

Original Article**Analysis of factors associated with disease outcomes in hospitalized patients with 2019 novel coronavirus disease****Wei Liu¹, Zhao-Wu Tao², Lei Wang¹, Ming-Li Yuan¹, Kui Liu³, Ling Zhou³, Shuang Wei³, Yan Deng³, Jing Liu⁴, Hui-Guo Liu³, Ming Yang⁵, Yi Hu¹**

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Conflicts of interest

None.

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Abstract

Background: Since early December 2019, the 2019 novel coronavirus disease (COVID-19) has caused pneumonia epidemic in Wuhan, Hubei province of China. This study aims to investigate the factors affecting the progression of pneumonia in COVID-19 patients. Associated results will be used to evaluate the prognosis and to find the optimal treatment regimens for COVID-19 pneumonia.

Methods: Patients tested positive for the COVID-19 based on nucleic acid detection were included in this study. Patients were admitted to three tertiary hospitals in Wuhan between December 30, 2019, and January 15, 2020. Individual data, laboratory indices, imaging characteristics, and clinical data were collected, and statistical analysis was performed. Based on clinical typing results, the patients were divided into a progression group or an improvement/stabilization group. Continuous variables were analyzed using independent samples *t*-test or Mann-Whitney *U* test. Categorical variables were analyzed using chi-squared test or Fisher's exact test. Logistic regression analysis was performed to explore the risk factors for disease progression.

Results: Seventy-eight patients with COVID-19-induced pneumonia met the inclusion criteria and were included in this study. Efficacy evaluation at 2 weeks after hospitalization indicated that 11 patients (14.1%) had deteriorated, and 67 patients (85.9%) had improved/stabilized. The patients in the progression group were significantly older than those in the disease improvement/stabilization group (66 [51, 70] years *vs.* 37 [32, 41] years, $U=4.932$, $P=0.001$). The progression group had a significantly higher proportion of patients with a history of smoking than the improvement/stabilization group (27.3% *vs.* 3.0%, $\chi^2=9.291$, $P=0.018$). For all the 78 patients, fever was the most common initial symptom, and the maximum body temperature at admission was significantly higher in the progression group than in the improvement/stabilization group (38.2 [37.8, 38.6]°C *vs.* 37.5 [37.0, 38.4]°C, $U=2.057$, $P=0.027$). Moreover, the proportion of patients with respiratory failure (54.5% *vs.* 20.9%, $\chi^2=5.611$, $P=0.028$) and respiratory rate (34 [18, 48] breaths/min *vs.* 24 [16, 60] breaths/min, $U=4.030$, $P=0.004$) were significantly higher in the progression group than in the improvement/stabilization group. C-reactive protein was significantly elevated in the progression group compared to the improvement/stabilization group (38.9 [14.3, 64.8] mg/L *vs.* 10.6 [1.9, 33.1] mg/L, $U=1.315$, $P=0.024$). Albumin was significantly lower in the progression group than in the improvement/stabilization group (36.62±6.60 g/L *vs.* 41.27±4.55 g/L, $U=2.843$, $P=0.006$). Patients in the progression group were more likely to

receive high-level respiratory support than in the improvement/stabilization group ($\chi^2=16.01$, $P=0.001$). Multivariate logistic analysis indicated that age (OR, 8.546; 95% CI: 1.628–44.864; $P = 0.011$), history of smoking (OR, 14.285; 95% CI: 1.577–25.000; $P = 0.018$), maximum body temperature at admission (OR, 8.999; 95% CI: 1.036–78.147, $P = 0.046$), respiratory failure (OR, 8.772, 95% CI: 1.942–40.000; $P = 0.016$), albumin (OR, 7.353, 95% CI: 1.098–50.000; $P = 0.003$) and C-reactive protein (OR, 10.530; 95% CI: 1.224–34.701, $P = 0.028$) were risk factors for disease progression.

Conclusions: Several factors that led to the progression of COVID-19 pneumonia were identified, including age, history of smoking, maximum body temperature on admission, respiratory failure, albumin, C-reactive protein. These results can be used to further enhance the ability of management of COVID-19 pneumonia.

Keywords: 2019 novel coronavirus disease (COVID-19); Disease outcome; Predictors

Introduction

Since December 2019, unexplained pneumonia has been successively identified in several patients with a history of exposure to the Huanan seafood market, in multiple hospitals in the city of Wuhan, Hubei Province, China. These patients have now been confirmed as acute respiratory infection (i.e., pneumonia) caused by a novel coronavirus.^[1,2] Clinical investigation of confirmed cases and cases under observation has shown that the number of patients with no history of exposure to the Huanan Seafood Market has been rapidly increasing. As of February 1, 2020, there were 14,380 confirmed cases of 2019 novel coronavirus disease (COVID-19) in China.^[3]

A previous study found that highest temperature, dyspnea, respiratory rate, white blood cell count, neutrophil count, lymphocyte count, D-dimer, albumin, procalcitonin were risk factors for ICU care in patients with COVID-19.^[4] Therefore, it is absolutely necessary to evaluate the possible factors affecting the progression of disease in COVID-19 patients. We investigated factors affecting the outcomes of COVID-19 patients to evaluate the prognosis and further improve the treatment of patients with COVID-19 associated pneumonia with the hope of reducing mortality.

Methods

Ethical approval

This study was conducted in accordance with the *Declaration of Helsinki*. The requirement for written informed consent was waived given the context of emerging infectious diseases.

Subjects

Patients included in the study had been diagnosed with COVID-19 associated pneumonia between December 30, 2019, and January 15, 2020, and hospitalized at one of three tertiary hospitals in Wuhan for over two weeks. Specific inclusion criteria were: (1) patients with confirmed diagnosis from a positive test result for COVID-19 nucleic acids by real-time fluorescence reverse transcription-polymerase chain reaction (RT-PCR) according to the "Diagnosis and Treatment Protocol for Novel Coronavirus Infection-Induced Pneumonia version 4 (trial)"^[5]; (2) patients who had been hospitalized for over two weeks when preparing the manuscript, died while hospitalized, or had recovered and been discharged.

Evaluation of conditions

All patients were evaluated and clinically typed upon admission, according to the "Diagnosis and Treatment Protocol for Novel Coronavirus Infection-Induced Pneumonia version 4 (trial)".^[5] Specific clinical types included: (1) common: fever, respiratory tract infection symptoms, and so on, with imaging indicating pneumonia; (2) severe (any of the following conditions): I, respiratory distress, respiratory rate (RR) ≥ 30 breaths/min; II, oxygen saturation $\leq 93\%$ at rest; III, partial pressure of oxygen (PaO₂)/fraction of inspired oxygen (FiO₂) ≤ 300 mmHg (1 mmHg = 0.133 kPa); (3) critical (any of the following conditions): I, respiratory failure and a requirement for mechanical ventilation; II, shock; III, concomitant failure of other organs and requirement for intensive care unit (ICU) monitoring and treatment.

In addition to clinical typing, laboratory indices of all patients were measured, the details of which are listed in the biochemical test section.

After two weeks of hospitalization, disease evaluation and clinical typing were performed on all patients according to the "Diagnosis and Treatment Protocol for Novel Coronavirus Infection-Induced Pneumonia version 4 (trial)".^[5] All patients were divided into a progression group or an improvement/stabilization group based on clinical typing results. Specific criteria were as follows: (1) progression group: common-type changed to severe- or critical-type, or death; severe-type changed to critical-type or death; critical-type progressed to death. (2) improvement/stabilization group: common-, severe-, and critical-types remained unchanged; severe-type changed to common-type; critical-type changed to severe- or common-type.

Specimen collection, etiology, and biochemical tests

COVID-19 was detected by real-time fluorescence RT-PCR of samples collected by using nasopharyngeal swabs. Influenza A virus, influenza B virus, respiratory syncytial virus, adenovirus, parainfluenza virus, chlamydia, and mycoplasma were detected by collecting

body fluid (nasopharyngeal swabs and sputum) samples. Relevant laboratory indicators were tested with conventional methods, including routine blood tests (white blood cell [WBC], lymphocytes, neutrophils, platelets), liver and kidney function (alanine transaminase [ALT], aspartate aminotransferase [AST], creatinine and albumin), infection indices (procalcitonin and C-reactive protein), D-dimer, and partial pressure of oxygen.

Data collection

The personal data and clinical data of patients included in the study were collected. Personal data included sex, age, epidemiological history, history of smoking, and comorbidities [e.g., chronic obstructive pulmonary disease (COPD), cancer, hypertension and/or diabetes]. Clinical data included initial symptoms, clinical presentation, vital signs, therapeutic drug-use, respiratory support, and disease outcomes.

Statistical analysis

Categorical variables were presented as numbers (percentages) and analyzed using chi-squared test or Fisher's exact test. Continuous variables with normal distribution were expressed as mean±standard deviation and analyzed using independent samples *t*-test, while those with skewed distribution were shown as median (Q₁, Q₃) and analyzed using Mann-Whitney *U* test. Univariate and multivariate logistic regression analysis were adopted to identify risk factors of disease progression. All variables from the univariate analysis with a *P* value <0.1 were entered into a forward-stepwise multivariate logistic regression analysis. SPSS software version 25.0 (SPSS Inc., Chicago, Illinois, USA) was used for statistical analysis. A two-sided *P* < 0.05 was considered statistically significant.

Results

General characteristics and clinical presentations

In the present study, 78 patients with COVID-19 associated pneumonia included 39 males and 39 females. No patient had a history of exposure to the Huanan Seafood Market. The median age (Q₁, Q₃) was 38 (33, 57) years, and only 15 patients were aged ≥60 years (19.2%). Among the 78 patients, there were 70 patients with the common-type (89.7%) and 8 patients with the severe-type (10.3%). Re-examination after two weeks of hospitalization showed that among the 70 patients with the common-type symptoms, there were 8 patients with progression and 62 patients with improvement/stabilization. Among the 8 patients with the severe-type symptoms, 3 patients showed progression (including 2 deaths) and 5 showed improvement/stabilization. A total of 11 patients (14.1%) were included in the progression group, and 67 patients (85.9%) were included in the improvement/stabilization group.

The patients in the progression group were significantly older than those in the improvement/stabilization group (66 [51, 70] vs. 37 [32, 41], $U=4.932$, $P=0.001$). This study suggested that the progression group had a significantly higher proportion of patients with a history of smoking than the improvement/stabilization group (27.3% vs. 3.0%, $\chi^2=9.291$, $P=0.018$). Twenty patients (25.6%) had comorbidities, of which hypertension was the most common. There was no significant difference in sex between the two groups ($P > 0.05$). There was no significant difference in any comorbidity including hypertension, diabetes, chronic obstructive pulmonary disease (COPD), cancer, and others between the two groups (all $P > 0.05$). Fever was the primary initial symptom. Fifty-seven patients (73.1%) sought treatment for fever, and 37.3°C–38.0°C was the most commonly observed maximum body temperature in 31 patients (39.7%). The maximum body temperature at admission was significantly higher in the progression group than in the improvement/stabilization group (38.2 [37.8, 38.6]°C vs. 37.5 [37.0, 38.4]°C, $U=2.057$, $P=0.027$). A total of 20 of the 78 patients (25.6%) developed respiratory failure, with the proportion of respiratory failure being significantly higher in the progression group than in the improvement/stabilization group (54.5% vs. 20.9%, $\chi^2=5.611$, $P=0.028$). The median respiratory rate of the 78 patients with COVID-19 was 24 breaths/min, and the respiratory rate in the progression group was significantly higher than in the improvement/stabilization group (34 [18, 48] breaths/min vs. 24 [16, 60] breaths/min, $U=4.030$, $P=0.004$). There were no significant differences in blood oxygen saturation, or heart rate between the two groups (both $P > 0.05$). Eight (10.3%) of the 78 patients with COVID-19 were severely ill, and the proportions of severely ill patients were not significantly different between the two groups (27.3% vs. 7.5%, $\chi^2=13.480$, $P > 0.05$) [Table 1].

Laboratory indices and imaging characteristics

In this study, relevant laboratory indices of the 78 patients with COVID-19 were determined at the time of admission. These results showed that C-reactive protein was significantly elevated in the progression group compared to the improvement/stabilization group (38.9 [14.3, 64.8] mg/L vs. 10.6 [1.9, 33.1] mg/L, $U=1.315$, $P=0.024$). Albumin was significantly decreased in the progression group compared to the improvement/stabilization group (36.62±6.60 g/L vs. 41.27±4.55 g/L, $U=2.843$, $P=0.006$). There were no significant differences in D-dimer, WBC, lymphocytes, neutrophils, platelets, ALT, AST, creatinine,

erythrocyte sedimentation rate, procalcitonin, partial pressure of oxygen, and extent and characteristics of lesions on CT scan between the two groups (all $P > 0.05$) [Table 2]. No patients had other concomitant microbial infection.

Treatment

Among the 78 hospitalized patients, the most common treatment was a combination of antivirals/antibacterials with glucocorticoids (45/78, 57.7%). The most commonly used antiviral drug was ribavirin, and the most commonly used antibacterial drugs were cephalosporins or quinolone antibiotics. The median glucocorticoids dose was 40 (20, 40) mg intravenously (iv) every day (qd) and there was no significant difference between the two groups (60 [40, 80] mg qd iv vs. 40 [20, 40] mg qd iv, $U=4.713$, $P=0.075$). The proportions of patients using different drug protocols including antivirals/antibacterials, antivirals/antibacterials + glucocorticoids, antivirals/antibacterials + gamma globulin, antivirals/antibacterial + thymosins, and antivirals/antibacterials + lopinavir between improvement/stabilization group and progression group were not significantly different ($P>0.05$). All hospitalized patients had some degree of hypoxia. Nasal cannula was the most common form of respiratory support (71/78, 91.0%), followed by continuous noninvasive positive pressure ventilation. The progression group typically had more severe hypoxia and was significantly more likely to receive higher levels of respiratory support compared to the improvement/stabilization group ($\chi^2=16.01$, $P=0.001$) [Table 3].

Risk factors for disease progression in COVID-19 patients

The results of univariate logistic analysis found that age (odds ratio [OR], 10.575; 95% confidence interval [CI]: 2.095–53.386; $P=0.004$), history of smoking (OR, 12.187; 95% CI: 1.762–84.306; $P=0.011$), maximum body temperature at admission (OR, 9.709; 95% CI: 1.176–83.330; $P=0.035$), respiratory failure (OR, 8.021; 95% CI: 2.022–31.821; $P=0.003$), severe illness (OR, 4.651; 95% CI: 0.930–23.250; $P=0.061$), albumin (OR, 12.536; 95% CI: 2.409–65.233; $P=0.003$), creatinine (OR, 6.800; 95% CI: 1.424–32.470; $P=0.016$), procalcitonin (OR, 3.831; 95% CI: 0.551–27.027; $P=0.071$), C-reactive protein (OR, 5.988; 95% CI: 1.179–30.30; $P=0.031$) were significantly associated with the disease progression. Furthermore, the multivariate logistic analysis indicated that age (OR, 8.546; 95% CI: 1.628–44.864; $P=0.011$), history of smoking (OR, 14.285; 95% CI: 1.577–25.000; $P=0.018$), maximum body temperature at admission (OR, 8.999; 95% CI: 1.036–78.147, $P=0.046$), respiratory failure (OR, 8.772, 95% CI: 1.942–40.000; $P=0.016$), albumin (OR, 7.353, 95% CI: 1.098–50.000; $P=0.003$) and C-reactive protein (OR, 10.53; 95% CI:

1.224–34.701, $P = 0.028$) were risk factor for disease progression [Table 4].

Discussion

Coronavirus is a highly contagious pathogen found in several domestic animals, pets, and humans, causing a variety of acute and chronic diseases.^[6] Currently, six coronaviruses are known to infect humans, including 229E and NL63 in the α -genus. The β -genus comprises OC43, HKU1, Middle East respiratory syndrome-related coronavirus (MERSr-CoV),^[7] and severe acute respiratory syndrome-related coronavirus (SARSr-CoV).^[8] Coronavirus has gradually become a popular topic of research in the field of virology because of the outbreak of SARSr-CoV in 2003 and MERSr-CoV in 2012.^[9] The current outbreak is due to a novel coronavirus in the β -genus, which was isolated from the lower respiratory tract in patients with unexplained pneumonia, in Wuhan, China.^[10,11] Currently, the source and pathogenesis of the COVID-19 remain unclear, and there are no uniform diagnostic and treatment standards. Unfortunately, in certain patients, the disease progresses rapidly, and respiratory failure can occur within a short time, even leading to death. Therefore, we investigated the disease outcomes and factors affecting the outcomes of patients with COVID-19 pneumonia at three tertiary hospitals in Wuhan to provide a theoretical basis for improving hospitals' efforts to effectively treat patients with COVID-19 pneumonia.

The present study included 78 patients diagnosed with the COVID-19. All patients were evaluated for therapeutic efficacy after at least two weeks of hospitalization. These results indicated progression in 11 patients (14.1%) and improvement/stabilization in 67 patients (85.9%). 80.8% of the patients were younger than 60 years, and the median age of the patients was 38 (33, 57) years, which suggest that middle-aged people are susceptible to COVID-19. Also, the age of patients in the progression group was significantly higher than that in the improvement/stabilization group, and multivariate logistic analysis indicated that higher age was a risk factor for disease progression. Elderly individuals are physically frail and are likely to have several comorbidities, which not only increases the risk of pneumonia^[12] but also affects their prognosis^[13]. The assessment of comorbidities is an essential component in determining the prognosis of several diseases, especially pneumonia.^[14] Probably because of the small sample size, there was no significant difference in any comorbidity including hypertension, diabetes, COPD, cancer, and others between the two groups. The potential impact of comorbidities on the disease outcomes of patients with COVID-19 pneumonia requires further observation and research. The proportion of patients with a history of smoking was significantly higher in the progression group compared to the

improvement/stabilization group, suggesting that smoking is associated with disease progression.

A significant symptom of SARS is a body temperature above 38°C for over two weeks. Additionally, 60% of patients diagnosed with MERS presented with fever.^[15] In the present study, 73.1% of patients with COVID-19 sought treatment for the fever. The results showed that the maximum body temperature at admission in the progression group was significantly higher than in the improvement/stabilization group, and multivariate logistic models indicated that higher temperature was a risk factor for disease progression. Therefore, patients presenting with a high fever, long fever duration, and rapid fever progression should be monitored more closely during clinical diagnosis and treatment in order to avoid complications associated with high fevers, which lead to poor prognosis.

Vital signs are essential indicators for assessing the current symptoms of patients. Respiratory system indices, such as respiratory rate and whether respiratory failure occurred, are particularly crucial for assessing the condition severity in patients with COVID-19. The present study found that the median respiratory rate of 78 patients with COVID-19 pneumonia was 24 breaths/min, which was higher than the normal respiratory rate (12-20 breaths/min). The respiratory rate and proportion of patients with respiratory failure in the progression group were significantly higher than in the improvement/stabilization group. Abnormal respiratory indices can directly reflect the extent of lung invasion and multivariate logistic models revealed that respiratory failure was a risk factor for disease progression. Therefore, respiratory indices should be one of the top priorities in the efficacy evaluation.

The present study suggests that elevated C-reactive protein, and decreased albumin are factors associated with poor prognosis of COVID-19 infection. Albumin is the most intuitive index of the nutritional status of the body. When albumin decreases, the body loses resistance to the virus, leading to disease progression.^[16] Elevated C-reactive protein is an important inflammatory index in addition to abnormal blood coagulation function. Close monitoring of dynamic changes in these indices has a significant proactive effect on understanding changes in the patient's condition. In addition, studies have shown that lymphocytes are the main target cells of viral infections.^[17] Viral infections in the human body primarily involve damage to the immune system, which presents as decrease in the absolute number of lymphocytes.^[18] The present study did not find these indices significant for assessing the outcome of COVID-19 patients, and their correlation requires further investigation. This study included CT scan characteristics of patients with COVID-19 pneumonia for analysis and suggested that the extent and characteristics of the lesion had no statistical significance

on disease outcomes. However, the use of CT scans at earlier stages for disease assessment is still of great significance for early detection, early diagnosis, and improved prognosis.

Appropriate antibiotic treatment can be administered to prevent secondary infection in critical type viral pneumonia.^[19] We analyzed the diagnosis and treatment protocols of patients with COVID-19 pneumonia, and results suggested that some patients undergoing antiviral treatment were also proactively undergoing antibacterial treatment. Whether viral pneumonia should be treated with glucocorticoids has been controversial. Some researchers believe that the use of glucocorticoids in viral pneumonia can easily aggravate the disease and increase the risk of secondary infections, leading to an increase in mortality, thus advocating against the use of glucocorticoids.^[20] Other studies have suggested that the use of an appropriate dose of glucocorticoids at early stages could inhibit the elevated secretion of inflammatory cytokines due to excessive activation of immune cells because of the viral infection, thereby preventing continued exacerbation of lung injury.^[21] We found that the combination of antivirals, antibacterials, and glucocorticoids had the highest use rate in the treatment of COVID-19 pneumonia. Moreover, other researchers have suggested using thymosin and gamma globulin during the early stages of infection to improve patient immunity. In addition, current ongoing related studies suggest that COVID-19 and HIV have structural similarities. Thus, certain researchers have proposed that the anti-HIV drug, lopinavir, may play a role in inhibiting COVID-19. In this study, a comparison of efficacy of antivirals/antibacterials, antivirals/antibacterials + glucocorticoids, antivirals/antibacterials + gamma globulin, antivirals/antibacterial + thymosins, and antivirals/antibacterials + lopinavir was performed. The results did not suggest that drug protocols affected disease outcomes. Therefore, further studies should include more drugs for the treatment of COVID-19. COVID-19 pneumonia is characterized by an acute onset and rapid progression. Therefore, the early use of glucocorticoids with proactive antiviral and antibacterial treatment after comprehensive evaluation may block the inflammatory cascade caused by severe viral infections and prevent acute inflammation. The lung damage caused by such infections can further progress to acute respiratory distress syndrome. Respiratory support is an essential treatment for patients with severe viral infections. The present study revealed that all patients with COVID-19 were treated with respiratory support, and the majority of patients were administered nasal cannula oxygen and continuous positive air pressure. The progression group was significantly more likely to receive higher levels of respiratory support. No patients in this study were treated with invasive ventilation and ECMO due to the refusal of the patients' family. Treating patients with severe viral pneumonia, timely application of glucocorticoids and respiratory

support therapy is essential, in combination with personalized treatment specific to each patient.

There were a few limitations for this observational study. CT scan imaging has delayed scanning time, which may introduce bias in our results. In addition, a relatively small sample size was included in this study, which may lead to biased results. Thus, a multi-center large-scale study with additional researchers is required. Currently, the best diagnostic and treatment protocols for COVID-19 are still being investigated. Early diagnosis and dynamic monitoring of prognostic factors are essential for improving the ability to treat the COVID-19.

Conflicts of interest

None.

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Table 1: Demographic data and clinical presentations of COVID-19 patients.

Items	Total (n=78)	Improvement/ stabilization (n=67)	Progression (n=11)	Statistics	P
Age, years	38 (33, 57)	37 (32, 41)	66 (51, 70)	4.932 [*]	0.001
Male	39 (50.0)	32 (47.8)	7 (63.6)	0.953 [†]	0.517
History of smoking	5 (6.4)	2 (3.0)	3 (27.3)	9.291 [†]	0.018
Comorbidity					
Hypertension	8 (40.0)	6 (9.0)	2 (18.2)	0.874 [†]	0.318
Diabetes	5 (25.0)	3 (4.5)	2 (18.2)	2.958 [†]	0.143
COPD	2 (10.0)	1 (1.5)	1 (9.1)	2.184 [†]	0.264
Cancer	4 (20.0)	2 (3.0)	2 (18.2)	4.485 [†]	0.093
Others	10 (50.0)	7 (10.4)	3 (27.3)	2.393 [†]	0.144
History of exposure to Huanan seafood market	0	0	0	-	-
Initial symptom					
Maximum body temperature on admission, °C	37.8 (37.1, 38.2)	37.5 (37.0, 38.4)	38.2 (37.8, 38.6)	2.057 [*]	0.027
Cough	34 (43.6)	30 (44.8)	4 (36.4)	0.272 [†]	0.748
Respiratory failure	20 (25.6)	14 (20.9)	6 (54.5)	5.611 [†]	0.028
Respiratory rate, breaths/min	24 (16, 60)	24 (16, 60)	34 (18, 48)	4.030 [*]	0.004
Blood oxygen saturation, %	96 (50, 99)	96 (50, 99)	95 (89, 98)	0.086 [*]	0.436
Heart rate, beats/min	94 (68, 130)	94 (70, 112)	100 (68, 130)	0.073 [*]	0.737
Severe illness	8 (10.3)	5 (7.5)	3 (27.3)	13.480 [†]	0.079

Data were shown as median (Q₁, Q₃) or n (%). ^{*}U values; [†]χ² values. COVID-19: 2019 novel coronavirus disease; COPD: chronic obstructive pulmonary disease; -: not applicable.

Table 2: Laboratory indices and imaging characteristics of COVID-19 patients.

Items	Total (n=78)	Improvement/stabilization (n=67)	Progression (n=11)	Statistics	P
D-dimer, ng/mL	0.42 (0.20, 1.08)	0.39 (0.20, 1.07)	0.56 (0.21, 6.84)	1.282*	0.501
Albumin, g/L	40.47±5.21	41.27±4.55	36.62±6.60	2.843†	0.006
WBC, ×10 ⁹ /L	5.31±2.63	5.18±1.63	6.08±2.56	1.057†	0.294
Lymphocytes, ×10 ⁹ /L	0.98 (0.61, 1.35)	1.00 (0.68, 1.39)	0.53 (0.30, 1.15)	0.458*	0.075
Neutrophils, ×10 ⁹ /L	3.11 (2.25, 4.82)	2.94 (2.20, 4.60)	4.69 (2.96, 7.06)	1.562*	0.059
Platelets, ×10 ⁹ /L	169.10±57.26	173.20±55.37	143.90±64.81	1.589†	0.116
ALT, U/L	18.1 (13.7, 30.7)	18.5 (12.5, 27.7)	17.4 (13.9, 43.9)	0.301*	0.776
AST, U/L	20.5 (13.8, 33.5)	20.0 (13.9, 30.9)	21.6 (12.0, 45.6)	2.006*	0.788
Creatinine, μmol/L	65.10 (51.20, 80.40)	71.75 (48.78, 114.80)	64.50 (51.45, 78.95)	2.528*	0.385
Erythrocyte sedimentation rate, mm/1 h	31 (17, 43)	31 (11, 40)	30 (22, 52)	0.155*	0.794
Procalcitonin, ng/mL	0.06 (0.04, 0.10)	0.06 (0.04, 0.09)	0.12 (0.05, 0.49)	0.388*	0.195
C-reactive protein, mg/L	11.1 (2.3, 36.0)	10.6 (1.9, 33.1)	38.9 (14.3, 64.8)	1.315*	0.024
Partial pressure of oxygen, %	56 (48, 79)	56 (51, 78)	55 (41, 76)	0.199*	0.666
CT characteristics at initial diagnosis					
Extent				0.786‡	0.782
Unilateral lung involvement	23 (29.5)	20 (29.9)	3 (27.3)		
Bilateral lung involvement	45 (57.7)	38 (56.7)	7 (63.6)		
Lesion characteristics				2.705‡	0.100
Multifocal opacity	44 (56.4)	40 (59.7)	4 (36.4)		
Bilateral lung ground glass opacity	13 (16.7)	10 (14.9)	3 (27.3)		
Other concomitant microbial infection	0	0	0	-	-

Data were shown as mean±standard deviation, median (Q₁, Q₃), or n (%). *U value; †t test; ‡χ² value. COVID-19: 2019 novel coronavirus disease; WBC: white blood cell; ALT: alanine transaminase; AST: aspartate aminotransferase; CT: computed tomography; -: not applicable.

Table 3: Treatment for COVID-19 patients.

Items	Total (n=78)	Improvement/stabilization (n=67)	Progression (n=11)	Statistics	p
Respiratory support				16.01*	0.001
Nasal cannula	71 (91.0)	64 (95.5)	7 (63.6)		
High-flow nasal cannula	2 (2.6)	0	2 (18.2)		
NPPV	5 (6.4)	3 (4.5)	2 (18.2)		
Invasive ventilation	0	0	0		
ECMO	0	0	0		
Treatment protocol				4.267*	0.371
Antiviral/antibacterial	12 (15.4)	10 (14.9)	2 (18.2)		
Antiviral/antibacterial + lopinavir	24 (30.8)	21 (31.3)	3 (27.3)		
Antiviral/antibacterial + gamma globulin	14 (17.9)	9 (13.4)	5 (45.5)		
Antiviral/antibacterial + thymosin	24 (30.8)	21 (31.3)	3 (27.3)		
Antiviral/antibacterial + glucocorticoids	45 (58.0)	38 (56.7)	7 (63.6)		
Glucocorticoids dose, mg qd iv	40 (20, 40)	40 (20, 40)	60 (40, 80)	4.713†	0.075

The data were presented as median (Q₁, Q₃) or n (%). * χ^2 value; † U value. COVID-19: 2019 novel coronavirus disease; NPPV: Noninvasive positive pressure ventilation; ECMO: Extracorporeal membrane oxygenation; qd: every day; iv: intravenously.

Table 4: Logistic analysis results of risk factors for disease progression (n = 78).

Variables	Univariate analysis			Multivariate analysis		
	OR	95% CI	P	OR	95% CI	P
Age (≥ 60 years vs. < 60 years)	10.575	2.095–53.386	0.004	8.546	1.628–44.864	0.011
Sex (male vs. female)	1.914	0.512–7.156	0.335			
History of smoking (yes vs. no)	12.187	1.762–84.306	0.011	14.285	1.577–25.000	0.018
Hypertension (yes vs. no)	2.259	0.394–12.958	0.360			
Diabetes (yes vs. no)	4.741	0.695–32.350	0.112			
Maximum body temperature at admission ($\geq 37.3^{\circ}\text{C}$ vs. $< 37.3^{\circ}\text{C}$)	9.709	1.176–83.330	0.035	8.999	1.036–78.147	0.046
Cough (yes vs. no)	1.063	0.295–3.834	0.925			
Respiratory failure (yes vs. no)	8.021	2.022–31.821	0.003	8.772	1.942–40.000	0.016
Respiratory rate (> 20 breaths/min vs. ≤ 20 breaths/min)	3.952	0.473–33.333	0.204			
Blood oxygen saturation ($\leq 93\%$ vs. $> 93\%$)	2.259	0.394–12.958	0.360			
Heart rate (≥ 100 beats/min vs. < 100 beats/min)	1.536	0.315–7.519	0.596			
Severe illness (yes vs. no)	4.651	0.930–23.250	0.061	2.524	0.339–18.784	0.336
D-dimer (> 1 $\mu\text{g/mL}$ vs. ≤ 1 $\mu\text{g/mL}$)	1.799	0.363–8.928	0.742			
Albumin (< 40 g/L vs. ≥ 40 g/L)	12.536	2.409–65.233	0.003	7.353	1.098–50.000	0.003
WBC ($\geq 4 \times 10^9/\text{L}$ vs. $< 4 \times 10^9/\text{L}$)	1.488	0.163–2.770	0.582			
Lymphocytes ($< 1.1 \times 10^9/\text{L}$ vs. $\geq 1.1 \times 10^9/\text{L}$)	1.600	0.167–2.336	0.485			
Neutrophils ($\geq 1.8 \times 10^9/\text{L}$ vs. $< 1.8 \times 10^9/\text{L}$)	2.037	0.236–17.544	0.518			
Platelets ($< 100 \times 10^9/\text{L}$ vs. $\geq 100 \times 10^9/\text{L}$)	2.259	0.394–12.958	0.360			
ALT (> 50 U/L vs. ≤ 50 U/L)	1.032	0.231–2.148	0.923			
AST (> 40 U/L vs. ≤ 40 U/L)	2.088	0.443–9.901	0.352			
Creatinine (> 111 $\mu\text{mol/L}$ vs. ≤ 111 $\mu\text{mol/L}$)	6.800	1.424–32.470	0.016	0.713	0.021–1.350	0.062
Erythrocyte sedimentation rate (> 15 mm/1 h vs. ≤ 15 mm/1 h)	2.625	0.574–12.048	0.213			
Procalcitonin (≥ 0.5 ng/mL vs. < 0.5 ng/mL)	3.831	0.551–27.027	0.071	0.174	0.012–2.353	0.696
C-reactive protein (> 8.2 mg/L vs. ≤ 8.2 mg/L)	5.988	1.179–30.30	0.031	10.53	1.224–34.701	0.028
Partial pressure of oxygen ($< 60\%$ vs. $\geq 60\%$)	1.742	0.167–3.312	0.535			

OR: Odds Ratio; CI: Confidence interval; WBC: White blood cell; ALT: Alanine transaminase; AST: Aspartate aminotransferase.