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Clinical characteristics of 11 asymptomatic patients with COVID-19



Características clínicas de 11 pacientes asintomáticos con COVID-19

Dear Editor:

In December 2019, a novel coronavirus that occurred in Wuhan, China, has spread to all over the world. The disease was named coronavirus disease 2019 (COVID-19) and the virus was designated as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) by WHO. Person-to-person transmission has been demonstrated and the main infection source was the patients who with COVID-19. Respiratory droplet transmission is the main route of transmission, and it can also be transmitted through contact.¹ SARS-CoV-2 has high pathogenicity and transmissibility, being more infectious than MERS-CoV and SARS-CoV.² Therefore, the Chinese government has implemented the most stringent control measures, and effectively reduced the spread of the epidemic. The vast majority of patients with COVID-19 presented with fever and cough, but we found that some patients were infected with SARS-CoV-2 without any symptoms. Here, we reported 11 asymptomatic patients were found in Guizhou Province. They were laboratory-confirmed positive for the COVID-19 virus by testing RNA of the pharyngeal swab samples.

One of the 11 patients was a 6-year-old child, and the rest were young or middle-aged (27–56 years old, Table 1). Of 11 patients, 6 were male and 5 female. 2 male had hypertension and 1 female had a history of breast carcinoma (Table 1). 5 patients had a history of exposure in Wuhan, and all of them were isolated at home after return. 2 of the 5 patients were in isolation, and their relatives (without history of exposure to Wuhan) developed symp-

toms and were diagnosed. They were subsequently diagnosed with COVID-19. The other 3 patients returned to Guizhou province from Wuhan with their relatives and were then isolated at home. Some of their relatives developed fever or cough and were diagnosed with COVID-19. None of these 3 patients showed any symptoms at admission and during admission. Therefore, we cannot determine whether their relatives' infections originated from them. After returning from Wuhan, 1 of the 5 patients had been solitary isolated without infecting others.

6 of the 11 patients had no history of exposure to Wuhan and were all clustered cases. They had a history of close contacts with relatives or colleagues diagnosed with COVID-19, so it is difficult to determine whether they are the index patient. The lymphocytes of 11 patients were not significantly decreased. 6 of the 11 patients had abnormal CT findings, mainly showed ground-glass opacities. The other 5 patients had normal chest CT. All patients' blood cells, liver function, renal function, coagulation function and high-sensitivity C-reactive protein were in normal range. None of the 11 patients developed severe pneumonia as of March 5, 2020, and 4 patients showed typical symptoms (fever, cough, fatigue, etc.) during hospitalization. Generally, these asymptomatic patients were mildly ill as compared to those reported in Wuhan, Hubei.³

On January 24, The Lancet reported a familial cluster of SARS-CoV-2 infection.⁴ In this family, there was an asymptomatic child presenting with no fever, respiratory tract or gastrointestinal symptoms, but with ground glass lung opacities on chest CT. Subsequently, asymptomatic patients appeared in many Chinese cities, in which majority having an epidemiological history. A recent report suggested that an asymptomatic carrier was able to transmit the SARS-CoV-2 to another person in Germany.⁵ In our report, 2 patients were the index patient and transmitted virus to their relatives. Hence, asymptomatic persons have become a potential

Table 1
summary of asymptomatic patients.

	Patient 1	Patient 2	Patient 3	Patient 4	Patient 5	Patient 6	Patient 7	Patient 8	Patient 9	Patient 10	Patient 11
Gender	Male	Female	Male	Female	Female	Female	Male	Male	Male	Male	Female
Age (years)	56	6	37	40	45	27	26	29	55	40	30
Expoure to Wuhan	Yes	No	Yes	Yes	No	No	Yes	No	No	Yes	No
Comorbidity	Hypertension	None	None	Breast carcinoma	None	None	None	None	None	Hypertension	None
Chest CT	Bilateral	Normal	Bilateral	Bilateral	Normal	Normal	Normal	Right	Right	Bilateral	Normal
Lymphocytopenia (10 ⁹ /L; normal range 1.1–3.2)	1.14	2.81	2.68	1.66	1.60	1.27	1.62	2.74	0.9	1.12	2.2
Fever, cough and other symptoms	No	No	No	No	No	No	No	No	No	No	No
Infect others	Relatives	^a	^a	Relatives	^a	^a	^a	^a	^a	^a	^a
Confirmed time or onset time	7 days after leaving Wuhan	6 days after contacting with confirmed person	11 days after leaving Wuhan	8 days after leaving Wuhan	5 days after contacting with confirmed person	8 days after contacting with confirmed person	5 days after leaving Wuhan	4 days after contacting with confirmed person	10 days after contacting with confirmed person	10 days after leaving Wuhan	12 days after contacting with confirmed person

^a Unknown information that cannot be obtained.

source of SARS-CoV-2 infection. To prevent and find asymptomatic carriers are the key to prevent the spread of the epidemic. Persons with family members with SARS-CoV-2 infection should be closely monitored and examined to rule out infection, even if they do not have any symptoms. After discharge, patients should be further isolated and received continuous SARS-CoV-2 RNA tests.

Compliance with ethical standards

Written consent from the patient was waived, because of entirely anonymized images from which the individual cannot be identified.

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Author contributions

FC collected clinical data. BF drafted the manuscript. XYF designed the study.

Consent for publication

Not applicable.

Availability of supporting data

The data sets supporting the results of this article are included within the article.

Conflicts of interest

All authors declare that they have no conflict of interest.

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Cierre de orejuela izquierda como alternativa a la anticoagulación en la fibrilación auricular



Left atrial appendage occlusion as an alternative to anticoagulation in patients with atrial fibrillation

Sr. Editor:

Durante años la única alternativa a la heparina han sido los antagonistas de vitamina K (AVK), hasta la aparición de los anticoagulantes de acción directa (ACOD). Sin embargo, no están exentos de riesgo hemorrágico por su propio efecto anticoagulante, presentan limitaciones para los pacientes con insuficiencia renal y pueden tener efectos secundarios¹.

Diversos estudios han demostrado que la principal fuente de trombos en pacientes con fibrilación auricular (FA) es la orejuela izquierda (OI), por lo que su exclusión mediante escisión quirúrgica o por técnicas percutáneas reduce la tasa de eventos tromboembólicos y permite eliminar el tratamiento anticoagulante^{1,2}.

Presentamos el caso de una mujer de 84 años, independiente para las actividades básicas de la vida diaria, con antecedentes de: hipertensión arterial, FA paroxística, insuficiencia mitral y aórtica leves, dislipemia, obesidad, anemia crónica y hemicolectomía derecha por adenocarcinoma de colon. Hace un año se le suspendió el tratamiento con acenocumarol, por labilidad de INR y epistaxis, y se anticoaguló con enoxaparina. Actualmente en tratamiento

con: bisoprolol 2,5 mg/24 h, simvastatina 20 mg/24 h, furosemida 40 mg/24 h y enoxaparina 60 mg/24 h.

Fue citada en consulta de cardiología para valoración del tratamiento anticoagulante que realizaba.

Durante la anamnesis refirió astenia de largo tiempo de evolución, visita a urgencias 2 meses antes por palpitaciones (objetivándose el último episodio de FA) y epistaxis frecuentes el último mes.

Como único hallazgo en la exploración se auscultó un soplo sistólico II/VI con segundo tono conservado. Se realizó en consulta un electrocardiograma (ritmo sinusal a 68 lpm, conducción AV conservada, sin anomalías de la conducción intraventricular ni alteraciones de la repolarización) y se solicitaron diversas pruebas complementarias que se revisaron en una consulta posterior: en la ecocardiografía transtorácica se objetivó una aurícula izquierda ligeramente dilatada con área de 26 cm², un ventrículo izquierdo no dilatado con fracción de eyección preservada, cavidades derechas normales, insuficiencia aórtica y mitral ambas ligeras y degenerativas, así como regurgitación tricuspídea moderada que permitía estimar una hipertensión pulmonar ligera.

También se realizó un Holter de tensión arterial que no presentó anomalías y una analítica donde destacaba una anemia macrocítica hipocrómica con hemoglobina de 7 g/dl, un aclaramiento de creatinina de 35 ml/min y un ProBNP de 6.796 pg/ml; siendo el resto de valores normales.