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CORRESPONDENCE

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COVID-19 Among Liver Transplant Recipients



Dear Editors:

Mansoor et al¹ sought to examine the rates of hospitalization, mortality, thrombosis, or intensive care (ICU) requirement of liver transplant (LT) patients infected with coronavirus disease 2019 (COVID-19) in the United States compared with patients without LT and COVID-19. The authors found that upon adjusted analyses LT patients with COVID-19 had a significantly higher risk of hospitalization, but not a higher risk of mortality, thrombosis, or ICU requirement compared with patients without LT and COVID-19.¹ However, a recent analysis addressing the same question among LT and non-LT patients with COVID-19 showed no difference with regard to the proportion of hospitalizations or ICU needs.²

The question here is how the decision-making process of admitting patients with COVID-19 is made across different institutions and physicians. Are there any specific or universal guidelines or algorithms used to help physicians make these decisions? I suspect that the threshold to admit LT patients with COVID-19 might be lower compared with non-LT patients owing to concerns that these patients might be at increased risk of adverse outcomes from COVID-19 because of coexisting comorbidities and the use of immunosuppressants. Also, it is not clear from the analysis about the access of patients to telemedicine and adequate outpatient care. This will definitely vary among hospitals in the United States and can affect the decision to admit patients with COVID-19 in a limited resource health care system.³

In addition, the authors did not provide further insights on the low in-hospital mortality of LT COVID-19 patients in their cohort (8%), which was significantly lower than the recent analyses (17%–19% in hospitalized patients)^{2,4} and recent analyses in kidney transplant populations where inpatient mortality was even higher (19.9%).⁵ One possible explanation might be that many patients in the LT COVID-19 group were admitted in the absence of severe disease thus their chances of recovery were significantly higher.

Finally, the authors omitted the characteristics of LT COVID-19 patients regarding the time of COVID-19 diagnosis and the time of transplant. These findings are of paramount clinical importance and might partially explain the recovery rates in this study since due to intensive immunosuppression, recent transplant recipients (<3 months after transplantation) are expected to develop severe disease owing to COVID-19 more frequently than old transplants.⁶ Data from ELITA/ELTR COVID-19 registry showed that the mortality in LT recipients was 16% and was higher in older recipients (>60 years old) and in patients with longer time since transplantation (>2 years).⁷

All in all, despite the discrepancies among studies on the outcomes of transplant patients infected by COVID-19, large collaborative efforts can shed more light to many unanswered questions by providing crucial information on a potentially at-risk population, with an efficiency and scale only possible through international collaboration.

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Conflicts of interest

The author discloses no conflicts.

Most current article

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Characteristics of Liver Transplant Patients Infected with COVID-19



Dear Editors:

With great interest, we have read this multicenter research network study from Mansoor and colleagues entitled “Clinical Characteristics, Hospitalization and Mortality Rates of COVID-19 Among Liver Transplant Patients in the United States.”¹ The study had described the characteristics of liver transplant (LT) patients infected with coronavirus disease 2019 (COVID-19) and the rates of hospitalization, mortality, thrombosis, and intensive care unit (ICU) requirements. Within their study, fever (10%) was the most common presenting symptom, followed by cough (8%), malaise and fatigue (8%), dyspnea (10%), and gastrointestinal symptoms (8%). The incidence of hospitalization, ICU care admission, and mortality among LT patients were 40%, 8%, and 8%, respectively, and these outcomes were significantly higher than in the non-LT cohort. The study was designed retrospectively with incomplete documentation