The role of haematological parameters in patients with COVID-19 and influenza virus infection

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Abstract

SARS-CoV-2, the causative agent of coronavirus disease 19 (COVID-19), was identified in Wuhan, China. Since then, the novel coronavirus started to be compared to influenza. The haematological parameters and inflammatory indexes are associated with severe illness in COVID-19 patients. In this study, the laboratory data of 120 COVID-19 patients, 100 influenza patients and 61 healthy controls were evaluated. The eosinophils, lymphocytes, DNI, NLR and PLR were found in COVID-19 and influenza groups compared to healthy controls. The eosinophils, lymphocytes and PLR made the highest contribution to differentiate COVID-19 patients from healthy controls (area under the curves (AUCs): 0.819, 0.817 and 0.716, respectively; P-value is <0.0001 for all). The NLR, the optimal cut-off value was 3.58, which resulted in a sensitivity of 30.8 and a specificity of 100 (AUC: 0.677, P < 0.0001). Higher leucocytes, neutrophils, DNI, NLR, PLR and lower lymphocytes, red blood cells, haemoglobin, haematocrit levels were found in severe patients at the end of treatment. Nonsevere patients showed an upward trend for lymphocytes, eosinophils and platelets, and a downward trend for neutrophils, DNI, NLR and PLR. However, there was an increasing trend for eosinophils, platelets and PLR in severe patients. In conclusion, NLR and PLR can be used as biomarkers to distinguish COVID-19 patients from healthy people and to predict the severity of COVID-19. The increasing value of PLR during follow-up may be more useful compared to NLR to predict the disease severity.

Introduction

In January 2020, the severe acute respiratory syndrome virus 2 (SARS-CoV-2) was identified in China and the disease was termed coronavirus disease 2019 (COVID-19) [1, 2]. Since then, this novel RNA beta-coronavirus began to be compared to the influenza virus. Both viruses that cause respiratory disease are transmitted by contact and droplets. A result, the same public health measures, such as hand hygiene and good respiratory etiquette are important precautions to prevent infection. It has been observed that patients with COVID-19 and influenza could experience a range of clinical manifestations, from no symptoms to severe illness [3]. Recently, it has been reported that haematological parameters and inflammatory indexes based on blood cell analysis had an important predictive value for the prognosis of infections, and many other diseases [4–6]. To date, clinical and laboratory features such as lymphopenia, elevated C-reactive protein (CRP), D-dimer and liver enzymes have been associated with severe COVID-19 [7, 8]. Moreover, haematological parameters and indexes such as the neutrophil-to-lymphocyte ratio (NLR) and platelet-to-lymphocyte ratio (PLR) were investigated as potential indicators of the severity of the COVID-19 [9, 10].

First, this study aimed to use haematological parameters (e.g. neutrophils, lymphocytes and platelets) and blood cell count indexes, particularly NLR, PLR and delta neutrophil index (DNI) to differentiate COVID-19 patients from influenza virus infection and healthy controls. Second, we analysed the alterations in laboratory parameters of 120 patients with COVID-19 to determine the predictors of severe illness.

Materials and methods

Study design and participants

The current study retrospectively enrolled 120 confirmed COVID-19 patients who were hospitalised in a tertiary hospital from 15 March to 30 April 2020. The diagnosis was confirmed by detecting SARS-CoV-2 RNA in oro-nasopharyngeal swab samples. A total of 100 patients were
diagnosed with definite influenza infection by positive nucleic acid
detection in throat swab samples of which 37 had influenza A and
24 had influenza B. The influenza group was chosen in the Northern
Hemisphere influenza season from 1 October 2018 to 1 March 2019.
Also, 61 healthy controls without any chronic disease and respira-
tory symptoms were recruited for the control group.

Demographic data and laboratory values were extracted from
electronic medical records and patients’ files. The following vari-
ables were recorded for each COVID-19 patient: age, sex, severity
assessment on admission, laboratory findings of admission and
end of treatment (the fifth day of hospitalisation). A complete
blood count (CBC) was performed using the ADVIA 2120
Hematology System (Siemens Healthcare Diagnostics, Erlangen,
Germany). Biochemical parameters were measured using
Atellica Solution Immunomassay & Clinical Chemistry Analyzers
(Siemens Healthcare Diagnostics, Erlangen, Germany). Prothrombin
time (PT), activated partial thromboplastin time, international
normalised ratio (INR) and D-dimer were analysed
using the Sysmex CS-5100 System (Siemens Healthcare Diagnostics,
Erlangen, Germany). On admission, patients with
COVID-19 were categorised into two groups (nonsevere and
severe illness) according to the National Institutes of Health
(NIH) classification based on disease severity [11].

The severe illness was defined as:

- Respiratory frequency >30 breaths per min, SpO2 <94% on room air at sea
  level, a ratio of the arterial partial pressure of oxygen to fraction of
  inspired oxygen (PaO2/FiO2) <300 or lung infiltrates >50%.

Approval from the local ethics committee was obtained for this
study (confirmation date and number: 21.05.2020/E1-20-617).
This study was conducted by the principles of the Declaration
of Helsinki.

Statistical analysis

Statistical analyses were performed using SPSS software version
24.0. Comparisons for categorical variables were executed using
the Pearson’s chi-square test or Fisher’s exact test. Kolmogorov–
Smirnov test was performed to check the normality of the con-
tinuous variables. Differences between the two groups were
compared using the Mann–Whitney U test. Kruskal–Wallis test
was used for comparisons of more than two groups and the
significant (P < 0.05) results from the Mann–Whitney test (with
post-hoc Bonferroni correction) were analysed. The receiver
operation characteristic (ROC) curve analysis was performed to
determine the efficacy of various parameters in distinguishing
the patients with COVID-19 from influenza and healthy controls.
The ROC curve analysis was also used to predict the severity of
COVID-19. Statistical significance was defined as P < 0.05.

Results

Laboratory parameters in COVID-19 and influenza patients and
healthy controls on admission

The COVID-19 group median age was higher than the influenza
group and healthy controls. There were several significant differ-
ces, including lower lymphocytes, eosinophils, basophils and pla-
telets, and higher DNI, NLR and PLR were found in COVID-19
and influenza groups compared to healthy controls. The
COVID-19 group had lower white blood cell (WBC) levels
compared to healthy controls. The influenza group had higher neu-
trrophils compared to the COVID-19 group. The influenza group
had significantly lower red blood cells (RBCs), haemoglobin and
haematocrit levels compared to the COVID-19 group and healthy
controls and higher red cell distribution width (RDW) compared to
healthy controls. The biochemical parameters, higher alanine ami-
notransferase (ALT), aspartate aminotransferase (AST) and lactate
dehydrogenase (LDH) levels were found in the COVID-19 group
compared to the influenza group and healthy controls. The increase
of CRP was observed in COVID-19 and influenza groups com-
pared to healthy controls (Table 1).

The ROC curve analysis was performed to distinguish the
patients with COVID-19 from healthy controls. Eosinophils, lym-
phocytes and PLR had the highest area under the curves (AUCs)
in the ROC analysis (0.819, 0.817 and 0.716, respectively; P-value
< 0.0001 for all). The NLR, the optimal cut-off value was 3.58,
which resulted in a sensitivity of 30.8 and a specificity of 100
(AUC: 0.677, P < 0.0001).

To distinguish the patients with COVID-19 from influenza,
the ROC curve was used. PLR, NLR and lymphocytes had the
highest AUCs in the ROC analysis (0.746, 0.730 and 0.729,
respectively; P-value < 0.0001 for all).

Laboratory parameters on admission and end of treatment
day with COVID-19 severity

On admission, patients with COVID-19 were categorised as non-
severe (n = 85) and severe (n = 35) groups. The severe group had
an older median age compared to the nonsevere group (P <
0.001). The optimal cut-off value of age was found to be >48
when the ROC curve analysis was used (P < 0.0001, AUC: 0.82,
sensitivity: 85.71, specificity: 71.76). The presence of hyperten-
sion, coronary artery disease and chronic obstructive pulmonary
disease (COPD) was more common in the severe group signifi-
cantly (P = 0.003, 0.022, 0.036, respectively). Higher leucocytes,
neutrophils, AST, LDH, creatinine kinase (CK), PT, INR,
D-dimer, CRP, interleukin-6 (IL-6), ferritin, NLR and PLR, and
lower lymphocyte levels were found in the severe group on admis-
sion (Tables 2 and 3).

Higher leucocytes, neutrophils, DNI, NLR, PLR and platelets,
and lower lymphocytes, RBCs, haemoglobin and haematocrit
levels were found in the severe group at the end of treatment
(Table 3).

In comparison of the admission and end of treatment labora-
tory values for each group, a significant increase of lymphocytes,
eosinophils and platelets, and a decrease of neutrophils, DNI,
NLR and PLR were found in the nonsevere group. In the severe
group, a significant increase in eosinophils, platelets and PLR
was found. A downward trend in RBC, haemoglobin and haem-
atocrit levels was found in nonsevere and severe groups (Table 4).

Discussion

Since the SARS-CoV-2 was identified, this novel virus began to be
compared to influenza. First, we described laboratory parameters
in COVID-19 and influenza patients with healthy controls. Also,
the admission and end of treatment (the fifth day of hospitalisa-
tion) values of these laboratory parameters were investigated in
COVID-19 patients with disease severity.

In recent years, several biomarkers of systemic inflammation
have become available as part of the expanded CBC. These bio-
markers based on CBC are investigated in several areas because
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Normal range (unit)</th>
<th>Healthy controls (n = 61)</th>
<th>Influenza group (n = 100)</th>
<th>COVID-19 group (n = 120)</th>
<th>$\chi^2$</th>
<th>$P$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>–</td>
<td>28 (24–56)</td>
<td>28 (16–66)</td>
<td>45 (16–83)</td>
<td>78.264</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Male gender</td>
<td>–</td>
<td>34 (55.7%)</td>
<td>33 (33%)</td>
<td>72 (60%)</td>
<td>17.133</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Leucocytes</td>
<td>4200–10 800 (/$\mu$l)</td>
<td>6830 (3940–11 660)</td>
<td>5695 (2500–15 370)</td>
<td>5370 (2230–16 520)</td>
<td>16.222</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Neutrophils</td>
<td>1700–7900 (/$\mu$l)</td>
<td>4090 (1950–7530)</td>
<td>4385 (1150–12 960)</td>
<td>3365 (1110–13 770)</td>
<td>9.699</td>
<td>0.008</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>1500–4500 (/$\mu$l)</td>
<td>1960 (1020–3920)</td>
<td>795 (160–2750)</td>
<td>1265 (390–3030)</td>
<td>104.539</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Monocytes</td>
<td>100–900 (/$\mu$l)</td>
<td>380 (190–780)</td>
<td>425 (110–1240)</td>
<td>380 (40–1380)</td>
<td>5.077</td>
<td>0.079</td>
</tr>
<tr>
<td>Eosinophils</td>
<td>20–550 (/$\mu$l)</td>
<td>110 (30–620)</td>
<td>40 (0–440)</td>
<td>40 (0–290)</td>
<td>61.572</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Basophils</td>
<td>0–200 (/$\mu$l)</td>
<td>40 (10–200)</td>
<td>30 (0–330)</td>
<td>20 (0–600)</td>
<td>13.223</td>
<td>0.001</td>
</tr>
<tr>
<td>RBCs</td>
<td>4.3–5.75 (10^12/l)</td>
<td>5.06 (3.79–7.02)</td>
<td>4.54 (2.97–5.79)</td>
<td>4.87 (3.97–5.82)</td>
<td>22.988</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>13–16.6 (g/dl)</td>
<td>15 (10–17.3)</td>
<td>13.15 (7.4–17.4)</td>
<td>14.3 (9.6–17.7)</td>
<td>26.389</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Haematocrit</td>
<td>38–49 (%)</td>
<td>43.7 (31–49.6)</td>
<td>39 (26.3–48.9)</td>
<td>41.1 (15.2–52.5)</td>
<td>24.021</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>RDW</td>
<td>11.5–16 (%)</td>
<td>13.1 (12–15.9)</td>
<td>13.6 (11.9–19.8)</td>
<td>13.4 (11.7–27.3)</td>
<td>6.404</td>
<td>0.041</td>
</tr>
<tr>
<td>Platelets</td>
<td>16 000–383 000 (/$\mu$l)</td>
<td>254 000 (166 000–602 000)</td>
<td>227 000 (47 000–489 000)</td>
<td>219 500 (119 000–506 000)</td>
<td>14.097</td>
<td>0.001</td>
</tr>
<tr>
<td>Platecrit</td>
<td>0.12–0.36 (%)</td>
<td>0.21 (0.14–0.46)</td>
<td>0.18 (0.04–0.33)</td>
<td>0.18 (0.1–0.41)</td>
<td>18.934</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DNI</td>
<td>(%)</td>
<td>0.1 (0.1–0.82)</td>
<td>0.1 (0.1–1.2)</td>
<td>0.1 (0.1–9.5)</td>
<td>30.663</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>NLR</td>
<td>–</td>
<td>1.89 (0.82–3.59)</td>
<td>5.72 (0.98–54)</td>
<td>2.61 (0.47–15.54)</td>
<td>64.398</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PLR</td>
<td>–</td>
<td>130 (60–230)</td>
<td>290 (70–1050)</td>
<td>180 (60–620)</td>
<td>82.671</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>ALT</td>
<td>&lt;50 (U/l)</td>
<td>20.5 (10–85)</td>
<td>21 (5–71)</td>
<td>25 (3–199)</td>
<td>17.766</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>AST</td>
<td>&lt;35 (U/l)</td>
<td>20 (10–41)</td>
<td>23 (1–61)</td>
<td>24 (1–188)</td>
<td>7.399</td>
<td>0.025</td>
</tr>
<tr>
<td>LDH</td>
<td>120–246 (U/l)</td>
<td>181 (135–361)</td>
<td>193 (42–327)</td>
<td>217.5 (123–697)</td>
<td>31.081</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CK</td>
<td>32–294 (U/l)</td>
<td>95 (49–361)</td>
<td>87 (32–1090)</td>
<td>104 (26–2183)</td>
<td>0.244</td>
<td>0.885</td>
</tr>
<tr>
<td>CRP</td>
<td>0–5 (g/l)</td>
<td>0.9 (0.1–24)</td>
<td>14.5 (3–299)</td>
<td>8 (0.6–198)</td>
<td>59.394</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

RDW, red cell distribution width; MPV, mean platelet volume; DNI, delta neutrophil index; NLR, neutrophil-to-lymphocyte ratio; PLR, platelet-to-lymphocyte ratio; ALT, alanine aminotransferase; AST, aspartate aminotransferase; LDH, lactate dehydrogenase; RBCs, red blood cells; CRP, C-reactive protein; CK, creatinine kinase.

Pearson’s $\chi^2$, Kruskal-Wallis $H$ analysis. Data are $n$ (%) or median (min-max).
Table 2. Demographics and laboratory findings of patients with COVID-19

<table>
<thead>
<tr>
<th></th>
<th>Total (n = 120)</th>
<th>Nonsevere group (n = 85)</th>
<th>Severe group (n = 35)</th>
<th>χ²/Z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>45 (16–83)</td>
<td>39 (16–75)</td>
<td>59 (37–83)</td>
<td>−5.591</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Male gender</td>
<td>72 (60)</td>
<td>52 (61.2)</td>
<td>20 (57.1)</td>
<td>0.168</td>
<td>0.682</td>
</tr>
<tr>
<td>Diabetes</td>
<td>12 (10)</td>
<td>6 (7.1)</td>
<td>6 (17.1)</td>
<td>2.801</td>
<td>0.106</td>
</tr>
<tr>
<td>Hypertension</td>
<td>26 (21.7)</td>
<td>12 (14.1)</td>
<td>14 (40)</td>
<td>9.785</td>
<td>0.003</td>
</tr>
<tr>
<td>CAD</td>
<td>7 (5.8)</td>
<td>2 (2.4)</td>
<td>5 (14.3)</td>
<td>6.426</td>
<td>0.022</td>
</tr>
<tr>
<td>COPD</td>
<td>16 (13.3)</td>
<td>7 (8.2)</td>
<td>8 (22.9)</td>
<td>4.846</td>
<td>0.036</td>
</tr>
<tr>
<td>ALT</td>
<td>25 (3–199)</td>
<td>23 (3–199)</td>
<td>34 (10–112)</td>
<td>−1.958</td>
<td>0.05</td>
</tr>
<tr>
<td>AST</td>
<td>24 (1–188)</td>
<td>21 (1–188)</td>
<td>36 (11–85)</td>
<td>−4.896</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>LDH</td>
<td>217.5 (123–697)</td>
<td>202 (123–506)</td>
<td>320 (185–697)</td>
<td>−6.386</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CK</td>
<td>104 (26–2183)</td>
<td>93 (26–1102)</td>
<td>140 (28–2183)</td>
<td>−2.446</td>
<td>0.14</td>
</tr>
<tr>
<td>PT</td>
<td>12.1 (10.5–18.7)</td>
<td>12 (10.5–14.4)</td>
<td>12.7 (10.7–18.7)</td>
<td>−2.842</td>
<td>0.004</td>
</tr>
<tr>
<td>APTT*</td>
<td>25.1 (5.9–43.2)</td>
<td>25.3 (5.9–43.2)</td>
<td>24.75 (19–31.4)</td>
<td>−1.116</td>
<td>0.265</td>
</tr>
<tr>
<td>INRb</td>
<td>1.02 (0.86–1.62)</td>
<td>1.02 (0.86–1.23)</td>
<td>1.08 (0.91–1.62)</td>
<td>−3.014</td>
<td>0.003</td>
</tr>
<tr>
<td>D-dimer*</td>
<td>0.4 (0.05–28.49)</td>
<td>0.34 (0.05–2.93)</td>
<td>0.65 (0.22–28.49)</td>
<td>−4.653</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>CRP</td>
<td>8 (0.6–198)</td>
<td>5 (0.7–153)</td>
<td>55 (0.6–198)</td>
<td>−5.809</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>IL-6d</td>
<td>21.2 (2–118)</td>
<td>3 (2–19)</td>
<td>28.6 (2.69–118)</td>
<td>−3.416</td>
<td>0.001</td>
</tr>
<tr>
<td>Ferritin*</td>
<td>127.5 (5.2–1580)</td>
<td>84.9 (5.2–823)</td>
<td>330 (30.8–1580)</td>
<td>−5.498</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

ALT, alanine aminotransferase; AST, aspartate aminotransferase; LDH, lactate dehydrogenase; APTT, activated partial thromboplastin time; INR, international normalised ratio; CRP, C-reactive protein; PT, prothrombin time; CK, creatinine kinase; IL-6, interleukin-6.

Pearson’s χ², Fisher’s exact test, Mann-Whitney U analysis. Data are n (%)/median (min–max).

*Normal range: 21–32 sn.
*Normal range: 0.8–1.2.
*Normal range: <0.55 mg/l.
*Normal range: 0.3–4 pg/dl.
*Normal range: 10–291 µg/l.

they are simple and low cost, so many clinicians can easily use it in practice. According to the studies conducted with COVID-19 the haematology laboratory plays an important role in providing various useful prognostic markers [12]. In the current study, lower lymphocytes, eosinophils, basophils and platelets, and higher DNI, NLR and PLR were found in COVID-19 and influenza groups compared to healthy controls. Lymphopenia has been a common finding in influenza infection [6]. Lymphopenia has also been a common finding in patients with COVID-19 [13]. Eosinophils which are a small part of leucocytes have been shown to have various other functions, including immunoregulation and antiviral activity. It has been reported in studies that eosinopenia was detected in COVID-19 patients and may help predict severe prognosis [14, 15]. NLR and PLR were found to be useful indicators for diagnosis and differentiation of influenza A infection [16]. Yang et al. investigated the diagnostic and predictive role of NLR and PLR in COVID-19 patients, and they found these indexes were useful [10].

Our findings showed that parameters including eosinophils, lymphocytes and PLR made the highest contribution to differentiate the COVID-19 patients from healthy controls. Similarly, Sun et al. showed lower eosinophils and lymphocytes, and a higher PLR in patients with COVID-19 compared to controls [17]. The lymphocytes, NLR and PLR values were seen as more useful than other parameters to distinguish patients with COVID-19 from influenza according to this study.

The DNI, which is a calculated parameter that reflects the ratio of immature granulocytes over total neutrophil count in the peripheral blood, was previously reported to be more predictive of infection and prognosis than WBC counts and CRP [18]. In this study, the increase of DNI was observed in both COVID-19 and influenza groups compared to healthy controls. The DNI may be a useful parameter for viral respiratory infections compared to other various leucocyte-related parameters such as the total WBC and neutrophil counts.

Currently, it is well known that influenza viruses can agglutinate erythrocytes by binding to sialic acid receptors on the host cell [19]. Our data demonstrated that the influenza group had lower RBC, haemoglobin and haematocrit levels compared to the COVID-19 group and healthy controls. Higher RDW was found in influenza patients compared to healthy controls, although there was no difference between the COVID-19 group and the other groups. Topaz et al. showed that higher RDW was a predictor of severe hospital complications in patients with influenza [20]. Foy et al. showed a relation between elevated RDW (>14.5%) and mortality in COVID-19 patients [21]. One centre study showed that there was no difference in RBC and haemoglobin levels in COVID-19 patients compared to controls [22]. However, it is not yet fully known whether SARS-CoV-2 affects erythrocytes.

The biochemical parameters, higher ALT, AST and LDH levels were found in the COVID-19 group compared to the influenza group and healthy controls. This situation can be explained by pneumonia and severe infection would be higher in COVID-19 compared to what is observed for influenza infection. The increase of CRP was observed in COVID-19 and influenza groups compared to healthy controls. CRP is used clinically as a
### Table 3. Admission and end of treatment laboratory parameters of patients with COVID-19

<table>
<thead>
<tr>
<th></th>
<th>Admission</th>
<th>End of Treatment</th>
<th>Nonsevere group (n = 85)</th>
<th>Severe group (n = 35)</th>
<th>Z</th>
<th>P</th>
<th>Nonsevere Group (n = 85)</th>
<th>Severe Group (n = 35)</th>
<th>Z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leucocytes</td>
<td>5150 (2230–10 850)</td>
<td>5970 (2810–16 520)</td>
<td>−1.986</td>
<td>0.047</td>
<td></td>
<td></td>
<td>5410 (662–11 770)</td>
<td>6710 (3460–14 340)</td>
<td>−3.456</td>
<td>0.001</td>
</tr>
<tr>
<td>Neutrophils</td>
<td>3110 (1110–8120)</td>
<td>4270 (1740–13 770)</td>
<td>−3.199</td>
<td>0.001</td>
<td></td>
<td></td>
<td>2830 (4040–7090)</td>
<td>4390 (3370–13 270)</td>
<td>−4.570</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>1330 (390–3030)</td>
<td>1090 (560–2070)</td>
<td>−3.057</td>
<td>0.002</td>
<td></td>
<td></td>
<td>1770 (390–3800)</td>
<td>1080 (240–2690)</td>
<td>−4.885</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Monocytes</td>
<td>380 (40–940)</td>
<td>330 (40–1380)</td>
<td>−1.58</td>
<td>0.114</td>
<td></td>
<td></td>
<td>350 (140–890)</td>
<td>400 (190–770)</td>
<td>−1.395</td>
<td>0.163</td>
</tr>
<tr>
<td>Eosinophils</td>
<td>40 (0–290)</td>
<td>30 (0–150)</td>
<td>−1.637</td>
<td>0.102</td>
<td></td>
<td></td>
<td>80 (0–320)</td>
<td>90 (10–310)</td>
<td>−0.477</td>
<td>0.633</td>
</tr>
<tr>
<td>Basophils</td>
<td>20 (0–170)</td>
<td>30 (0–600)</td>
<td>−1.239</td>
<td>0.215</td>
<td></td>
<td></td>
<td>20 (0–160)</td>
<td>20 (10–70)</td>
<td>−1.746</td>
<td>0.081</td>
</tr>
<tr>
<td>RBCs</td>
<td>4.93 (3.98–5.82)</td>
<td>4.81 (3.97–5.79)</td>
<td>−1.62</td>
<td>0.105</td>
<td></td>
<td></td>
<td>4.72 (3.88–5.89)</td>
<td>4.57 (3.68–5.83)</td>
<td>−2.523</td>
<td>0.012</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>14.5 (9.6–17.7)</td>
<td>13.8 (11.2–17.4)</td>
<td>−1.733</td>
<td>0.083</td>
<td></td>
<td></td>
<td>13.8 (9.2–17.9)</td>
<td>12.6 (10.1–15.7)</td>
<td>−2.392</td>
<td>0.001</td>
</tr>
<tr>
<td>Haematocrit</td>
<td>42 (15.2–52.5)</td>
<td>40.2 (33.9–49.7)</td>
<td>−1.952</td>
<td>0.051</td>
<td></td>
<td></td>
<td>40.5 (29.8–53.5)</td>
<td>37.7 (31.1–96.6)</td>
<td>−2.339</td>
<td>0.019</td>
</tr>
<tr>
<td>RDW</td>
<td>13.3 (11.7–27.3)</td>
<td>13.5 (12.3–17.1)</td>
<td>−1.497</td>
<td>0.135</td>
<td></td>
<td></td>
<td>13.3 (11.9–17.6)</td>
<td>13.4 (12.1–17.2)</td>
<td>−1.381</td>
<td>0.167</td>
</tr>
<tr>
<td>Platelets</td>
<td>217000 (119000–488000)</td>
<td>221000 (131000–506000)</td>
<td>−0.110</td>
<td>0.913</td>
<td></td>
<td></td>
<td>231000 (104000–441000)</td>
<td>357000 (135000–654000)</td>
<td>−5.280</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Platecrit</td>
<td>0.18 (0.1–0.37)</td>
<td>0.18 (0.1–0.41)</td>
<td>−0.287</td>
<td>0.774</td>
<td></td>
<td></td>
<td>0.19 (0.08–0.37)</td>
<td>0.28 (0.12–0.57)</td>
<td>−5.283</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>DNI</td>
<td>0.1 (0.1–9.5)</td>
<td>0.1 (0.1–4.4)</td>
<td>−1.794</td>
<td>0.073</td>
<td></td>
<td></td>
<td>0.1 (0.1–5.5)</td>
<td>0.1 (0–6.4)</td>
<td>−2.211</td>
<td>0.027</td>
</tr>
<tr>
<td>NLR</td>
<td>2.31 (0.47–9.63)</td>
<td>4.04 (1.51–15.54)</td>
<td>−4.027</td>
<td>&lt;0.001</td>
<td></td>
<td></td>
<td>1.52 (0.57–7.29)</td>
<td>3.72 (0.64–40)</td>
<td>−6.12</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PLR</td>
<td>170 (60–620)</td>
<td>220 (100–490)</td>
<td>−2.792</td>
<td>0.005</td>
<td></td>
<td></td>
<td>130 (60–420)</td>
<td>300 (300–940)</td>
<td>−5.782</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

CAD, coronary artery disease; COPD, chronic obstructive pulmonary disease; RDW, red cell distribution width; DNI, delta neutrophil index; NLR, neutrophil-to-lymphocyte ratio; PLR, platelet-to-lymphocyte ratio; RBCs, red blood cells. Mann–Whitney U analysis. Data are median (min-max).
Table 4. Evaluation of the admission and end of treatment laboratory parameters in nonsevere and severe groups with COVID-19

<table>
<thead>
<tr>
<th></th>
<th>Nonsevere group (n = 85)</th>
<th></th>
<th>Severe group (n = 35)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admission</td>
<td>End of treatment</td>
<td>Z</td>
<td>P</td>
</tr>
<tr>
<td>Leucocytes</td>
<td>5150 (2230–10 850)</td>
<td>5410 (662–11 770)</td>
<td>−0.082</td>
<td>0.935</td>
</tr>
<tr>
<td>Neutrophils</td>
<td>3110 (1110–8120)</td>
<td>2830 (4040–7090)</td>
<td>−2.498</td>
<td>&lt;0.013</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>1330 (390–3030)</td>
<td>1770 (390–3800)</td>
<td>−5.258</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Monocytes</td>
<td>380 (40–940)</td>
<td>350 (140–890)</td>
<td>−0.875</td>
<td>0.382</td>
</tr>
<tr>
<td>Eosinophils</td>
<td>40 (0–290)</td>
<td>80 (0–320)</td>
<td>−4.391</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Basophils</td>
<td>20 (0–170)</td>
<td>20 (0–160)</td>
<td>−1.251</td>
<td>0.211</td>
</tr>
<tr>
<td>RBCs</td>
<td>4.93 (3.98–5.82)</td>
<td>4.72 (3.88–5.89)</td>
<td>−4.307</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>14.5 (9.6–17.7)</td>
<td>13.8 (9.2–17.9)</td>
<td>−4.617</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Haematocrit</td>
<td>42 (15.2–52.5)</td>
<td>40.5 (29.8–53.5)</td>
<td>−3.874</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>RDW</td>
<td>13.3 (11.7–27.3)</td>
<td>13.3 (11.9–17.6)</td>
<td>−1.855</td>
<td>0.064</td>
</tr>
<tr>
<td>Platelets</td>
<td>217000 (119000–488000)</td>
<td>231000 (104000–441000)</td>
<td>−2.268</td>
<td>0.023</td>
</tr>
<tr>
<td>Platecrit</td>
<td>0.18 (0.1–0.37)</td>
<td>0.19 (0.08–0.37)</td>
<td>−2.123</td>
<td>0.034</td>
</tr>
<tr>
<td>DNI</td>
<td>0.1 (0.1–9.5)</td>
<td>0.1 (0.1–5.5)</td>
<td>−2.769</td>
<td>0.006</td>
</tr>
<tr>
<td>NLR</td>
<td>2.31 (0.47–9.63)</td>
<td>1.52 (0.57–7.29)</td>
<td>−5.335</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>PLR</td>
<td>170 (60–620)</td>
<td>130 (60–420)</td>
<td>−4.237</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

RDW, red cell distribution width; MPV, mean platelet volume; PDW, platelet distribution width; DNI, delta neutrophil index; NLR, neutrophil-to-lymphocyte ratio; PLR, platelet-to-lymphocyte ratio; RBCs, red blood cells.

Wilcoxon’s signed ranks analysis. Data are median (min-max).
bm10 for various inflammatory conditions; a rise in CRP levels is determined in both COVID-19 and influenza groups.

Older age, hypertension, coronary artery disease and COPD were reported in various studies as predictors for severe COVID-19 similar to this study [23–26]. In this study, higher leucocytes, neutrophils, AST, LDH, CK, PT, INR, D-dimer, CRP, IL-6, ferritin, NLR and PLR, and lower lymphocyte levels were found in the severe group on admission. The comprehensive review by Kermali et al. mentioned that the increase of NLR, CRP, LDH and IL-6, and the decrease of lymphocyte was associated with severe COVID-19 [8]. Liu et al. showed that on admission, the levels of IL-6, CRP, LDH and ferritin were closely related to the severity of COVID-19. Virus-infected cells lead to cytokine storm and this is observed as an increase in IL-6 levels in COVID-19 [27, 28]. A study showed that when LDH and CRP levels were correlated with computed tomography scans, significantly higher levels reflected the severity of pneumonia [29]. Our analysis also revealed that NLR and PLR might be used to evaluate severe patients with COVID-19. The optimal cut-off values for PLR and NLR were 230 ($P < 0.0001$, AUC: 0.734, sensitivity: 77.14, specificity: 58.82) and 2.47 ($P = 0.005$, AUC: 0.663, sensitivity: 45.71, specificity: 89.41), respectively, in this study. Yang et al. found that the optimal cut-off values were 3.3 and 180 for NLR and PLR, respectively. Also, they highlighted that NLR and age are recommended as practical tools to evaluate the severity of COVID-19 patients [10].

Significantly higher leucocytes, neutrophils, DNI, NLR, PLR and platelets, and lower lymphocytes, RBC, haemoglobin and haematocrit levels were found in the severe group at the end of treatment. With these results, it can be said that the impairment in haematological parameters is related to the severity of COVID-19. When the difference in the laboratory values between admission and end of treatment was evaluated, a downward trend in RBC, haemoglobin and haematocrit levels was found in nonsevere and severe groups. The previous studies reported that lower haemoglobin levels were shown in patients with COVID-19 [17, 30]. These findings can suggest that SARS-CoV-2 may affect the RBC system in accordance with the previous studies [17]. Nonsevere patients showed an upward trend for lymphocytes, eosinophils and platelets, and a downward trend for neutrophils. However, severe patients had an increasing trend with eosinophils, platelets and PLR. Similarly, Liu et al. observed that 13 severe cases showed significant and sustained decreases in lymphocytes count but increases in neutrophil counts than 27 mild cases [28]. Chen et al. showed that restored levels of lymphocytes, eosinophils and platelets could serve as the predictors of recovery, whereas progressive increases in neutrophils, basophils and IL-6 were risk factors for fatal outcomes of COVID-19 [15]. These results suggest that an insufficient improvement in abnormal laboratory parameters may be a predictor for severe illness. In severe patients, although no change was observed in DNI and NLR at the end of treatment, the increase in PLR was detected. This situation can be interpreted as elevated PLR progression is more useful than NLR and DNI to predict the disease severity. No relation was found between eosinophil counts and the severity of the disease. On the other hand, the increase was shown in eosinophils between admission and end of treatment day in severe and nonsevere groups. A study that evaluated 10 COVID-19 patients showed that eosinophil values were low on admission, then all returned to normal before discharge [31].

In conclusion, respiratory infections are common and one of the leading causes of morbidity and mortality. Of respiratory infections, influenza is the most well studied viral infection and is commonly reported as the cause of epidemics. However, since the beginning of 2020, SARS-CoV-2 has become the most researched respiratory infection. The current study revealed that blood cell count analysis is a simple, cost-effective and rapid laboratory diagnostic basis for evaluating infectious inflammatory responses to respiratory infection. Also, the parameters based on CBC can be useful to predict the severity and the course of COVID-19.

**Supplementary material.** The supplementary material for this article can be found at https://doi.org/10.1017/S095026882000271X.

**Author contributions.** SK conceived the idea of the study and coordinated the data collection. SK and BOO performed statistical analyses and interpretation of the results. SK contributed to the literature search, discussing the results and writing the manuscript. AB and HB helped in drafting and revising the manuscript. BOO and NK participated in data collection and analysis. All authors have read and approved the final manuscript.

**Conflict of interest.** The authors declare no conflicts of interest.

**Data availability statement.** The authors confirm that the data supporting the findings of this study are available in the Supplementary materials.

**References**

15. Chen R et al. (2020) Longitudinal hematologic and immunologic variations associated with the progression of COVID-19 patients in China. *Journal of Allergy and Clinical Immunology* 146, 89–100.


