Introduction
A new type of coronavirus (SARS-CoV-2), which was identified by Chinese facilities as the causative organism using deep sequencing analysis of patients’ respiratory tract samples and named “coronavirus disease 2019” (COVID-19) (1), was introduced to the world in late December 2019 (2–4). Clinical presentations of confirmed patients with COVID-19 are fever, dry cough, and dyspnea, which are similar to any lower respiratory tract illness (1, 3).

SARS-CoV-2 strongly adheres to the human respiratory epithelial cell through the interaction between viral S protein (1) and angiotensin-converting-enzyme-2-receptor (1, 4, 5). Thus, SARS-CoV-2 leads to pneumonia and aggravates the disease with no reliable and specific treatment (2, 3, 5–7). The prevalence of acute respiratory distress syndrome (ARDS) among COVID-19 patients has been reported to be up to 17% (3). There are no pathognomonic changes in radiologic images in COVID-19 pneumonia (1, 6).

Treatment options, as known so far, for seriously ill patients are low-dose systematic corticosteroids, antiviral and/ or antimarial drugs, some herbal treatments (2, 4, 6, 7), convalescent plasma therapy (4, 7, 8), extracorporeal membrane oxygenation (ECMO) (4, 9) and prone positioning (3, 4).

Here, we report patient with a severe COVID-19 pneumonia who was successfully managed with prone positioning and convalescent plasma therapy.

Case Report
The written informed consent from the patient was obtained. On 27th March 2020, a 56-year-old-woman presented to the emergency department with a cough, weakness, and fever. She had no comorbidities except well-controlled diabetes. The chest CT of the patient on 27 March showed “ground-glass opacities,” especially in the posterior sites of both lungs (Fig. 1), consistent with a viral infection and RT-PCR amplification by a nasopharyngeal swab for SARS-CoV-2 was positive. Then, the patient was transferred to the specialized pandemic ward of the hospital. The initial physical examination was normal except bilateral pulmonary rales and roncus by chest auscultation with a high body temperature of 38.8°C measured by forehead thermometer. Her hemodynamic parameters were stable at the admission. The laboratory results of the patient were also in the normal range (Table 1).

Hydroxychloroquine (first day: 2*400 mg/day and on consecutive days: 2*200 mg/day), oseltamivir (2*75
mg/day), piperacillin/tazobactam IV (3×4.5 g/day) and moxifloxacin (1×400 mg/day) were applied to the patient as an initial treatment according to the guidelines of Turkish Ministry of Health (10).

Her vital signs remained stable for the first seven days apart from mild dyspnea and oxygen saturation (SPO₂) levels of 88% and 95%, on room air and under O₂ therapy with a face mask 5 L/min, respectively. On April 3rd, due to the deterioration of the patient’s oxygenation, a control chest CT scan was performed, and it revealed progression with widespread patched infiltration areas in both lungs, especially in upper lobes. The involvement rate of the lung was reported as between 25% and 50% (Fig. 2). Then the patient was transferred to the Intensive Care Unit (ICU) for further treatment. After admission to ICU, the patient was treated using non-invasive mechanic ventilation (NIMV), hydroxychloroquine (2×200 mg/day), favipiravir (First day: 2×1600 mg/day and on consecutive days: 2×600 mg/day) and the specific antibiotherapy according to culture-antibiogram results. Her all vital signs remained stable for the first four days in ICU, except worsening dyspnea and tachypnea (30 breath/min). On the 5th day in ICU, she was intubated and positioned to a standard “prone position” to provide better oxygenation. It was continued alternately with the prone position for 16 hours and the supine position for eight hours a day for three days. She was treated with three sessions of convalescent plasma therapy in sequential days due to the national guide of the Turkish Ministry of Health (8). Seven days after intubation, the patient was extubated, and then on the 27th day of the ICU admission; she was discharged back to the ward from ICU.

**DISCUSSION**

The most symptoms in patients with COVID19 pneumonia are fever, cough and dyspnea (1, 3, 6). Dizziness, diarrhea, vomiting, headache, generalized weakness (1, 6), myalgia and sore throat are other nonspecific symptoms of it (6). Shi et al. (1) reported that predisposing conditions for COVID19 pneumonia are older age and chronic comorbidities, such as chronic pulmonary diseases, diabetes mellitus and hypertension. The imaging characteristics are nonspecific in COVID19 pneumonia. Most images of these patients showed bilateral lung involvement where lesions mainly located peripherally and subpleurally with the diffuse distribution. The
CONCLUSION

COVID-19 still has no specific treatment. Urgent development of successful treatment modalities is necessary. However, until an effective treatment is found, the application of the existing alternative treatment methods and sharing the results may guide and help studies.

Informed Consent: Written informed consent was obtained from patient who participated this case report.

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