SYSTEMATIC REVIEW

Incidence of acute pulmonary embolism among patients hospitalized with COVID-19: a systematic review and meta-analysis [version 1; peer review: awaiting peer review]


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Abstract

Background: Coronavirus disease 2019 (COVID-19) is a global pandemic, which is associated with venous thromboembolism and pulmonary embolism (PE). This study aimed to estimate the pooled incidence of PE among patients hospitalized with COVID-19 within the published literature.

Methods: This systematic review and meta-analysis was performed according to PRISMA guidelines. An electronic search using MEDLINE /PubMed, ScienceDirect, Cochrane, and OpenGray databases was conducted May 19th, 2020. Search terms included "COVID 19", "SARS-CoV-2", "coronavirus disease 2019", "2019-nCoV", "Wuhan coronavirus", "Pulmonary embolism", "pulmonary thromboembolism", "Pulmonary embol*", "pulmonary thrombo*" and "PE". Eligible studies
included sufficient data to calculate the incidence of PE diagnosed during hospitalization in patients with COVID-19. Case reports were excluded. Quality was assessed using the Newcastle-Ottawa scale (observational cohort and case-control), AXIS tool (cross-sectional), and quality assessment tool (case series). Demographics and PE incidence data were extracted from the included studies and analyzed with R language. The pooled incidence of PE in patients hospitalized with COVID-19 was calculated.

**Results:** The database search identified 128 records. Ten observational studies were eligible and were included in the meta-analysis with a total of 1722 patients (mean age = 63.36). The pooled PE incidence in patients hospitalized with COVID-19 was 17% (95% CI: 0.1-0.26). There was a high degree of study heterogeneity (I² = 94%, p<0.01).

**Conclusion:** The pooled PE incidence in patients hospitalized with COVID-19 is 17%. This increased incidence is greater than that previously reported in the general population of non-COVID-19. Attention and further investigation of this risk is warranted.

**Keywords**

Pulmonary Embolism, Coronavirus, COVID-19, Venous thromboembolism, Incidence, Meta-analysis

This article is included in the Disease Outbreaks gateway.

This article is included in the Coronavirus collection.
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Introduction

In December 2019, pneumonia of unknown cause was detected in Wuhan, China. The causative agent was identified and named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). On March 11th, 2020, the World Health Organization characterized the coronavirus disease of 2019 (COVID-19) as a pandemic, resulting in 53,507,282 and 1,305,164 COVID-19-related cases and deaths, respectively, as of November 15th, 2020. While COVID-19 is primarily a pulmonary disease, there are multiple other pathologic manifestations and complications, including pulmonary embolism (PE).

The relationship between COVID-19 and thromboembolism is becoming established in the literature. Thromboembolism has been previously associated with zoonotic coronaviruses and may be attributed to several factors including; a hypercoagulable state associated with severe infection or inflammation, COVID-19 associated hemostatic abnormalities, recumbence, and possible drug interactions between investigational COVID-19 therapies (Lopinavir/ritonavir) and antithrombotics.

This systematic review and meta-analysis analyzed and estimated the pooled PE incidence from published literature of patients hospitalized with COVID-19 who developed PE.

Methods

This meta-analysis was performed following the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA) reporting guideline. Institutional review board approval was not required for this study.

Search strategy

A systematic literature search was performed on May 19th, 2020 using Medline/PubMed, Cochrane, OpenGrey, and ScienceDirect. PubMed, Cochrane, and OpenGrey were queried for the following strategy: (“COVID 19” OR “SARS-CoV-2” OR “coronavirus disease 2019” OR “2019-nCoV” OR “Wuhan coronavirus”) AND (“Pulmonary embolism” OR “pulmonary thromboembolism” OR “Pulmonary embol” OR “pulmonary thrombo” OR “PE”). ScienceDirect was queried using the same variables only without asterisks.

Duplicate citations and older versions of the same study population were removed. All included study bibliographies were-screened for additional articles investigating PE in patients hospitalized with COVID-19. All eligible studies underwent full-text screening.

Eligibility criteria

Studies reporting data sufficient to estimate PE incidence of patients hospitalized with COVID-19 were included in the analysis. Only English and published studies were included. Studies with insufficient data, case reports, editorials, proposals, and abstracts without full-text were excluded. The title and abstract of retrieved articles were screened by two independent reviewers for potential inclusion. Any discrepancy between the reviewers was resolved by consensus with two additional reviewers.

Quality appraisal and data extraction

Appraisal of individual study quality was performed by two independent reviewers using the Newcastle–Ottawa scale, AXIS tool, and quality assessment tool for observational cohort and case-control, cross-sectional, and case series, respectively. Articles were deemed of good quality if they scored 50% or more using an arbitrary cut-off.

Information was sought from each included study are: characteristics of participants (including age, gender, BMI, D dimer of patient with COVID-19, and total patients in the study), summary about included studies (first author, country, year of publication, study period, study design, method of diagnosing COVID-19) and the main data for meta-analysis (total patients in each study i.e., sample size and number of patients developing PE from the total). The data was subsequently extracted by five independent reviewers utilizing Microsoft Excel 2016 (Microsoft Corporation, Redmond, WA).

Analysis

Due to skewed proportions, the random effect model was used to pool the individual estimates through LOGIT transformation instead of double arcane transformation to avoid a paradoxical effect upon back-transformation.

Statistical analysis was performed using R language v.4, using “meta” and “metafor” packages. Random effects models were utilized to accommodate for the heterogeneity in the reported pooled incidences. Statistical heterogeneity was estimated using F statistics and further assessed using subgroup analysis, meta-regression, influence analysis, and Gosh analysis. Publication bias was evaluated by both the Egger test and funnel plot visual analysis.

Results

Study characteristics

The search yielded 81 and 47 records in both Medline/PubMed and ScienceDirect, respectively. No records were identified in OpenGrey and Cochrane databases. After eliminating duplicate data, 125 studies were included for abstract screening, of which 76 were excluded due to insufficient data. Full-text screening of the remaining 49 studies excluded 38 records with an agreement kappa of 0.813. Of the remaining studies, one scored <50% on the quality assessment tool, leaving ten studies for pooled analysis (Table 1). Nine studies were from Europe and one study was from North America (Table 1). Studies were divided into descriptive and analytic categories for subgroup analysis (Table 1). The reported PE incidence among patients hospitalized with COVID-19 in all included studies ranged from 3–35% (Table 2). Details of the selection process are summarized in (Figure 1).

Patients had a mean age of 63 years. The incidence of PE was noted to be higher in males (Table 3). The D-dimer levels were specified between PE group and non-PE group in only three studies, while the remaining either reported it improperly or had missing data (Table 3).
Table 1. Patient characteristics of the included studies.

<table>
<thead>
<tr>
<th>First author</th>
<th>Publication year</th>
<th>Region</th>
<th>Country</th>
<th>Study period MM/DD/YYYY</th>
<th>Study design type</th>
<th>Design (analytic or descriptive)</th>
<th>Method of COVID-19 diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lodigiani et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>Italy</td>
<td>02/13/2020 To 04/10/2020</td>
<td>Retrospective</td>
<td>Cohort</td>
<td>Laboratory</td>
</tr>
<tr>
<td>Middeldorp et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>Netherlands</td>
<td>03/02/2020 To 04/30/2020</td>
<td>Retrospective</td>
<td>Cohort</td>
<td>RT-PCR/ CT/ Clinical</td>
</tr>
<tr>
<td>Helms et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>France</td>
<td>03/03/2020 To 04/07/2020</td>
<td>Prospective</td>
<td>Cohort</td>
<td>RT-PCR</td>
</tr>
<tr>
<td>Bompard et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>France</td>
<td>03/01/2020 To 04/16/2020</td>
<td>Retrospective</td>
<td>Cohort</td>
<td>NA</td>
</tr>
<tr>
<td>Poyiadi et al., 2020</td>
<td>2020</td>
<td>North America</td>
<td>Detroit</td>
<td>03/16/2020 To 04/18/2020</td>
<td>Case Control</td>
<td>Analytic</td>
<td>RT-PCR</td>
</tr>
<tr>
<td>Grillet et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>France</td>
<td>03/15/2020 To 04/14/2020</td>
<td>Retrospective</td>
<td>Cross Sectional</td>
<td>RT-PCR / Strong Clinical Suspension</td>
</tr>
<tr>
<td>Leonard-Lorant et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>France</td>
<td>03/01/2020 To 03/31/2020</td>
<td>Retrospective</td>
<td>Cross Sectional</td>
<td>RT-PCR / CT and Clinical</td>
</tr>
<tr>
<td>Possiy et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>France</td>
<td>02/27/2020 To 04/09/2020</td>
<td>Case Series</td>
<td></td>
<td>PCR</td>
</tr>
<tr>
<td>Klok et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>Netherlands</td>
<td>03/07/2020 To 04/22/2020</td>
<td>Case Series</td>
<td>Descriptive</td>
<td>NA</td>
</tr>
<tr>
<td>Llitjos et al., 2020</td>
<td>2020</td>
<td>Europe</td>
<td>France</td>
<td>03/19/2020 To 04/11/2020</td>
<td>Retrospective</td>
<td>Cross sectional</td>
<td>PCR</td>
</tr>
</tbody>
</table>

Table 2. Primary data for calculation of the incidence of patients hospitalized with COVID-19.

<table>
<thead>
<tr>
<th>First author</th>
<th>Sample size</th>
<th>Number of CTPA</th>
<th>Number of PE</th>
<th>PE proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lodigiani et al., 2020</td>
<td>388</td>
<td>30</td>
<td>10</td>
<td>0.03</td>
</tr>
<tr>
<td>Middeldorp et al., 2020</td>
<td>198</td>
<td>NA</td>
<td>13</td>
<td>0.07</td>
</tr>
<tr>
<td>Helms et al., 2020</td>
<td>150</td>
<td>99</td>
<td>25</td>
<td>0.17</td>
</tr>
<tr>
<td>Bompard et al., 2020</td>
<td>135</td>
<td>135</td>
<td>32</td>
<td>0.24</td>
</tr>
<tr>
<td>Poyiadi et al., 2020</td>
<td>328</td>
<td>328</td>
<td>72</td>
<td>0.22</td>
</tr>
<tr>
<td>Grillet et al., 2020</td>
<td>100</td>
<td>100</td>
<td>23</td>
<td>0.23</td>
</tr>
<tr>
<td>Leonard-Lorant et al., 2020</td>
<td>106</td>
<td>106</td>
<td>32</td>
<td>0.30</td>
</tr>
<tr>
<td>Possiy et al., 2020</td>
<td>107</td>
<td>34</td>
<td>22</td>
<td>0.21</td>
</tr>
<tr>
<td>Klok et al., 2020</td>
<td>184</td>
<td>NA</td>
<td>65</td>
<td>0.35</td>
</tr>
<tr>
<td>Llitjos et al., 2020</td>
<td>26</td>
<td>NA</td>
<td>6</td>
<td>0.23</td>
</tr>
</tbody>
</table>

PE: pulmonary embolism; CTPA: CT pulmonary angiography.

Though anatomical distribution of PE was mentioned in most studies (except Lorant et al. and Grillet et al.), the clinical classification of PE into massive and sub-massive was not mentioned.

Meta-analysis

The pooled incidence of PE in hospitalized patients with COVID-19 was 17% (95% CI: 11-26%) (Figure 2). I² test revealed significant study heterogeneity (I²= 94%, p<0.01). The risk of
publication bias was tested for by Egger test (t-value = -1.867, p=0.0989) and examined visually using a funnel plot (Figure 3).

Subgroup analysis
The pooled PE incidence was estimated at 11% (95% CI: 5-23%) and 27% (95% CI 22-34%) in the analytic and descriptive studies, respectively. Higher heterogeneity was detected among the analytic group ($I^2= 95\%$, $p<0.01$), compared to the descriptive group ($I^2= 48\%$, $p=0.05$) (Figure 4).

Meta-regression
When categorizing the included studies into analytic or descriptive, the meta-regression model showed that the study design was significantly associated with the difference in PE incidence ($p<0.05$) (Figure 5).

Discussion
PE is the most common thromboembolic complication occurring in patients with COVID-19\textsuperscript{24,30,32}. This systematic review and meta-analysis estimated a pooled PE incidence among patients hospitalized with COVID-19 at 17% (95% CI: 10-26%) (Figure 2)\textsuperscript{24,33}. This pooled PE incidence is higher than the PE incidence of the general population, and most importantly, higher than that of hospitalized patients with other medical conditions\textsuperscript{34–40}.

This reported PE incidence could represent an over or under estimation of the true incidence. The increasing knowledge of higher incidences of venous thromboembolism in patients with COVID-19 may have led to a selection bias due to lower threshold of CT pulmonary angiography (CTPA) utilization\textsuperscript{41}.
Table 3. Characteristics of patients hospitalized with COVID-19 and those who developed pulmonary embolism (PE).

<table>
<thead>
<tr>
<th>First author</th>
<th>Age of patients with PE (years)</th>
<th>Male patients with PE (n (%))</th>
<th>BMI of patients with PE (kg/m²)</th>
<th>D-dimer of patients with PE</th>
<th>Age of total patients (years)</th>
<th>Male total patients (n (%))</th>
<th>BMI of total patients (kg/m²)</th>
<th>D-dimer of total patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lodigiani et al., 2020&lt;sup&gt;24&lt;/sup&gt;</td>
<td>Mean = 69.3</td>
<td>7 (70)</td>
<td>NA</td>
<td>Mean = 10669.9 ng/ml</td>
<td>Median (IQR)= 66 (55-75)</td>
<td>264 (68)</td>
<td>&gt;30 =24.1%</td>
<td>NA</td>
</tr>
<tr>
<td>Middeldorp et al., 2020&lt;sup&gt;25&lt;/sup&gt;</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Mean±SD = 61±14</td>
<td>130 (66)</td>
<td>Median (IQR) = 27 (24-31)</td>
<td>Median (IQR)= 1.1 (0.7-2.3) mg/l</td>
</tr>
<tr>
<td>Helms et al., 2020&lt;sup&gt;26&lt;/sup&gt;</td>
<td>Mean = 62</td>
<td>24 (96)</td>
<td>NA</td>
<td>NA</td>
<td>Median (IQR)= 63 (53-71)</td>
<td>122 (81.3)</td>
<td>NA</td>
<td>Median (IQR) = 2.27 (1.16-20) mg/l</td>
</tr>
<tr>
<td>Bomparde et al., 2020&lt;sup&gt;27&lt;/sup&gt;</td>
<td>Median (IQR) = 70 (59-77)</td>
<td>26 (81)</td>
<td>NA</td>
<td>Median (IQR) = 9841 (2921-10000) u/l</td>
<td>Median (IQR)= 64 (54-76)</td>
<td>94 (70)</td>
<td>NA</td>
<td>Median (IQR) = 1285 (891 - 2742) u/l*</td>
</tr>
<tr>
<td>Poyiadi et al., 2020&lt;sup&gt;28&lt;/sup&gt;</td>
<td>Mean±SD = 59±15</td>
<td>35 (49)</td>
<td>42 (58%) &gt;30</td>
<td>Mean±SD = 9.33±7 mg/ml</td>
<td>Mean = 61.3</td>
<td>150 (45.7)</td>
<td>155 (47.2%) &gt;30</td>
<td>Mean±SD = 2.54±3.67 mg/ml*</td>
</tr>
<tr>
<td>Grillet et al., 2020&lt;sup&gt;29&lt;/sup&gt;</td>
<td>Mean±SD = 67±11</td>
<td>21 (91)</td>
<td>NA</td>
<td>NA</td>
<td>Mean±SD = 66±13</td>
<td>70 (70)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Leonard-Lorant et al, 2020&lt;sup&gt;30&lt;/sup&gt;</td>
<td>Mean±SD = 64±22</td>
<td>25 (78)</td>
<td>Median (IQR) = 27±8</td>
<td>Median (IQR) = 15385±14410ug/l</td>
<td>Mean= 63.3</td>
<td>70 (66)</td>
<td>Mean= 28.4</td>
<td>Mean±SD = 1940 ± 3060 ug/l*</td>
</tr>
<tr>
<td>Possiy et al., 2020&lt;sup&gt;31&lt;/sup&gt;</td>
<td>Median (range) = 57 (29-80)</td>
<td>13 (59.1)</td>
<td>Median (range) = 30 (22-53)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Klok et al., 2020&lt;sup&gt;32&lt;/sup&gt;</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Mean±SD= 64±12</td>
<td>139 (76)</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Llitjos et al., 2020&lt;sup&gt;33&lt;/sup&gt;</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Mean±SD= 68±11.5</td>
<td>20 (77)</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*data in non-PE group
An underestimation is known to occur in the general population for the diagnosis of PE related to the majority of massive PE being diagnosed on post-mortem examination. Similarly, patients with COVID-19 could be assumed to have a lower reported incidence of PE diagnosis due to limited CT scan availability, patients instability, concern over hospital exposure to others related to transportation, early hospital mortality and death outside of healthcare.
Most of the patients included in this meta-analysis were males and aged sixty years and above. Not only was PE higher in elderly and males patients hospitalized with COVID-19, but also other COVID-19 related complications and death were seen more in this population[45, 46]. This observation is consistent with the higher PE incidence across the elderly in the general population as well[47]. Therefore, hospitalized male and elderly patients with COVID-19 could be at a higher risk of developing PE compared to their COVID-19-afflicted female and young counterparts, respectively.
To account for the variability of CTPA timing effect on PE incidence, a study assigned each patient with COVID-19 two time points in the CTPA and demonstrated a higher incidence at the later time point. Such an observation may help in interpreting the variation in PE incidence across different studies with similar population characteristics and may also highlight underestimation of PE incidence in population with single-time CTPA.

PE mortality was reported in only 3 out of the 10 studies using different formats. Therefore, the estimated pooled mortality could not be calculated.

**Strength, limitations, and recommendations**

This study was designed and executed in accordance with PRISMA guidelines. The heterogenous severity of the included COVID-19 cohort included the complete spectrum of hospitalized patients with COVID-19. Therefore, this estimated incidence could apply to any hospitalized patients with COVID-19, regardless of disease acuity. However, these findings need to be interpreted in the context of some limitations. First, neither articles in non-indexed journals nor non-published papers were searched, which may have introduced some publication bias. Second, the inclusion of studies published only in English literature may have led to language bias. Third, the presence of a subpopulation in whom PE was suspected and CTPA could not be performed for various reasons, such as allergy to contrast material, and could result in skewed incidence. Fourth, both clinical indications for CTPA and PE classification or risk stratification were not specified in the different studies. Sixth, due to variability of the way of reporting specific data on some variables (d-dimer, mortality data), it was difficult to make meaningful predictions. Lastly, some relevant clinical and para-clinical variables were not mentioned.

Further research is warranted to accurately characterize the patients hospitalized with COVID-19 who develop PE in terms of; risk factors profile, PE diagnostic indications, CTPA timing, PE prophylaxis and management, and PE pathogenesis.

**Conclusion**

This systematic review and meta-analysis reported a pooled PE incidence among patients hospitalized with COVID-19 at 17%, suggesting that almost in every five hospitalized patients with COVID-19, one may develop PE. This represents around a 243-fold increase in incidence when compared to the general population. Healthcare professionals should be aware of this observed increase in risk of PE incidence among patients hospitalized with COVID-19. Development of accurate and precise risk stratification scores and point of care biomarkers to guide prophylactic and therapeutic strategies in this vulnerable population are warranted.

**Data availability**

**Underlying data**

All data underlying the results are available as part of the article and no additional source data are required.

**Extended data**


This project contains the following extended data:
- Code for publishing plots (.R file).
- Code for meta-analysis (.R file).

**Reporting guidelines**


Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CCO 1.0 Public domain dedication).

**References**


2. Web2-WHO: Naming the coronavirus disease (COVID-19) and the virus that causes it. [cited 2020 Jun 18].


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