

Do chronic respiratory diseases or their treatment affect the risk of SARS-CoV-2 infection?



Coronavirus disease 2019 (COVID-19), caused by the novel severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), is an acute respiratory disease that can lead to respiratory failure and death.¹ Previous epidemics of novel coronavirus diseases, such as severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS), were associated with similar clinical features and outcomes.² One might anticipate that patients with chronic respiratory diseases, particularly chronic obstructive pulmonary disease (COPD) and asthma, would be at increased risk of SARS-CoV-2 infection and more severe presentations of COVID-19. However, it is striking that both diseases appear to be under-represented in the comorbidities reported for patients with COVID-19, compared with the global burden of disease estimates of the prevalence of these conditions in the general population (table); a similar pattern was seen with SARS. By contrast, the prevalence of diabetes in patients with COVID-19 or SARS is as high as or higher than the estimated national prevalence, as might be expected.

The lower reported prevalence of asthma and COPD in patients diagnosed with COVID-19 might be due to one or a number of factors. First, it is possible that, in contrast to the diagnosis of diabetes, there was substantial underdiagnosis or poor recognition of chronic respiratory disease in patients with COVID-19, particularly in China. However, this seems unlikely, as in very recent data (March 23, 2020) from Italy, among 355 patients dying with COVID-19 (mean age 79.5 years), diabetes was reported in 20.3% of patients but COPD was not listed as a comorbidity for any patient.³ Similarly, provisional data from the USA (March 31, 2020) show that chronic respiratory diseases and diabetes were comorbidities in 8.5% and 10.2% of patients with COVID-19, respectively, compared with Global Burden of Disease figures for the population as a whole of 11.3% for chronic respiratory diseases and 10.2% for diabetes; however these data are based on only 7162 of the 74 439 patients reported.⁴

A second possibility is that having a chronic respiratory disease protects against COVID-19, perhaps through a different immune response elicited by the chronic disease itself. However, this theory is not supported by

Lancet Respir Med 2020

Published Online
April 3, 2020
[https://doi.org/10.1016/S2213-2600\(20\)30167-3](https://doi.org/10.1016/S2213-2600(20)30167-3)

	Number of patients	Health-care workers (%)	Mean or median age (years)	Prevalence (%)			
				Chronic respiratory disease	COPD	Asthma	Diabetes
Patients with COVID-19							
China ¹²	44 672	3.8%	~51	2.4%	..	..	5.3%
Wuhan, China ¹³	140	..	57*	..	1.4%	..	12.1%
Patients with SARS							
Toronto, Canada ¹⁴	147	51%	45*	..	1.0%	..	11.0%
Taipei, Taiwan ¹⁵	67	37%	51.0	6.0%	..	..	23.9%
Kaohsiung, Taiwan ¹⁶	52	31%	48.1	..	10.0%	..	..
Hong Kong ¹⁷	88	19%	42.1	..	0	1.0%	10.0%
Hong Kong ¹⁸	112	61%	39.3	..	2.6%	..	4.5%
General population†							
China ¹⁹	..	..	..	6.9%	4.9%	2.3%	6.6%
Canada ¹⁹	..	..	..	10.4%	5.4%	5.4%	8.2%
Taiwan ¹⁹	..	..	..	13.1%	10.4%	3.9%	10.6%
Hong Kong ²⁰	..	..	..	..	1.4%	1.9%	3.8%

Table references are listed in the appendix. COPD=chronic obstructive pulmonary disease. COVID-19=coronavirus disease 2019. SARS=severe acute respiratory syndrome. *Median age. †Estimates for China, Canada, and Taiwan from the Global Burden of Disease Study; Hong Kong estimates from the Department of Health, Hong Kong Special Administrative Region Government.

Table: Prevalence of chronic respiratory diseases and diabetes in patients with COVID-19 and SARS

See Online for appendix

the finding that among those with COVID-19 who have COPD as a comorbidity, mortality is increased, as would otherwise be expected.⁵

A third possibility is that therapies used by patients with chronic respiratory diseases can reduce the risk of infection or of developing symptoms leading to diagnosis. It is important to note that, at most, only around half of patients with COPD in China take treatments that are standard in Europe and North America,⁶ but up to 75% of people in China with asthma use inhaled corticosteroids.⁷ Furthermore, in in-vitro models, inhaled corticosteroids alone or in combination with bronchodilators have been shown to suppress coronavirus replication and cytokine production.^{8,9} Low-quality evidence also exists from a case series in Japan, in which improvement was seen in three patients with COVID-19 requiring oxygen, but not ventilatory support, after being given inhaled ciclesonide;¹⁰ however, no control group was used and it is not known whether these patients would have improved spontaneously. Yet, the possibility that inhaled corticosteroids might prevent (at least partly) the development of symptomatic infection or severe presentations of COVID-19 cannot be ignored. By contrast, a systematic review on the use of systemic corticosteroids to treat SARS, once established, showed no benefit but possible harm.¹¹

The potential benefits or harms of inhaled corticosteroids and other treatments for people at risk of SARS-CoV-2 infection or patients with COVID-19 are unclear at present, and no changes to the treatment or management of chronic respiratory conditions, including COPD and asthma, should be considered at this stage. However, collecting accurate data for the comorbidities and previous therapy of patients with COVID-19 will be essential to understanding risk factors for becoming infected, developing symptoms, and being diagnosed, as well as enabling answers to questions about possible benefits or harms of therapy for asthma and COPD during the COVID-19 pandemic. This could be

achieved using a standard dataset as advocated by WHO, including information about the presence and severity of comorbidities and all medication that was being taken at the time of infection.

DMGH has received personal fees from AstraZeneca, Boehringer Ingelheim, Chiesi, GlaxoSmithKline, Novartis, Pfizer, and Sanofi, and non-financial support from Boehringer Ingelheim and Novartis, outside of the submitted work. RF has received grants from GlaxoSmithKline and Menarini, outside of the submitted work. AA has received grants from AstraZeneca, GlaxoSmithKline, and Menarini, and personal fees from AstraZeneca, Chiesi, GlaxoSmithKline, and Menarini, outside of the submitted work. OS and JRB declare no competing interests.

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