Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

	Summary estimate (95% CI) from Schierhout et al (2020)[1]	Diagnoses at discharge in patients with HTLV-1 in Spain[2] (n=115)
Due to shared acquisition routes with HTLV-1 (ie, other sexually transmitted infections)		
Cervical cancer	OR 3·59 (0·68–19·11)	0 (0%)
Liver cancer	OR 1·46 (0·85–2·51)	0 (0%)
Due to immune impairment as a result of infection of CD4-positive T-lymphocytes by HTLV-1		
Infections		
Strongyloides stercoralis	OR 120·00 (11·43–1259·64)	1 (1%)
Tuberculosis	OR 1·70 (0·94–3·08)	0 (0%)
Bronchiectasis, bronchitis, and bronchiolitis	OR 2·90 (2·00–4·30)	1 (1%)
Community-acquired pneumonia	OR 1·36 (1·00–1·85)	3 (3%)
Kidney and bladder infections	OR 1·80 (1·00–3·20)	15 (13%)
Dermatophytosis	OR 3·32 (1·50–7·35)	1 (1%)
Allergic inflammatory disorders		
Asthma	OR 3·40 (1·20–3·30)*	4 (3%)
Seborrheic dermatitis (adults)	OR 3·89 (2·07–7·29)	0 (0%)
Arthritis	RR 2·84 (1·51–5·33)	0 (0%)
Sicca syndrome	OR 3·25 (1·85–5·70)	2 (2%)
Due to persistent immune activation as a result of sustained HTLV-1 replication		
Lymphoma other than ATL	OR 2·76 (1·36–5·62)	0 (0%)
Chronic inflammation and accelerating ageing (eg, cardiovascular events, neurodegenerative diseases, metabolic abnormalities, and osteoporosis)	..	28 (24%)

Data are n (%) unless otherwise indicated. ATL=adult T-cell leukaemia-lymphoma. HAM=HTLV-1-associated myelopathy. TSP=tropical spastic paraparesis. HTLV-1=human T-cell lymphotropic virus type 1. OR=odds ratio. RR=relative risk. *In the meta-analysis by Schierhout and colleagues,[1] the OR for asthma was reported only for men.

***Table*: Diseases other than ATL and HAM/TSP associated with HTLV-1 infection**

papillomavirus is a major cause of cervical cancer). Second, infection of CD4-positive T-lymphocytes by HTLV-1 might lead to immune impairment and therefore an increased risk of infections (eg, pulmonary and urinary infections) and allergic inflammatory disorders (eg, asthma, eczema, arthritis, and sicca syndrome). Finally, persistent immune activation caused by HTLV-1 infection might account for the increased risk of lymphomas other than ATL in these patients.

Most of the diagnoses newly linked to HTLV-1 are not fatal and therefore cannot explain the increased relative risk of premature death in carriers of HTLV-1 that do not have ATL, or HAM/TSP.[1] In other chronic viral illnesses, such as HIV, chronic hepatitis B, and chronic hepatitis C, prolonged viral replication despite antiviral therapy results in persistent immune activation and chronic inflammation that ultimately might harm different organs, such as the liver, kidneys, and brain, and cause accelerated ageing.[3–5] Likewise, we propose that common age-related illnesses, such as cardiovascular events, neurodegenerative diseases, metabolic abnormalities, and osteoporosis, might occur at an earlier age in HTLV-1 carriers than in non-carriers and are largely responsible for the shortened survival of these patients in the absence of ATL or HAM/TSP. 28 (24%) of the 115 patients admitted to hospital in Spain and diagnosed with HTLV-1 had these age-related illnesses. Because these age-related diseases are so prevalent in the general population, these illnesses could have been missed in the meta-analysis by Schierhout and colleagues.[1]

Published **Online** February 18, 2020 https://doi.org/10.1016/S1473-3099(20)30111-0

This online publication has been corrected. The corrected version first appeared at thelancet.com/infection on February 24, 2020

We declare no competing interests.

*José-Manuel Ramos, Carmen de Mendoza, *Vicente Soriano, on behalf of the Spanish HTLV Network*
vicente.soriano@unir.net

Internal Medicine Department, General University Hospital of Alicante, Alicante, Spain (J-MR); Infectious Disease Unit, Miguel Hernandez University, Elche, Spain (J-MR); Laboratory of Internal Medicine, Puerta de Hierro Research Institute, Madrid, Spain (CdM); Internal Medicine Department, Puerta de Hierro University Hospital, Madrid Spain (CdM); Microbiology Department, San Pablo-CEU University, Madrid, Spain (CdM); and UNIR Health Sciences School and Medical Center, Madrid 28040, Spain (VS)

1 Schierhout G, McGregor S, Gessain A, Einsiedel L, Martinello M, Kaldor J. Association between HTLV-1 infection and adverse health outcomes: a systematic review and meta-analysis of epidemiological studies. *Lancet Infect Dis* 2020; **20:** 133–43.
2 Ramos JM, de Mendoza C, Aguilera A, et al. Hospital admissions in individuals with HTLV-1 infection in Spain. *AIDS* 2020; published online February 17. DOI:10·1097/QAD.0000000000002508.
3 Stoff DM, Goodkin K, Jeste D, Marquine M. Redefining aging in HIV infection using phenotypes. *Curr HIV/AIDS Rep* 2017; **14:** 184–99.
4 Wu VC, Chen TH, Wu M, et al. Comparison of cardiovascular outcomes and all-cause mortality in patients with chronic hepatitis B and C: a 13-year nationwide population-based study in Asia. *Atherosclerosis* 2018; **269:** 178–84.
5 Wong G, Wong V, Yuen B, et al. An aging population of chronic hepatitis B with increasing comorbidities: a territory-wide study from 2000 to 2017. *Hepatology* 2020; **71:** 444–55.

The first Vietnamese case of COVID-19 acquired from China

An outbreak of a novel coronavirus was reported in Wuhan, China in late December, 2019, and has since become a global health emergency.[1,2] This letter describes the first Vietnamese case of coronavirus disease 2019 (COVID-19) acquired from China.

A 25-year-old Vietnamese woman who had been in Wuhan for a 2-month business trip returned to Vietnam on Jan 17, 2020. In Wuhan, she lived with two Vietnamese colleagues. They did not visit the Huanan market, which was located

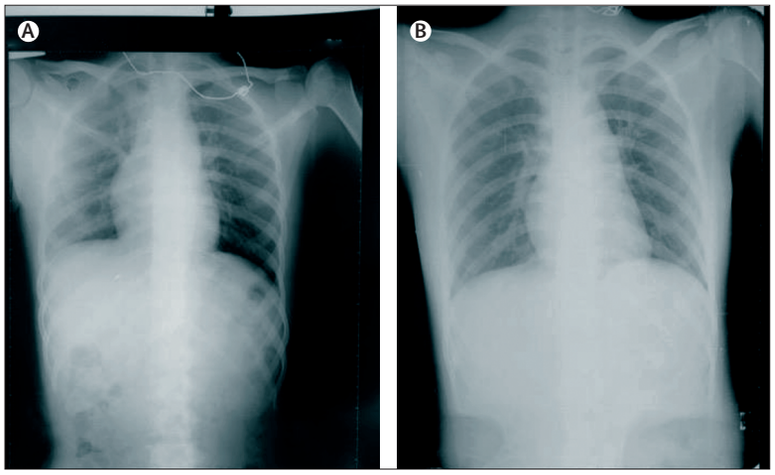

***Figure*: Patient x-ray**
(A) X-ray done at admission (January 24). (B) X-ray done 4 days after admission (January 28).

20 km away, and cannot recall contact with anyone who had influenza-like symptoms. All three individuals returned to Vietnam on the same flight. On January 23, the patient presented with coughing, sneezing, fever, and chest pain. After an initial visit to a district hospital, she was transferred to Thanh Hoa General Hospital with suspected severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection and the Thanh Hoa Provincial Center for Disease Control was informed. Her two colleagues had similar symptoms and were admitted to another hospital, where they tested positive for SARS-CoV-2. Individuals who had substantial contact with the patient and her two colleagues were quarantined and all accommodations and transit methods were decontaminated.

On admission to hospital, the patient was alert but exhausted, with mild chest pain, a temperature of 39·2°C, blood pressure of 120/70 mm Hg, a pulse of 100 beats per min, and a respiratory rate of 25 breaths per min. The patient had no crackles or bronchi rales on lung auscultation. All other clinical findings were normal. Initial laboratory tests showed a white blood cell count of $3{\cdot}7 \times 10^6$/L, a red blood cell count of $4{\cdot}28 \times 10^9$/L, a platelet count of 185×10^6/L, and a haemoglobin concentration of 127 g/L. Chest radiography showed no abnormalities (figure). The patient's serum C-reactive protein level was 6·6 mg/dL and her serum aspartate aminotransferase and alanine transferase concentrations were 28·7 U/L and 14·6 U/L, respectively. The patient's glucose concentration was 6·8 mmol/L, her serum creatinine was 66 mmol/L, and serum urea was 3·8 mmol/L. A nasopharyngeal swab specimen was obtained to detect influenza type A and B by rapid test, as well as parainfluenza types 1–3, respiratory syncytial virus, rhinovirus, adenovirus, and human metapneumovirus by RT-PCR; results were negative for all listed pathogens. A blood sample was obtained for culture and the result was negative for bacterial infection after 5 days. Malaria testing was negative, and cardiac and pleural ultrasound results were unremarkable. The patient's nasopharyngeal specimen was tested for SARS-CoV-2 by RT-PCR at the National Institute of Hygiene and Epidemiology (Hanoi, Vietnam), and the result after 6 days was positive for SARS-CoV-2.

The patient was then isolated in a negative pressure room. Treatment included ceftazidime 4 g daily, paracetamol, and 1 L of intravenous saline daily. Antibiotic treatment was discontinued after 4 days. The patient had a high fever, dry cough, and chest pain for the first 2 days. On day 3, her fever subsided and her clinical condition began to improve. On day 5, the patient's body temperature returned to normal and cough and chest pain decreased substantially. No further notable findings occurred during her 9-day hospital stay.

21 people with direct contact with this patient were also isolated. Until February 6, none of these individuals had developed symptoms. As the patient's two colleagues tested positive for SARS-CoV-2,[3] this suggested transmission via respiratory droplets.

We declare no competing interests. LVC and HTNG contributed equally to this work. Patient consent was obtained for publication.

*Le Van Cuong, Hoang Thi Nam Giang, Le Khac Linh, Jaffer Shah, Le Van Sy, Trinh Huu Hung, Abdullah Reda, Luong Ngoc Truong, Do Xuan Tien, *Nguyen Tien Huy*
tienhuy@nagasaki-u.ac.jp

Thanh Hoa General Hospital, Thanh Hoa, Vietnam (LVC, LVS, DXT); University of Da Nang, Da Nang, Vietnam (HTNG); College of Health Sciences, VinUniversity, Hanoi, Vietnam (LKL); Drexel University College of Medicine, Drexel University, Philadelphia, PA, USA (JS); Thanh Hoa Department of Health, Thanh Hoa, Vietnam (THH); Faculty of Medicine, Al-Azhar University, Cairo, Egypt (AR); Thanh Hoa Provincial Center for Disease Control, Thanh Hoa, Vietnam (LNT); and Department of Clinical Product Development, Institute of Tropical Medicine, School of Tropical Medicine and Global Health, Nagasaki University, Nagasaki 852-8523, Japan (NTH)

1 WHO. Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (2019-nCoV). Jan 30, 2019. https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov) (accessed Feb 12, 2020).

2 WHO. Novel Coronavirus (2019-nCoV) Situation Report—13. Feb 2, 2020. https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200202-sitrep-13-ncov-v3.pdf?sfvrsn=195f4010_6 (accessed Feb 12, 2020).

3 Ministry of Health. COVID-19: Latest updates, constantly. https://suckhoedoisong.vn/Virus-nCoV-cap-nhat-moi-nhat-lien-tuc-n168210.html?fbclid=IwAR2VuytNA9ed9WE3N-l5wjVGDbDN8624XiKZcGoFki175-gCc_azo8AYBEI (accessed Feb 5, 2020) (in Vietnamese).