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湖北省十堰市新型冠状病毒肺炎49例临床分析

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[摘要] **目的** 分析湖北省十堰市新型冠状病毒肺炎(coronavirus disease 2019, COVID-19)临床特点,并与近期收治流行性感冒(12例合并肺炎)患者进行比较。**方法** 收集十堰市人民医院(湖北医药学院附属人民医院)2020年1月23日至2月9日确诊的49例COVID-19患者(COVID-19组),分析其临床表现、流行病学史、实验室检查、螺旋CT(MSCT)检查结果,并与2019年12月1日至2020年1月31日治疗的31例流行性感冒(12例合并肺炎)组(流感组)进行比较和分析。**结果** (1)发热和体温变化:COVID-19组以发热为主诉占87.76%,低于流感组(96.77%,$P<0.05$);COVID-19组以低热(22例)、中度发热(21例)为主,与流感组以中度发热(12例)、高热(18例)为主不同($P<0.05$)。(2)咳嗽、咳痰:COVID-19组咳嗽、咳痰发生率为65.31%,低于流感组(93.55%,$P<0.01$)。(3)喷嚏、流涕:COVID-19组喷嚏、流涕发生率为2.04%,低于流感组(96.77%,$P<0.001$)。(4)气促、胸闷:COVID-19组发生率为12.24%,低于流感组(29.03%,$P<0.05$)。(5)乏力、纳差:COVID-19组发生率为34.69%,高于流感组(6.45%,$P<0.01$)。(6)腹泻:COVID-19组发生率为6.12%,流行性感冒(12例合并肺炎)组无腹泻病例。(7)白细胞计数(WBC):COVID-19组WBC低于正常发生率为77.55%,高于流感组(16.13%,$P<0.01$)。(8)淋巴细胞计数:COVID-19组淋巴细胞计数低于正常发生率为38.78%,高于流感组(6.45%,$P<0.01$)。(9)COVID-19组MSCT表现:1~3次MSCT检查,病灶位于双侧占91.84%,具有典型影像学表现。(10)新型冠状病毒核酸检测:第1次阳性率为77.55%,第2次总阳性率为89.80%,第3次总阳性率为97.96%,第4次阳性率为100%。**结论** 与流行性感冒相比,十堰地区COVID-19发热以低至中度为主,畏寒少见;干咳,咳痰少见;喷嚏、流涕极少见;WBC下降、淋巴细胞下降发生率不高;诊断需结合临床、流行病学、核酸检查和MSCT表现。

[关键词] 新型冠状病毒肺炎;临床症状;核酸检测;螺旋CT
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Clinical analysis of 49 cases of coronavirus disease 2019 in Shiyan, Hubei Province

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[**Abstract**] **Objective** To analyze the clinical characteristics of coronavirus disease 2019 (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in Shiyan, Hubei Province, and to compare the features with those of the recent treatment of influenza. **Methods** Forty-nine diagnosed COVID-19 patients admitted to the People's Hospital of Shiyan City from January 23 to February 9, 2020 were recruited in this study. Their clinical manifestations, epidemiological history, results of laboratory tests, and images of

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multi-slice CT (MSCT) examination were collected and analyzed, and the results were compared with the features of 31 cases of influenza virus infection (12 cases, accompanying pneumonia) during the same period. **Results** ① Fever and body temperature: Fever was the main complaint of the COVID-19 patients (87.76%), and the rate was significant lower than the influenza group (96.77%, $P<0.05$). The COVID-19 group had low fever (22 cases) and moderate fever (21 cases) which were mainly different from those with moderate fever (12 cases) and high fever (18 cases) in the influenza group ($P<0.05$). ② Cough and sputum: The incidence of cough and sputum was 65.31% in the COVID-19 group, which was significantly lower than that of the influenza group (93.55%, $P<0.01$). ③ Sneezing and rhinorrhea: The incidence in the COVID-19 group was 2.04%, obviously lower than that of the influenza group (96.77%, $P<0.001$). ④ Shortness of breath and chest tightness: The incidence was 12.24% in the COVID-19 group, and 29.03% in the influenza group ($P<0.05$). ⑤ Fatigue and anorexia: The incidence rate was 34.69% in COVID-19 group, significantly higher than that of the influenza group (6.45%, $P<0.01$). ⑥ Diarrhea: The incidence rate was 6.12% in the COVID-19 group, and no case was seen in the influenza group. ⑦ WBC count: The COVID-19 patients having a lower WBC count accounted for 77.55%, which was lower than the health control but higher than that of the influenza group (16.13%, $P<0.01$). ⑧ Lymphocyte count: 38.78% COVID-19 patients had a lower lymphocyte ratio, but only 6.45% in the influenza group ($P<0.01$). ⑨ Multi-slice CT (MSCT): All COVID-19 patients underwent 1 to 3 times of MSCT examination, and typical imaging features (bilateral lesions) were found in 91.84% patients. ⑩ Nucleic acid test: 77.55% patients were positive in the first time, 89.80% was in the second, 97.96% in the third, and 100% in the fourth. **Conclusion** Compared with influenza, COVID-19 are characterized by mainly low to moderate fever, rare chills, dry cough and sputum, very rear sneezing and runny nose, decreased WBC count, and not higher incidence of lymphocyte decline. The diagnosis needs based on the combination of clinical manifestation, epidemiological data, nucleic acid test and MSCT findings.

[**Key words**] coronavirus disease 2019; clinical symptoms; nucleic acid test; multi-slice CT

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新型冠状病毒肺炎(coronavirus disease 2019,COVID-19)病原确定为新型冠状病毒(2019 novel coronavirus,SARS-CoV-2),已被确定为乙类传染病,采取甲类传染病的预防、控制措施[1-6]。自疫情发生以来,我科共诊断 COVID-19 49 例。COVID-19 与流行性感冒一样,均为呼吸系统急性传染病。冬春季节是流行性感冒发病高峰季节(严重者合并肺炎),临床上对两者进行鉴别有重要意义。因此,本研究以近期收治的住院治疗的流行性感冒(12 例合并肺炎)患者作对照,分析 COVID-19 临床特点,为其他地区临床诊治 COVID-19 提供参考。

1 资料与方法

1.1 临床资料

收集 2020 年 1 月 23 日至 2 月 9 日在十堰市人民医院(湖北医药学院附属人民医院)感染性疾病科发热门诊和隔离病房诊断的 COVID-19 患者 49 例,诊断标准符合《新型冠状病毒肺炎诊疗方案(第 3~6 版)》[3-6],诊疗过程符合《中华人民共和国传染病防治法》和中华人民共和国国家卫生健康委员会《新型冠状病毒肺炎诊疗方案》相关规定。回顾性分析患者病史和体检、辅助检查结果。并与十堰市人民医院感染性疾病科 2019 年 12 月 1 日至 2020 年 1 月 31 日住院治疗的 31 例流行性感冒(12 例合并肺炎)进行对比分析。流行性感冒诊断标准符合《流行性感冒诊疗方案(2018 年版)》[7]。本研究得到十堰市人民医院(湖北医药学院附属人民医院)医学伦理委员会批准(批准号:syrmyy2020-602)。

1.2 检测设备

实时荧光逆转录聚合酶链反应(RT-PCR)检测设备(美国 ABI Step One Plus),新型冠状病毒(2019-nCoV)核酸检测试剂盒为上海伯杰医疗科技有限公司

生产。WBC、L-WBC、流行性感冒病毒抗原、呼吸道病原学九联检、降钙素原(PCT)、超敏C反应蛋白(hCRP)、血沉、血气分析、多层螺旋CT(MSCT)等检测使用我院常规设备。

1.3 检测指标

根据流行性感冒确诊需要,检测患者血常规、甲型/乙型流行性感冒抗原、呼吸道病原九联检、PCT、hCRP、血沉、血气分析、MSCT[7]。COVID-19患者在流行性感冒患者检测基础上加查2019-nCoV核酸(1月23日后)。

1.4 统计学分析

采用SPSS19.0统计软件,两组比较采用χ^2检验,检验水准:$\alpha=0.05$。

2 结果

2.1 一般资料

49例COVID-19患者(COVID-19组)中男性25例(51.02%),女性24例(48.98%);年龄11~80(47.9±10.8)岁。以近期住院治疗的流行性感冒(12例合并肺炎)患者31例,男性16例(53.33%),女性15例(46.67%),年龄13~79(48.6±10.4)岁。两组一般临床资料无统计学差异。

2.2 临床表现

2.2.1 体温 COVID-19患者以发热为主诉者43例(87.76%),低于流感组(30/31,96.77%,$P<0.05$)。COVID-19组低热(37.3~<38.0 ℃)22例(44.90%),中度发热(38.0~39.0 ℃)21例(42.86%),体温正常6例(12.24%),无高热病例。流感组入院时中度发热12例(38.71%),高热(39.1~41.0 ℃)18例(58.06%),体温正常1例(3.23%)。中度发热以上患者COVID-19组显著低于流行性感冒(12例合并肺炎)组,差异有统计学意义($P<0.01$)。

2.2.2 咳嗽、咳痰 COVID-19组咳嗽32例(65.31%),其中21例为干咳,11例咳白色粘痰;流行性感冒组咳嗽、咳痰29例(93.55%)。COVID-19组咳嗽、咳痰发生率明显低于流感组($P<0.01$)。

2.2.3 气促、胸闷 COVID-19组胸闷、气促患者6例(12.24%),发生率低于流感组(29.03%,9/31,$P<0.05$)。

2.2.4 乏力、纳差 COVID-19组乏力、纳差者17例(34.69%),发生率高于流行性感冒组(6.45%,2例,$P<0.01$)。

2.2.5 腹泻 COVID-19组发生腹泻3例(6.12%),流感组无腹泻病例,COVID-19组腹泻发生率高于流感组。

2.2.6 头晕、头痛 COVID-19组12例(24.49%),流感组2例(6.45%),COVID-19组头晕、头痛发生率高于流感组($P<0.01$)。

2.2.7 喷嚏、流涕 COVID-19组喷嚏、流涕患者1例(2.04%),流感组30例(96.77%),两组发生率比较差异具有统计学意义($P<0.001$)。

2.3 既往病史

COVID-19组有慢性疾病史患者18例(28例次),占全部患者36.73%,分别为冠心病(8例次)、高血压病(8例次)、2型糖尿病(4例次)、慢性支气管炎(4例次)、慢性乙型肝炎(4例次)。

2.4 流行病学史

COVID-19组中45例有近期武汉地区生活史,2例有与武汉回十堰亲属聚餐史,2例不能明确感染来源。

2.5 白细胞计数和淋巴细胞计数化验结果

2.5.1 白细胞计数(WBC) COVID-19组患者WBC计数低于正常值[(4.0~10.0)×10^9/L]38例(77.55%),正常11例(22.45%);流感组WBC计数低于正常值5例(16.13%),正常20例(64.52%),高于正常值6例(19.35%),COVID-19组WBC计数低于正常的比例高于流感组($P<0.01$)。

2.5.2 淋巴细胞计数 COVID-19组淋巴细胞计数低于正常值[(1.1~3.2)×10^9/L]19例(38.78%),正常30例(61.22%);流感组淋巴细胞计数正常11例(35.48%),高于正常值18例(58.06%),低于正常值2例(6.45%),COVID-19组淋巴细胞计数低于正常的比例显著高于流感组($P<0.01$)。

2.6 COVID-19组螺旋CT(MSCT)表现

全部病例进行1~3次MSCT检查。第1次发现肺部病变43例,阳性率87.76%;第2次发现肺部病变合计达47例,阳性率达95.92%;第3次阳性率达到100%。病灶位于双侧45例,占91.84%;单侧4例,占8.16%。以胸膜下及两下肺野多见;早期以胸膜下斑片状、团状、节段或亚段性磨玻璃影多见,常合并血管增粗穿行;进展期病灶增多、范围扩大,发展为双肺多叶受累的磨玻璃影与实变影,小叶间隔增厚及纤维化,也可呈“铺路石”征。

2.7 2019-nCoV核酸检测

第1次检测阳性率为77.55%(38/49),第2次检测总阳性率为89.80%(44/49),第3次检测总阳性率为97.96%(48/49),第4次阳性率为100%。

3 讨论

湖北省十堰市位于鄂西北,距武汉500多公里,截至2月9日,本地报告病例481例,总发病数、每日发病数、死亡病例数均居于湖北省低水平,这与本地区

COVID-19 为输入病例和二代病例有关。

2019-nCoV 核酸检测阳性是确定 COVID-19 的金标准,阴性是病原学治愈标准。目前核酸检测阳性率不高,核酸检测影响因素较多:一是检测方法的敏感性,现有检测方法总的敏感性不高;二是患者病毒载量,理论上病毒载量越高,阳性率越高;三是采样方法正确与否、运输送达是否得当(病毒的 RNA 容易降解)。强化采样、送检、检测的培训和质量控制,对可疑病例多次检查十分重要。本组核酸检测第 1 次检测阳性率为 77.55%(38/49),第 2 次检查总阳性率为 89.80%(44/49),第 3 次检查总阳性率 97.96%(48/49),第 4 次阳性率为 100%。与国内文献报告相似。

流行病学史在 COVID-19 诊断中非常重要。但第 2 代病例、输入性难辨病例(INCIP)、隐瞒个人史的病例需要引起重视。从传染病传播途径而言,只要仔细询问,ICOVID-19 是可以查明的[8]。1 例十堰居民,没有武汉出差史,因低热、咳嗽就诊,WBC 下降,淋巴细胞下降,影像学符合 COVID-19 的征象,经核酸检测确诊。询问家族史发现其丈夫半个月前在武汉开会后“感冒、咳嗽”,后在我院确诊为 COVID-19。值得注意的是有 2 例不能明确流行病史的患者,最后发现其家属作为传播媒介。

发热仍是 COVID-19 的常见症状和体征,但 COVID-19 以低热和中度发热为主,与流行性感冒以中度发热、高热为主不同;也高于其他报告 COVID-19 50%左右的发热比例。我们将在后续大样本研究中进一步分析探讨。本组以发热为主诉者占全部病例的 87.76%,入院时体温升高者也占 87.76%。说明通过发热门诊筛查,可以发现绝大多数 COVID-19 患者。如果联合呼吸道症状筛查,可以发现 95.92%(47/49)的患者。

值得注意的是,COVID-19 患者可以消化道症状就诊,本组有 2 例患者因腹泻入住消化内科,常规检查发现 WBC 下降、淋巴细胞占比下降,因处于疫情发作期,立即进行 MSCT 检查确定诊断。其他非特异性消化道症状如乏力、纳差高达 34.69%,需要引起同道注意。据文献报道人冠状病毒感染导致的下呼吸道感染患儿一般伴随消化道症状,并可以通过粪-口途径传播[9-12]。在成人还没有文献报道,发病机理有待进一步研究。

血常规化验在 COVID-19 临床诊断中具有重要价值,表现为 WBC 下降,淋巴细胞比例下降[13-14]。本组 WBC 低于正常占全部病例 77.55%,淋巴细胞下降占全部病例的 38.78%,与文献报道有所不同。临床上发现 2 例有疫区生活史,以发热、干咳为临床表现,WBC、淋巴细胞分类下降,首次 MSCT 未发现异常,在病情观察中逐渐出现肺部改变,最后通过核酸检测确定病原学诊断。对于这类患者是否可以早诊断、早隔离、早治疗成为未来研究的方向之一。

MSCT 是发现肺部炎症病变,并进而确定 COVID-19 临床诊断的手段,可以随时开展检查,具有可对比、可重复检查的优势,发现病灶的敏感性较核酸检查高[13-14],湖北省卫健委已经将其作为临床诊断的主要依据之一。但 MSCT 对 COVID-19 病因诊断的特异性不高,患者暴露于大剂量射线下,临床应用应权衡利弊。

COVID-19 临床表现不典型,与流行性感冒相比,十堰地区 COVID-19 发热以低至中度为主,畏寒少见;COVID-19 咳嗽、喷嚏、流涕等发生率低,咳嗽为干咳;消化道症状如腹泻、乏力、纳差发生率较高;WBC 下降、淋巴细胞下降发生率不高。诊断需结合临床、流行病学、核酸检查、MSCT。早发现、早诊断、早隔离、早治疗能控制病情传播,改善预后。由于我院不是 COVID-19 治疗定点医院,所有临床确诊患者的治疗转十堰市传染病医院,其治疗结果有待后续报道。

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