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Perspective

Tropical Effects on Lassa Fever and its Impact on Rural Areas

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DESCRIPTION

Lassa Fever (LF) is an acute viral hemorrhagic disease caused by the Lassa virus and is endemic to parts of West Africa such as Nigeria, Sierra Leone, Guinea and Liberia. Infection to humans is usually due to contact with feces of infected rodents (mainly mastomirats), ingestion or handling of contaminated food or household items (mainly women and children), or infected persons (usually). It is caused by direct contact with the body fluids of the employee).

Lassa fever has symptoms and signs that are indistinguishable from febrile illnesses such as malaria and other viral hemorrhagic fever such as Ebola hemorrhagic fever. Although difficult to diagnose clinically, it should be suspected in patients with fever (above 38°C) who have an inadequate response to antimalarial drugs and antibiotics. The most useful clinical predictors of Lassa fever are fever, sore throat, posterior sternal pain, and proteinuria for diagnosis. Fever, sore throat, vomiting occur.

No regulatory-approved drug has been approved to treat LF. Ribavirin is currently used in combination with supportive care as the first-line treatment for LF and is included in national and international treatment guidelines. Ribavirin is on the World Health Organization (WHO) list of essential medicines for the treatment of viral hemorrhagic fever. However, the evidence base for this recommended treatment is low because only one clinical trial was conducted to evaluate its efficacy. More evidence in the form of clinical trials is needed to confirm the efficacy and safety of ribavirin and to test new therapies.

Most cases of LF are asymptomatic and mild (asymptomatic or self-restrictive), but severe illnesses include facial edema, bleeding, hypotension, acute nephropathy, severe anemia, confusion, coma, and in some cases. It is associated with a wide range of histological orientations characterized by asymptomatic death, which occurs 14 to 20 days after the onset of symptoms, the main route of transmission of this disease is human contact with contaminated urine and infected rodent feces, especially Mastomys natalensis (multi-breasted mice born at birth). Secondary infections with LF usually occur in a hospital environment through human contact with body fluids from an infected individual. This has serious implications for Health Care Workers (HCWs) who lack knowledge of infection prevention and management practices.

Humans are usually infected with the Lassa virus by being exposed to the urine and feces of infected mastomirats. The Lassa virus can also spread among people through direct contact with the blood, urine, feces, or other excrement of people infected with Lassa fever. There is no epidemiological evidence of airborne transmission between humans. Human-to-human transmission occurs in both communities and medical settings, and the virus spreads through contaminated medical devices, sexually transmitted diseases of Lassa virus have been reported.

Lassa fever occurs in all age groups and genders. The most endangered are those who live in rural areas where mastomys are common, especially in poorly sanitized areas and in cramped living environments. Inadequate barrier care and infection prevention and management practices put healthcare professionals at risk when caring for patients with Lassa fever.

Despite the growing number of research outputs on LF, the limited number of cases and the challenges of mounting clinical trials in LF-endemic regions highlight the need for efficient approaches to research. The results of this review have been leveraged to inform the development of standardized clinical trial methodologies with efficient and pragmatic design to address the research priorities above. A consultation group has been established to develop-through a consensus approach-clinical trial eligibility criteria, case definition, core data collection variables and outcomes.

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