America, United Kingdom and Italy. In Egypt, the first case of COVID-19 was discovered on February 14 and reached to 24,985 total confirmed cases and 959 total deaths till 31 May 2020 (worldometers. 2020; European Centre for Disease Prevention and Control (ECDC). 2020).

According to (WHO situation report no 7. 2020), COVID-19 can infect people of all ages, ranging from 2 to 74 while the median age of cases is 45 years 71% of them were males. Ilaria Capua, a virologist and director of the One Health Center of Excellence at the University of Florida, USA, suggested that Italy has a high spread of COVID-19 because it has the highest number of deaths from antibiotic resistance in the European Union. Good differentiation should be done by pathologist to distinguish between SARS-CoV-2 as the primary pathogen or opportunistic pathogen by multidrug-resistant bacteria (Paterlini 2020). The history of viral pandemics and epidemics is shown in detail in table (1) and illustrated in figure (3) where most of the viruses causing pandemics are RNA enveloped viruses with a high mutation rate.

**Viral structure of COVID-19**

Genetic recombination or convergent evolution events at spike protein of SARS-CoV-2 could be the reason
causing its high transmission rate compared to SARS-CoV (Shereen et al. 2020). The S protein of both SARS-CoV-2 and SARS-CoV are similar where they are interact with human angiotensin-converting enzyme-2 (ACE2) receptor which is the reason of the human transmission, but they are differ in the salt bridge which help SARS-CoV-2 for a more efficient binding (Khalifa et al. 2020).

The spike glycoprotein of the coronavirus is responsible for the determination of the host range, tissue tropism of coronaviruses and viral entry to host cells by binding to a host receptor through its highly variable S1 subunit, then fusion to host membrane through the more conserved S2 subunit.

The S1 subunit is divided into N terminal domain (NTD) and a C terminal domain (CTD) (figure 4), in most of CoVs the NTD attached to a sugar on the cell surface of human galectins, galactose-binding lectins after structural folding, and the CTD is responsible for binding of the virus with ACE2 on host receptor (Walls et al. 2020).

Fig 2. Pie charts represent the world population with COVID-19; A. Black area represents the healthy non infected population. B. The infected population with COVID-19 divided into active cases, recovery and deaths.

Fig 3. Illustration of the history of some viral epidemics and pandemics.

Fig 4. Schematic of 2019-nCoV S primary structure colored by domain. Domains that were excluded from the ectodomain expression construct or could not be visualized in the final map are colored white. Starting from the N-terminus domain (NTD) of S1, C-terminal domain (CTD), the S1/S2 first protease cleavage site, the fusion peptide (FP) which contains the second protease cleavage site (S2'), heptad repeat 1 (HR1), central helix (CH), connected domain (CD), heptad repeat 2 (HR2), cytoplasmic tail (CT). Protease cleavage sites represented with arrows (Wrapp et al., 2020).
| Virus                  | Pandemics and Epidemics                                                                 | Structure                                                                 | R0*  | Host                  | Symptoms                                                                 | Transmission                    | Treatment and vaccine | Mortality rate | References                                                                 |
|-----------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------|------|------------------------|---------------------------------------------------------------------------|---------------------------------|----------------------|-------------------|---------------------------------------------------------------------------|
| Smallpox               | First outbreak in the 3rd century BCE (Before Common Era)                             | Species of the genus Orthopoxvirus Poxviridae.                            | 5-7  | Human Only             | Fever and a distinctive, progressive skin rash.                          | Inhalation of airborne Variola virus.                                  | Smallpox vaccines     | 30%              | (Babkin and Babkina 2015; Dubochet et al. 1994)                           |
| Variola virus          | - Many outbreaks and on May 8, 1980, the 33rd World Health Assembly officially declared the world free of this disease. | Enveloped with a single linear double stranded DNA genome.                     |      |                        |                                                                           |                                 |                      |                  |                                                                            |
| Measles morbillivirus  | In the early of the 4th century BCE was the first outbreak many other outbreaks.       | Member of the genus Morbillivirus family Paramyxoviridae.                   | 12-18| Human only             | Rash, fever and respiratory symptoms.                                    | Passed through direct contact and through the air.                   | Measles vaccine (Live attenuated vaccine). | 20% from West Africa. And 2 % in the developing world.                  | (Chun et al. 2020; Guerra et al. 2017; Sundell et al. 2017) |
|                       | - Last outbreak was in Sweden 2017-2018.                                               |                                                                           |      |                        |                                                                           |                                 |                      |                  |                                                                            |
| Yellow fever virus     | The first definitive outbreak of yellow fever in the New World was in 1647 on the island of Barbados. Followed by many outbreaks and epidemics. From the end of 2017 to mid-May 2018, we experienced a YF epidemic in the southern region of Brazil. | Species of the genus Flavivirus, family Flaviviridae.                       | 2.6-3.4| Humans, other primates, and several types of mosquitoes. | Fever, headache, jaundice, muscle pain, nausea, vomiting and fatigue. | Transmitted by mosquitoes, belonging to the Aedes and Haemogogus species. | The yellow fever vaccine. (attenuated live vaccine) | 20–50%           | (Gubler 2018; Nasidi et al. 1989; Nunes Duarte-Neto et al. 2019; Zhao et al. 2018) |
|                       | - The first definitive outbreak of yellow fever in the New World was in 1647 on the island of Barbados. Followed by many outbreaks and epidemics. From the end of 2017 to mid-May 2018, we experienced a YF epidemic in the southern region of Brazil. | Enveloped, positive-sense, single-stranded RNA viruses.                    |      |                        |                                                                           |                                 |                      |                  |                                                                            |
| Zika virus             | Uganda in 1947 last outbreak in Brazil in 2016                                         | Member of the genus Flavivirus family Flaviviridae                         |      | Humans and mosquitoes. | Rash, fever, arthralgia, conjunctivitis, headache, vomiting and edema with severe neurological complications including microcephaly in newborn. | Bite of an infected mosquito from the Aedes Genus, contaminated blood and sexual transmission. | No available treatment and vaccine | 8.3% in cases of microcephaly.                                      | (Heang et al. 2012; Da Cunha et al. 2016) |
|                       | - Uganda in 1947 last outbreak in Brazil in 2016                                         | Enveloped, positive single stranded genomic RNA                           |      |                        |                                                                           |                                 |                      |                  |                                                                            |
| Ebola virus disease    | its discovery in 1976 in areas of sub-Saharan Africa the biggest outbreak is in 2014-2016 in West Africa | Belonged to genus Ebolavirus family Filoviridae.                           | 1.5-2.5 | Wild animals and human | Viral hemorrhagic fever.                                                   | From wild animals then human-to-human transmission.                 | Ervebo is a genetically engineered live attenuated vaccine contains a protein from the Zaire ebolavirus. | 25-90%            | (WHO 2020; Baize et al. 2014; Grosseth, Feldmann, and Strong 2007)      |
| Virus                          | Pandemics and Epidemics | Structure                   | R0* | Host                      | Symptoms                                                                 | Transmission                                                        | Treatment and vaccine                              | Mortality rate | References                                                                 |
|-------------------------------|-------------------------|-----------------------------|-----|---------------------------|--------------------------------------------------------------------------|---------------------------------------------------------------------|--------------------------------------------------|---------------|---------------------------------------------------------------------------|
| Influenza viruses             |                         | family enveloped, Orthomyxoviridae, negative-stranded RNA viruses |     | Human, birds and pigs     | abrupt onset of headache, high-grade fever, chills, dry cough, pharyngeal irritation, myalgias, malaise, and anorexia. | Airborne transmission (aerosol droplets and contaminated hands). | Influenza vaccines are inactivated, attenuated, or recombinant. |               | (Taubenberger et al. 2000; Taubenberger and Morens 2006)                 |
| Spanish flu (H1N1)            | 1918-1919               |                             | 1.47–2.27 |                           |                                                                           |                                                                     |                                                  | 4-20%         |                                                                            |
| Asian flu (H2N2)              | 1957-1958 originated in China |                             | 1.6 |                           |                                                                           |                                                                     |                                                  | <1%           |                                                                            |
| Swine flu (H1N1)              | 2009-2010 originated in Mexico |                             | 1.5 |                           |                                                                           |                                                                     |                                                  | 0.3%          |                                                                            |
| Human CoronaViruses: SARS    | 2002-2003 originated in Guangdong - China | Family Coronaviridae, order Nidovirales, Enveloped, large, single, plus-stranded RNA viruses | 2-5 | Bats, civets and human    | Fever, cough, chest pain and maybe pneumonia                             | Respiratory droplet transmission.                                  | No available treatment and vaccine.                | 10%           | (Desforges et al. 2019; Ban and Ocahy 2013; Ashour et al. 2020; Wilson et al. 2020; Oboho et al. 2015) |
| MERS                          | 2015- till now. Originated in Saudi Arabia. |                             | <1 (0-6-9) | Bats, camels and human.   |                                                                           |                                                                     |                                                  | 40%           |                                                                            |
| COVID-19                      | 2019- till now. Originated in Wuhan, China |                             | 1.4-5.5 | Human and Unknown origin. | fever, cough, and myalgia or fatigue.                                    |                                                                     |                                                  | 3.4%          |                                                                            |

**Table 2** Different types of serology tests

| Test type                     | Time to results | Sample                        | Data obtained                                                                 | Missed data                                                                 |
|-------------------------------|-----------------|-------------------------------|------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Rapid diagnostic test (RDT)   | 10-30 minutes   | Blood, serum, saliva samples, or nasal swab fluids | Qualitative detection of antibodies against the virus in patient sample. | Quantification detection of antibodies and the ability of antibodies to protect against future viral infection. |
| Enzyme linked immunosorbent assay (ELISA) | 1-5 hours | whole blood, plasma, or serum samples | Quantitative and/or qualitative detection of antibodies against the virus in patient serum or blood. | The ability of antibodies to protect against future viral infection. |
| Neutralization assay          | 3-5 days        | whole blood, serum, or plasma samples | Detect the active antibodies (that can protect against future infection) in patient serum and can inhibit virus replication ex vivo, in a cell culture system. | The antibodies to viral proteins that are not involved in replication. |
Wrapp et al. (2020) found that the cryo-electron microscopy of SARS-CoV-2 S protein illustrate that the S1/S2 subunits, which is furin subunit, are the first cleavage site and is the main difference between SARS-CoV-2 from SARS-CoV and SARS-related CoVs. Coronaviruses S protein is additionally cleaved by cellular proteases of the host at S2′ site, within S2 subunit, like human airway trypsin-like protease (HAT), cathepsins and transmembrane protease serine 2 (TMPRSS2) then they proposed to activate the fusion protein by many irreversible conformational changes (Millet and Whittaker 2015; Park et al. 2016). Spike (S), envelope (E), membrane (M) and nucleocapsid (N) genes are four structural genes that encode the structural proteins.

The non-structural proteins that are vital for viral replication are generated by the proteolytic cleavage of the polyprotein at 11 different sites (Anand et al. 2003). These processes are mediated by non-structural proteins 3-chymotrypsin-like protease (3CL<sup>pro</sup>) or also called main protease (M<sup>pro</sup>) which plays a very important role in the virus replication and a potential target for drug development (Needle et al. 2015).

The SARS-CoV-2 3CL<sup>pro</sup> polypeptide is considered as a stable protein, a hydrophilic molecule capable of establishing hydrogen bonds, and an important target for anti-SARS-CoV-2 inhibitors. The molecular weight of 3CL<sup>pro</sup> polypeptide is 33,796.64 Da with 306 amino acids and a GRAVY score of -0.019 (ul Qamar et al. 2020).

**Pathogenesis of COVID-19**

Pathogenesis of Covid-19 from the point of entry of the lungs till the appearance of the symptoms is poorly investigated. To fully understand the pathogenesis of COVID-19, we must understand the mechanisms of MERS-CoV and SARS-CoV as the genetic system of the COVID-19 displayed more than 80% and 50% similarity for SARS-CoV and MERS-CoV, respectively (Lu et al. 2020; Ren et al. 2020). Pathogenesis of COVID-19 is divided into 3 parts including viral entry and replication, cytokine storm and corona virus immune evasion.

**Viral entry and replication**

The envelope S glycoprotein causing attachment of viral particles to the host cells (Li et al. 2003). After the entry of the virus to the cells, the viral RNA genome is released into the cytoplasm and converted into structural proteins and polyproteins, after which the viral genome starts to replicate (Perlman and Netland 2009). Then, viral particles germinate into the endoplasmic reticulum-Golgi intermediate compartment (ERGIC). Finally, the vesicles containing the virus particles fuse with the plasma membrane to release the virus to outside the infected cells (De Wit et al. 2016).

**Cytokine storm in COVID-19**

Acute Respiratory Distress Syndrome (ARDS) is the common immunopathological episode for SARS-CoV, COVID-19 and MERS-CoV infections (Xu et al. 2020). In case of SARS-CoV infection, the main mechanism for ARDS is the cytokine storm which is the uncontrolled deadly systemic inflammatory response resultant from the release of large amounts of pro-inflammatory cytokines (IL-1β, IL-6, IL-18, IL-33, IL-12, FN-α, IFN-γ, TNF-α, TGFβ, etc.) and chemokines (CXCL8, CXCL9, CXCL10, CCL2, CCL3, CCL5, etc.) by immune effector cells (Channappanavar and Perlman 2017). The cytokine storm triggers a vicious attack by the immune system to the body, causing ARDS and multiple organ failure which may finally lead to death in severe cases of COVID-19, just like what occurs in SARS-CoV (Xu et al. 2020).

**Coronavirus immune evasion**

To improve survival in host cells, MERS-CoV and SARS-CoV use numerous strategies to avoid the immune counterattack. The conserved microbial structures named pathogen-associated molecular patterns (PAMPs) can be recognized by pattern recognition receptors (PRRs) which play a crucial role in the function of the innate immune system. However, SARS-CoV and MERS-CoV can produce double-membrane vesicles that don’t contain PAMPs and begin replication in these vesicles, by this means it avoids the host detection of their dsRNA (de Wilde et al. 2017).

**Symptoms and Risk factors of COVID-19**

The most common symptoms in patients with COVID-19 were fever, cough, and dyspnea. By contrast, upper respiratory tract symptoms were less common in these patients, indicating that the cells targeted by the virus might be in the lower airway. Other non-specific symptoms included dizziness, diarrhea, vomiting, headache, and generalized weakness, which occurred in around 2–9% of patients. Notably, abnormal lung findings on CT scans can help in the diagnosis of asymptomatic infected patients, (Shi et al. 2020) suggested that chest CT scans or serum antibody tests should be done in asymptomatic high-risk individuals with a history of exposure to patients with COVID-19 to facilitate early identification of the disease.

The results of the study have been done by (Chen et al.2020) on 9 pregnant women with confirmed COVID-19 infection showed that the clinical features were similar with that reported in non-pregnant women, none of them
developed severe pneumonia or died of COVID-19 pneumonia and no evidence of vertical transmission of COVID-19 infection (Karimi-Zarchi et al. 2020).

Children are not far away from COVID-19; it spreads rapidly in children, so it suggests that it has a strong transmission capacity in the special population (neonate, children). The potential risk of transmission maybe because of the delayed clearance of viral RNA unaffected by the severity of symptoms. An observational cohort study in China was conducted on 36 confirmed COVID-19 children and found that 28% were asymptomatic, 19% with upper respiratory symptoms and 53% had moderate symptoms and mild pneumonia. The clinical features of COVID-19 infection were found to be milder in children than adults (Qiu et al. 2020).

Blood levels of d-dimer and Sequential Organ Failure Assessment (SOFA) scores were higher in critically ill or fatal cases, whereas lymphopenia and cardiovascular disease have been less commonly observed in non-critical or surviving patients with COVID-19 infection. Other risk factors, including older age and high fever were associated with a greater risk of development of ARDS and death (Wu et al. 2020). Zhou et al. (2020) found that around half of confirmed patients had comorbidity, 30% of them with hypertension, 19% diabetics and the rest with coronary heart disease.

**Transmission and incubation period of COVID-19**

COVID-19 spreads via direct contact routes, droplets or by touching any surface carrying the droplet then touch your face, eyes, nose, mouth or ear (Singhal 2020). In general, coronavirus can persist on inanimate objects and surfaces like metal, glass or plastic for up to 9 days, at room temperature according on the material of the surface and its concentration can reach about 100 million viral particles per ml in sputum (Cleri et al. 2010).

Ong et al. (2020) reported that COVID-19 is not an airborne transmission disease in an investigation for 75,465 Chinese patients suffering from COVID-19 infection. In hospitals, SARS-CoV-2 might be aerosol transmitted up to 4 meters (13 feet) in both ICU and general wards which considered a high infection risk for medical staff and other close contacts (Guo et al. 2020).

The environment can affect the human-to-human transmission of SARS-CoV-2, where unsuitable climates other than average temperatures of 5-11°C, and absolute humidity (4-7 g/m3) can reduce the stability of the virus and reduce its transmission (Sajadi et al. 2020). It is still unclear if SARS-CoV-2 will be able to spread in all seasons as MERS or unable to sustain itself with high temperature and disappear, just as SARS-CoV did so in 2003.

WHO (2020) has stated that the incubation period of COVID-19 between 2 days to 2 weeks. Although several studies confirm a 14-day medical incubation period for patients exposed to the virus, there is some literature supposes that the incubation period of this virus can be extended more than two weeks and it is reflected double exposure of infection (Wu et al. 2020). The time from the start of symptoms of COVID-19 to death estimated to ranges from 1 week to 6 weeks with an average time estimated to be 2 weeks (Wu et al. 2020). This time is dependent on various factors includes the status of the patient’s immune system and age.

**Diagnosis of COVID-19**

COVID-19 diagnosis is mostly depending on clinical manifestations, epidemiological history, and some secondary examinations, such as CT scan, nucleic acid detection, immune identification technology Point-of-care Testing (POCT) of IgM/IgG, blood culture and enzyme-linked immunosorbent assay (ELISA). However, the clinical symptoms and signs of the infected patients with COVID-19 alone are highly atypical and cannot be used alone, so, secondary examinations and epidemiological history are essential for the diagnosis of COVID-19 (Cederroth and Nef 2009). Here we will discuss the three most important detection methods as following:

**Nucleic acid detection technology**

The two commonly used nucleic acid detection technologies for COVID-19 are high-throughput sequencing and real-time quantitative polymerase chain reaction (RT-qPCR). The sequencing method is of limited use in clinical diagnosis, due to its high cost and equipment dependency (Zhou et al. 2020). Therefore, RT-qPCR is the most effective, common and straightforward way for identifying pathogenic viruses in blood and respiratory secretions. The Chinese Center for Disease Control and Prevention (China CDC) recommends the use of specific primers and probes in the N gene and ORF1ab regions for the detection of COVID-19 by RT-qPCR and is confirmed positive patient when both targets are positive.

**CT scans and other diagnostic methods**

Although RT-qPCR for the diagnosis of COVID-19 is specific, its false-negative percentage cannot be mistreated due to the serious consequences of missed diagnosis. CT scan, proposed by many clinicians, should be a necessary secondary diagnostic method (Xie et al. 2020). For persons with a high clinical suspicion of COVID-19 infection with negative RT-qPCR screening, a
combination of repeated RT-qPCR tests and the beginning of a chest CT scan may be useful. CT images typically show bilateral pulmonary parenchymal ground-glass and consolidative pulmonary opacities, sometimes with a peripheral lung distribution and a rounded morphology, these findings also were observed in patients with MERS-CoV and SARS-CoV (Ajlan et al. 2014; Ooi et al. 2004).

**Serology assays**

The demand to discover serology testing for SARS-CoV-2 is increased for better detection and surveillance of cases of COVID-19, including those that may be asymptomatic or have recovered. On the 1st of April 2020, The Food and Drug Administration (FDA) has authorized one Emergency Use Authorization (EUA) for a serological test to be used in clinical laboratories (Table 2). To date, over 70 serological tests are available and ready to be used (Stephen 2020). Immunoassays are less accurate than PCR, but they are easier to use and rapid as it delivers results in 20–60 minutes (Sheridan 2020).

**Treatment and vaccination**

In general, there are no confirmed specific antiviral drugs or effective vaccines for SARS-CoV-2 or any other human CoV infection to date. All the drug options come from experience treating SARS, MERS, or some other new influenza virus.

Active symptomatic support remains key to treatment (Cascella et al. 2020). Among all the studies conducted and the clinical trials for numerous candidate drugs, this study will show the drugs with a positive and promising impact so far. Chloroquine a known drug for the treatment of malaria and autoimmune disease (Guo et al. 2020). It was also found to possess antiviral activity against RNA viruses like HIV (Boelaert et al. 2001), hepatitis C virus (Mizui et al. 2010) and influenza A H5N1 virus (Yan et al. 2013). Chloroquine also found to be used for the prevention and therapeutic of SARS-CoV and SARS-CoV-2 infections by elevation of endosomal pH required for virus/cell fusion, as well as interfering with the glycosylation of host receptors (ACE-2) of SARS-CoV (Vincent et al. 2005; Wang et al. 2020).

The Hydroxychloroquine was preferred than chloroquine for the treatment of SARS-CoV-2 infection for these reasons; (i) hydroxychloroquine is likely to attenuate the severe progression of COVID-19 through inhibiting the cytokine storm by reducing CD154 expression in T cells; (ii) hydroxychloroquine may confer a similar antiviral effect at both pre- and post-infection stages, as found with chloroquine; (iii) hydroxychloroquine has fewer side effects, safe in pregnancy and cheaper (Zhou et al. 2020).

Elifky (2020) found that sofosbuvir, ribavirin, and remdesivir showed promising results against the SARS-CoV-2 after in-silico testing. The FDA approved anti-parasitic drug ivermectin, showed broad-spectrum *in-vitro* anti-viral activity and ability to reduce SARS-CoV-2 titer by 5000-fold at 48 hours (Caly et al. 2020).

Lim et al. (2020) found that Kaletra (lopinavir/ ritonavir) showed improved clinical symptoms during the treatment with a reduction in the viral load, and they recommended their use with relatively high-risk groups of COVID-19 pneumonia. On the other hand, Cao et al. (2020) observed that in hospitalized patients with severe COVID-19, there were no benefits on viral load or mortality rate with lopinavir/ ritonavir compared to standard treatment. For children with confirmed COVID-19, lopinavir-ritonavir is of choice for treatment in combination with a low dosage of nebulized IFN-α, or ribavirin (Wang and Zhu 2020).

Favipiravir is another antiviral drug that has been approved in Japan in 2014 for the treatment of pandemic influenza virus and other RNA viral infections (Delang et al. 2018). A preprint randomized clinical trial found that in moderate COVID-19 patients, favipiravir can be considered as a safer and preferred treatment compared to arbidol (antivirus used in the treatment of influenza) because of superior clinical recovery rate and more effectively reduced incidence of fever, cough (Chen et al. 2020).

As recently being investigated, therapeutic plasma exchange (TPE) has made a huge impact as an alternative treatment for seriously ill COVID-19 patients.

Convalescent plasma also called passive antibody therapy, is a type of passive immunity that can provide antibodies from the host which is COVID-19 patient to another host, but the proteins will only last for a short period of time like weeks or maybe a few months. Keith et al. (2020) have been mentioned in their trial the mortality rate of 80 seriously ill patients on the ventilator had decreased from being 81% to 47.3% which proves the impact of TPE. Recently the FDA has approved the TPE to be regulated as an investigational product that can be tested clinically or due to the vicious pandemic which can be tested against patients with serious or immediately life-threatening Covid-19 (FDA, 2020). The Ministry of Health in Egypt also apply TPE therapy from recovered patients and described oseltamivir, hydroxychloroquine, chloroquine or lopinavir/ritonavir for mild and severe ICU care.

Vaccination development activities of COVID-19 are distributed over 19 countries including 46% of developers in North America, China, others in Asia and Europe.
However, there is no information about any developers in Africa and Latin America. As shown in figure (5), these pipelines categorized into exploratory early planning without in-vivo testing (confirmed and unconfirmed), and preclinical in the in-vivo stage and/or phase I manufacturing clinical trials (Le et al. 2020).

Fig 5. COVID-19 vaccination candidates in pipelines by technology platform. (Le et al., 2020).

**Prevention and control**

Social distancing is one of the most important decisions taken by policy makers as school closure which alone would prevent only 2-4% of COVID-19 deaths (Viner et al. 2020). Other prevention parameters include washing hands, wearing masks and sanitizing surfaces contribute to decreasing the outbreak of virus. Coronaviruses can be significantly inhibited and inactivated by disinfecting the surfaces using 62-71% ethanol, 0.1% sodium hypochlorite or 0.5% hydrogen peroxide for 1 min. Personal quarantine, travel restrictions, besides staying home if person is sick, except to get medical care is success trials for controlling outbreak of COVID-19. Boosting the immunity is very important in fighting the pathogens through different nutrients such as; edible mushrooms, wheat germ, yogurt, tea, sweet potato, broccoli and garlic. All these food contain different supplementary materials such as; selenium, vitamins, antioxidants, probiotics, omega-3, zinc and iron (Zhang and Liu, 2020).

**Conclusion and future prospective**

The COVID-19 disease induces clusters of lethal pneumonia with serious clinical features similar to SARS-CoV. In the lack of vaccines and deficiency of antivirals, it is necessary to monitor the spread of COVID-19 using many aspects. First, empathize the susceptibility of these viruses to transmit between different species, to recognize the viral infection in new hosts as well as the detection of coronaviruses reservoirs will effectively help to predict where and when potential infection may happen. Second, several of the non-structural proteins encoded by coronaviruses genomes still uncharacterized till now with unknown functions and unidentified biological roles, and it will be interest to explore the molecular mechanisms of these proteins as well as identifying their role in pathogenesis and viral replication. Third, in addition to discovering new antivirals and clinical investigation of old drugs, developing and design, new vaccines for COVID-19 is also required. Fourth, getting a comprehensive knowledge of particulars of some viral replication enzymes such as replicase transcriptase will aid on empathizing the unique process of RNA replication used by coronaviruses, leading to develop a new inhibitors or competitors for these enzymes. Fifth, developing new vaccines target S protein or the spike protein owing to its role in the stimulation of protective immunity through infection with COVID-19 by inducing T-cell responses and neutralizing-antibodies. As a summary in order to know more and discover the hidden secrets beyond the COVID-19 we should study carefully different parameters and they are summarized in graphical abstract. Finally, exploring the mechanism of how COVID-19 caused and improving the immunity of patients and contacted persons will be potentially improve their health and reduce the morbidity and mortality rates.

**Conflict of interest**

The authors have no conflicts of interest to declare. All co-authors have seen and agree with the contents of the manuscript.
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