Impact of smoking on COVID-19 outcomes: a HOPE Registry subanalysis


ABSTRACT

Background Smoking has been associated with poorer outcomes in relation to COVID-19. Smokers have higher risk of mortality and have a more severe clinical course. There is paucity of data available on this issue, and a definitive link between smoking and COVID-19 prognosis has yet to be established.

Methods We included 5224 patients with COVID-19 with available smoking history in a multicentre international registry Health Outcome Predictive Evaluation for COVID-19 (NCT04334291). Patients were included following an in-hospital admission with a COVID-19 diagnosis. We analysed the outcomes of patients with a current or prior history of smoking compared with the non-smoking group. The primary endpoint was all-cause in-hospital death.

Results Finally, 5224 patients with COVID-19 with available smoking status were analysed. A total of 3983 (67.9%) patients were non-smokers, 934 (15.9%) were former smokers and 307 (5.2%) were active smokers. The median age was 66 years (IQR 52.0–77.0) and 58.6% were male. The most frequent comorbidities were hypertension (48.5%) and dyslipidaemia (33.0%). A relevant lung disease was present in 19.4%. In-hospital complications such as sepsis (23.6%) and embolic events (4.3%) occurred more frequently in the smoker group (p<0.001 for both). All cause-death was higher among smokers (active or former smokers) compared with non-smokers (27.6 vs 18.4%, p<0.001). Following a multivariate analysis, current smoking was considered as an independent predictor of mortality (OR 1.77, 95% CI 1.11 to 2.82, p=0.017) and a combined endpoint of severe disease (OR 1.68, 95% CI 1.16 to 2.43, p=0.006).

Conclusion Smoking has a negative prognostic impact on patients hospitalised with COVID-19.

INTRODUCTION

COVID-19 was declared a pandemic on 11 March 2020 by the WHO.1 COVID-2019 has a wide spectrum of manifestations ranging from subclinical infection to acute respiratory distress syndrome (ARDS) and multiorgan failure.2 3 Although some poor prognostic factors have been observed,4 5 its clinical course remains unpredictable.

Since pulmonary alveolar epithelial cells are one of the targets of SARS-CoV-2, underlying respiratory risk factors may play a role in modifying respiratory response. Available findings regarding smokers are inconsistent, and the impact of smoking on SARS-CoV-2 infection is uncertain.6 7

A large case series from China reported a higher prevalence of active smokers in severe COVID-19 infections, in comparison to milder cases.8 Nevertheless, some studies failed to demonstrate a link between smoking and poorer prognosis of the disease. Even some previous series suggested a theoretical ‘protective’ effect of smoking habit.9 10 This last hypothesis can be deduced from the lower rates of smoking observed in patients...
with COVID-19 in comparison with the general population. The prevalence of smokers among SARS-CoV-2-infected patients has been estimated between 1.4% and 12.5% according to different studies.\(^5\)\(^{–}\)\(^{15}\) These rates are notably lower than those recorded in the Chinese general population (25.2%).\(^16\)

The pathophysiology of lung damage has not been fully understood. It has been suggested that high levels of proinflammatory cytokines in serum can induce the hyperinnate inflammatory response. This cascade produces a ‘cytokine release syndrome’ with an overproduction of immune cells and cytokines, which leads to an ARDS and septic shock.\(^17\)\(^{–}\)\(^{20}\) Smoking may modulate the immune response and smokers could present an attenuated immune response presenting lower levels of inflammation markers compared with non-smokers.\(^21\)\(^{–}\)\(^{22}\)

On the one hand, the ACE2 protein is known to play a role in the infection’s mechanism. The ACE2 protein is expressed on the surface of lung type 2 pneumocytes and is the principal receptor molecule for SARS-CoV-2.\(^23\)\(^{–}\)\(^{25}\) On the other hand, some authors have described decreased levels of ACE2 in smokers.\(^26\)\(^{–}\)\(^{27}\) Conversely, it has been suggested that ACE2 is upregulated on the airway epithelium of smokers. In a study in resected lung specimens, Leung and coworkers found an increase of ACE2 gene expression in patients with chronic obstructive pulmonary disease (COPD). Likewise, a higher ACE2 gene expression was observed in smokers when compared with non-smoker individuals.\(^28\)\(^{–}\)\(^{29}\) The question of whether smokers are more prone to contract SARS-CoV-2 infection remains unresolved.

Based on the aforementioned, we aimed to assess if smokers are more likely to die or develop more severe forms of COVID-19.
factors with a p value of <0.01 on the mentioned univariate analysis in the smoker cohort were entered into the multivariate analysis (binary logistic regression) to define independent risk factors for the principal outcome and focusing on the smoking status (current, former or never). Mortality analysis was performed using Kaplan-Meier estimates and log-rank tests to compare factors. Two-sided p values of <0.05 were accepted as statistically significant. Likewise, in order to eliminate potential confounding factors, propensity scores for mortality and the combined endpoint were performed. Statistical analysis was performed using SPSS V. 22.0 and STATA V. 14.0.

RESULTS

A total of 5224 patients with COVID-19 were included in this analysis. The majority patients, 3983 (77.9%), were non-smokers, while 934 (15.9%) were former smokers and only 307 (5.2%) were active smokers. Smoking habits were not available in 644 patients (11%); thus, finally, 5224 patients were entered in the study (figure 1). The median age was 66 years (IQR 52.0–77.0) and 3060 (58.6%) were male. Most individuals were Caucasian (4333, 82.9%) followed by Hispanic ethnicity (710, 13.6%).

In the overall cohort, the most frequent comorbidities were hypertension (2626, 48.5%) and dyslipidemia (1716, 32.0%). Other conditions included heart disease (of any form; 1191, 23%) and obesity (981, 22.1%). A relevant lung disease was present in 1012 patients (19.4%). The most frequent lung disease was COPD (39.4%) followed by asthma (26.9%).

Comparing smoking patterns, we found that former smokers were older and had a higher comorbidity burden compared with both active and non-smoker groups. Ex-smokers had higher rates of hypertension (64.3%), dyslipidemia (48.6%) and obesity (30.6%), as well as a higher prevalence of lung disease (39.3%) and heart disease (38.3%) (p<0.001 for all). Ex-smokers presented the highest prevalence of COPD (24.6%) compared with smokers (16.3%) and non-smokers (3%) (p<0.001). Asthma was predominantly observed among non-smokers (5.7%). Consequently, cardiovascular medications such as ACE inhibitor/angiotensin receptor blockers, antplatelets or inhaled beta agonist were more prevalent among former smokers. Differences in baseline characteristics and previous treatment are displayed in table 1.

Regarding clinical manifestations, current smokers presented with different symptoms complaining of anosmia, dysgeusia and sore throat to a higher degree than the two other groups. The most common symptoms were fever (73%) and cough (65.6%), whereas dyspnoea was less frequently described among smokers. It is worth noting that acute-phase reactants such as C reactive protein, lactate dehydrogenase and ferritin were less frequently elevated in the smoking group, while white cell count was higher than in non-smokers or ex-smokers. Clinical presentation and analytical results are described in online supplemental table S1.

The current smoker group received more beta interferon but less antibiotics or prophylactic anticoagulation compared with both non-smoker and ex-smoker groups (p<0.001) (online supplemental table S2). In line with this, in-hospital complications such as sepsis (23.6%) and embolic events (4.3%) occurred more frequently in the smoker group (p<0.001 for both) (online supplemental table S3).

The secondary endpoint of ICU admission was greater among the active-smoker group in comparison with the former-smoker group and the non-smoker patients (p<0.001), while the prone position was more frequently used among ex-smokers (online supplemental table S3). In the univariate analysis, all-cause death was higher in smokers (20.1%) when compared with non-smokers (18.4%) (p<0.001), while the highest mortality was observed among the former-smoker group (30.0%) (p<0.001). Mortality according to age groups is shown in figure 2 and online supplemental table S4.

The impact of a smoking history was then compared with the absence of a smoking history. All-cause in-hospital mortality and the combined endpoint (ICU admission, prone, death) are depicted in online supplemental table S5.

Following this, a multivariate analysis was performed. After adjusting for confounding factors, current smokers presented a greater risk of death from all causes (OR 1.77, 95% CI 1.11 to 2.82, p=0.017) when compared with non-smokers. Likewise, former smokers had an increased risk of death compared with non-smokers (OR 1.32 95% CI 1.0 to 1.73 p=0.049), but this independent risk was not as strong as that observed in the current smokers’ group.

Other independent predictors of mortality were older age, hypertension, previous heart disease and elevated LDH. Moreover, we performed a multivariate analysis for a combined endpoint of death, ICU admission or need of prone position. As well, the highest risk for the combined endpoint was observed among active smokers when compared with non-smokers (OR 1.68, 95% CI 1.16 to 2.43, p=0.006). There were no significant differences in the combined endpoint between former smokers and non-smokers after adjusting for comorbidities (OR 1.09, 95% CI 0.86 to 1.39, p=0.467). The multivariate analysis is presented in the table 2.

In online supplemental table S6 propensity scores for mortality and the combined endpoint are depicted. In propensity scores, any kind of smokers (former or current) were compared with non-smokers.

Kaplan-Meier survival curve for all-cause mortality is displayed in figure 3.

DISCUSSION

The main finding in our study was the fact that current smoking was independently associated with a twofold increased risk of mortality compared with non-smoking, after adjusting for confounding factors in a large international cohort admitted with COVID-19.
As well, active smokers presented a higher risk for critical illness (combined endpoint of death, prone position and ICU admission) in comparison with non-smokers (1.7-fold). Interestingly, in spite of the fact that former smokers were sicker, the risk of mortality was not as strong as the risk of current smokers after adjusting for comorbidities.

According to previous series, smoking has been associated with higher mortality and complication rates in patients with COVID-19.4-7 Our aim was to clarify if the detrimental effect of smoking was independently associated with poor prognosis in COVID-19 after adjusting for other factors.

SARS-CoV-2 targets pulmonary alveolar epithelial cells and can cause severe pneumonia and respiratory distress.2-5 Thus, underlying respiratory risk factors such as previous lung disease or smoking may alter the respiratory response. Some studies have shown that COPD is associated with a worse prognosis of COVID-19.5 15 The pathogenesis of acute lung injury remains largely unknown. It has been suggested that high levels of proinflammatory cytokines in serum can induce the hyperinnate inflammatory response. The hyperinnate inflammatory response leads to the activation of Th1 cell-mediated immunity and accumulation of alveolar macrophages and neutrophils. This cascade produces a ‘cytokine release syndrome’

<table>
<thead>
<tr>
<th>Table 1 Baseline characteristics and previous treatment</th>
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<tbody>
<tr>
<td>Baseline characteristics</td>
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<tr>
<td>Female</td>
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<tr>
<td>Male</td>
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<tr>
<td>Hypertension</td>
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<tr>
<td>Dyslipidaemia</td>
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<td>Type 1 diabetes mellitus</td>
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<td>Type 2 diabetes mellitus</td>
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<td>Insulin therapy</td>
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<td>Obesity</td>
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<td>Renal failure</td>
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<td>Atrial fibrillation</td>
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<td>HIV</td>
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<td>Heart disease</td>
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<td>Cerebrovascular disease</td>
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<td>Connective disease</td>
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<td>Liver disease</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Immunosuppression</td>
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<td>Partially dependent</td>
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<td>Totally dependent</td>
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<td>Home oxygen therapy</td>
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<tr>
<td>Aspirin</td>
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<tr>
<td>Other antiplatelet</td>
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<tr>
<td>Anticoagulants</td>
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<tr>
<td>ACEI/ARB</td>
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<tr>
<td>Beta blockers</td>
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<td>Beta2 agonist</td>
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<td>Glucocorticoids</td>
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<td>Vitamin D supplement</td>
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<td>Benzodiazepines</td>
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Values are n (%). All p values were determined by using an analysis of variance with Bonferroni method. 
*P<0.05 compared to ex-smokers. 
†P<0.05 compared to smoker subjects. 
‡P<0.05 compared to non-smoker subjects. 
ACEI, ACE inhibitor; ARB, angiotensin receptor blocker.
with an overproduction of immune cells and cytokines, which leads to an ARDS and septic shock. Smoking may alter and attenuate immune response by lowering inflammatory marker levels. In line with this, smokers in our cohort presented lower levels of C reactive protein, ferritin and dehydrogenase lactate when inflammatory marker levels were compared between groups (online supplemental table S1). Likewise, SIRS was less frequently observed in the current smoker group (online supplemental table S3).

Despite these findings, globally, smoking has detrimental effects on the immune system and infectious response, and has been associated with a worse prognosis of pulmonary disease. Moreover, smokers were noted to have higher mortality in the previous MERS-CoV outbreak compared with non-smokers (37% vs 19%, OR=3.14, 95% CI 1.10 to 9.24, n=146). Concerning SARS-CoV-2 infection, previous studies have suggested that active smokers and former smokers are more prone to develop severe COVID-19 infections. Despite the apparent logical link between smoking and COVID-19 prognosis, this relationship has not been fully established. In some previous studies, statistical significance was not reached; sample sizes were small; and results were not entirely adjusted for other confounding factors.

Reviewing the available previous data, Guan et al described clinical characteristics and outcomes of 1099 patients with COVID-19 from China. This study reported a higher prevalence of active-smokers in severe COVID-19 (16.9%) compared with non-severe disease (11.8%). However, no statistical analysis for evaluating any association was performed. Moreover, Zhao et al conducted a meta-analysis with 11 case series. They studied the impact of smoking on the severity of COVID-19 among 2002 patients. This study concluded that active smoking increases the risk of severe COVID-19 (fixed effect model, OR=1.98, 95% CI 1.29 to

Table 2 Multivariate analysis for in-hospital mortality and for secondary combined endpoint

<table>
<thead>
<tr>
<th>Smoking status</th>
<th>Multivariate analysis for in-hospital mortality</th>
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<tr>
<td></td>
<td>OR</td>
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<tr>
<td>Current smoker</td>
<td>1.77</td>
</tr>
<tr>
<td>Former smoker</td>
<td>1.32</td>
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<tr>
<td>Age 52–66 years old</td>
<td>1.74</td>
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<tr>
<td>Age 66–77 years old</td>
<td>4.56</td>
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<tr>
<td>Age &gt;77 years old</td>
<td>10.63</td>
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<tr>
<td>Hypertension</td>
<td>1.71</td>
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<tr>
<td>Lung disease</td>
<td>1.06</td>
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<tr>
<td>Any cardiac disease</td>
<td>1.38</td>
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<tr>
<td>Elevated CRP</td>
<td>2.11</td>
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<tr>
<td>Elevated LDH</td>
<td>2.61</td>
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<tr>
<td>Elevated ferritin</td>
<td>1.22</td>
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Table 2 Multivariate analysis for the composite endpoint

<table>
<thead>
<tr>
<th>Smoking status</th>
<th>Multivariate analysis for the composite endpoint*</th>
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<tbody>
<tr>
<td></td>
<td>OR</td>
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<tr>
<td>Current smoker</td>
<td>1.68</td>
</tr>
<tr>
<td>Former smoker</td>
<td>1.09</td>
</tr>
<tr>
<td>Age 52–66 years old</td>
<td>1.33</td>
</tr>
<tr>
<td>Age 66–77 years old</td>
<td>1.77</td>
</tr>
<tr>
<td>Age &gt;77 years old</td>
<td>2.64</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.65</td>
</tr>
<tr>
<td>Lung disease</td>
<td>1.26</td>
</tr>
<tr>
<td>Any cardiac disease</td>
<td>1.53</td>
</tr>
<tr>
<td>Elevated CRP</td>
<td>2.27</td>
</tr>
<tr>
<td>Elevated LDH</td>
<td>2.16</td>
</tr>
<tr>
<td>Elevated ferritin</td>
<td>1.61</td>
</tr>
</tbody>
</table>

Statistically significant p value: p <0.05.

*Composite endpoint of intensive care unit admission, prone position or death.

CI, Confidence interval; CRP, C reactive protein; LDH, lactate dehydrogenase.

Figure 2 All-cause in-hospital death according to smoking status, stratified by age.

Figure 3 Kaplan–Meier survival curve free from all-cause death, according to smoking status.
3.05) by around twofold. Results were heavily influenced by one study and after removing it from analysis, association was not reached with the OR of 1.55 (95% CI 0.85 to 2.87).

In a similar fashion, Liu et al studied 78 patients with COVID-19. They found a higher proportion of smokers (27.3%) among adverse outcome group, compared with the group that showed improvement or stabilisation (3.0%) (p=0.018). In their multivariate logistic regression analysis, the history of smoking was a risk factor of disease progression (OR=14.28, 95% CI 1.58 to 25.00, p=0.018).6

Furthermore, in a meta-analysis conducted by Patanavanich and Glantz, a total of 11,590 patients with COVID-19 from 19 studies were included. In the overall cohort, 18.4% of the patients developed disease progression. Afterwards, results between smokers and non-smokers were compared. Smokers presented a higher rate of disease progression (29.8%) in contrast with non-smokers (17.6%) with a twofold increased risk for smokers (OR 1.91, 95% CI 1.42 to 2.59, p=0.01).31

In our cohort, pernicious effects of smoking have been observed by the finding of a relationship between smoking and worse outcomes in patients with COVID-19. Mortality was significantly higher among patients with a smoking history (both former and current) than in the non-smoker group (27.6 vs 18.4%, p=0.001). Likewise, a more severe disease was associated to both present and past smoking history (composite endpoint: 36.2 vs 26.1%, p<0.001; online supplemental table S5).

Our results are in line with those found in a meta-analysis conducted by Jiménez-Ruiz et al. This study analysed data from 34 studies including a total of 6,487 patients with SARS-CoV-2 infections. This meta-analysis showed a worse clinical course in current and former smokers (OR 1.96, 95% CI 1.36 to 2.83), as well as a greater risk of critical illness (OR 1.79, 95% CI 1.19 to 2.70), when compared with non-smokers.32

Moreover, Lowe et al evaluated the association between cumulative smoking exposure, as measured by pack-years, with COVID-19 outcomes. They studied a cohort of 7,102 patients recovered in Cleveland Clinic who tested positive for COVID-19. Eighty-five per cent (6,020) of them were non-smokers; 2.4% (172) were current smokers; and 12.8% (910) were former smokers. As well, they compared non-smokers with patients smoking 0–10, 10–30 and more than 30 pack-years, respectively. They found an association between the risk of bad outcomes and the number of pack-years, with a 1.89 and 2.25-fold increased risk of mortality and hospitalisation, respectively, among those patients smoking more than 30 pack-years. This relationship was dose-dependent with a progressive increment of risk according to the number of pack-years. They conclude that smoking is an independent risk factor for hospital admission and mortality in COVID-19.33

Likewise, a meta-analysis conducted by Vardavas reviewed five studies on COVID-19. All studies included patients’ smoking status with sample sizes ranging from 41 to 1099 patients. In all these studies, there was a higher prevalence of both current and former smokers among more severe cases (patients who needed ICU support, mechanical ventilation or who had died; relative risk (RR): 2.4, IQR 1.43–4.04).34

Another retrospective study conducted by Adrish et al analysed 1,173 patients with COVID-19 and smoking habit available. Among them, 837 patients never smoked while 336 were either current or past smokers. In this analysis, smokers developed more critical illness requiring mechanical ventilation (47% vs 37% p=0.005). Univariate Cox model for survival showed that only current smokers had higher risk of death compared with never smokers (HR 1.61, 95% CI 1.22 to 2.12, p<0.001).35

In our cohort, to clarify if the impact of smoking on COVID-19 outcome is rather linked to the smoking-related comorbidities, a multivariate logistic regression analysis was performed. After adjusting by confounding factors, mortality and severity (defined as the composite endpoint) were still higher among smokers compared with never smokers (multivariate analysis in table 2). Indeed, one of the most interesting findings in this work is the fact that active smokers, even if they presented less comorbidities than former smokers, presented the greatest risk of mortality and severity, once confounding factors were adjusted. Current smoking was found to be an independent predictor of mortality and poor prognosis in COVID-19. Former smokers presented a slightly increased risk of mortality (1.3-fold), but there were no statistically significant differences for the combined endpoint in contrast with non-smokers.

In our study, ex-smokers had a greater burden of comorbidities compared with the other two groups. It might explain a higher crude mortality rate among ex-smokers in comparison with active smokers.

Unlike our cohort, other studies did not include ex-smokers in their analysis.9 It is worth highlighting the importance of including ex-smokers, since both current and former smokers share characteristics and underlying respiratory comorbidities. Moreover, both groups have a similar expression of ACE2 receptors. Cai observed a higher ACE2 gene expression in the airway epithelia of healthy patients with a current or previous history of smoking compared with non-smokers.28

Contrastingly, it has been widely questioned whether a history of smoking contributes to an increased risk of contracting COVID-19. An important mechanism of SARS-CoV2 infection relates to the levels of ACE2 proteins that are produced. While the hyperinnate inflammatory response is mainly related to the clinical course of the disease, this second mechanism may play a role in the susceptibility to infection. The ACE2 protein is expressed on the surface of lung type 2 pneumocytes and is the principal receptor molecule for SARS-CoV-2. Some authors have described decreased levels of ACE2 in smokers, which proposes a protective role of smoking. This mechanism suggests that in the ACE/ANG II/AT1R arm, nicotine increases the expression and activity of renin, ACE and AT1R, whereas in the compensatory
ACE2/ANG-(1–7)/MasR arm, nicotine downregulates
the expression and activity of ACE2 and AT2R, thus
suggesting a possible contribution of acetylcholine recep-
tors in ACE2 regulation (nicotine).27

A theoretical ‘protective’ role of tobacco in COVID-19
infection has been suggested. It is worth noting the lower
rates of smoking observed in patients with COVID-19 in
comparison with the general population. This may indi-
cate a lower susceptibility to the infection in individuals
with a smoking history.

Previous Chinese studies have shown low rates of
current smokers among SARS-CoV-2-infected patients
(1.4%–12.5%).3–15 lower than the reported prevalence
of smoking in China (25.2%).16 Moreover, possible
selection biases need to be considered. It is remarkable
the median age of patients ranged from 38 to 59.7 years
in the previously mentioned series.6–9–14 These ages are
strikingly lower than expected results and differ notably
from our cohort with a median age of 66 years (IQR
52.0–77.0).

Similarly, Miyara et al studied 482 patients with
COVID-19 to evaluate smoker’s susceptibility to develop
SARS-CoV-2 infection. In their cohort, 4.4% of the
hospitalised patients and 5.3% of outpatients were
daily smokers. Finally, they compared these results with
the French general population (daily smokers’ rate
of 25.4%). An increased susceptibility to SARS-
COVID-19 infection cannot be extrapolated from these data.

It remains to be seen if smokers are more prone to
contracting SARS-CoV-2. Despite its relevance, the
current data do not answer this question. It is also worth
noting that the true prevalence of COVID-19 infection
rates in the general population is likely underestimated.

Limitations
In our study, only hospitalised patients with COVID-19
were evaluated; therefore, it is clear that these patients
had a more severe clinical course.

Moreover, as this study is an observational study, there
is the potential for bias, given the nature of the study
design. It must be considered that many individuals may
be asymptomatic, and it is not currently possible to estab-
lish the real prevalence of smoking among all COVID-19
cases.

Furthermore, another limitation of our study was the
fact that the number of pack-years of smoking was not
recorded in our database and, therefore, it was not
possible to classify the patients following this interesting
criterion. Likewise, the number smoke-free years was not
available, which would have provided a more accurate
classification of previous risk in former smokers.

CONCLUSIONS
In conclusion, current smoking has a detrimental impact
on COVID-19 prognosis. A history of active smoking is
related to worse COVID-19 outcomes, with increased
risk of mortality and the combined event, after adjusting
for comorbidities. Likewise, a greater risk of mortality
was still found among former smokers, compared with
non-smokers.

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Patient consent for publication. Not required.

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