

Perspective: COVID-19 and Its Neurologic Sequelae

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Abstract

COVID-19 led to a catastrophic, international, public health crisis after its first detection in 2019 [1]. Though it is primarily a respiratory virus, it impacts the central and peripheral nervous systems leading to further COVID-19-associated disability [2]. This Perspective reviews our current understanding of the neurological sequelae of COVID-19 and the gaps in our understanding of their treatment and epidemiology.

Keywords

COVID-19, Neurology, Stroke, SARS-CoV-2, Pandemic

Introduction

COVID-19, the viral illness caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), led to a catastrophic, international, public health crisis after its first detection in 2019 [1]. The virus has infected over 250 million people worldwide and has taken the lives of over 6 million people [3,4]. Though it is primarily a respiratory virus, it impacts several organ systems, including the central and peripheral nervous systems. Neurological sequelae of the virus represent a critical contribution to COVID-19-associated disability [2].

Coronaviruses like SARS-CoV-2 lead to neurologic sequelae either directly--through viral infection--or indirectly--via immune mediated mechanisms.

Table 1: Pooled prevalence of select neurological sequelae during COVID-19 infection based on meta-analyses.

Neurological Symptoms/ Diagnoses	Pooled Prevalence
Seizures	1-4.05% [29,30]
Encephalopathy	7-23.5% [29,30]
Ischemic stroke	1.3-3% [31-33]
Hemorrhagic stroke	0.4-0.6% [32,33]
Olfactory dysfunction	19-55% [29,30,34]
Gustatory dysfunction	21-41% [29,30,34,35]
Headache	13-47.1% [29,30,36,37]
Fatigue	32-37.8% [29,30,36]
Peripheral Neuropathy	1% [30]
Cognitive impairment	2% [30]

Directly, viral particles can invade the nervous system via the olfactory tract thus activating macrophages, microglia and astrocytes resulting in direct cell damage or meningitis/encephalitis [5]. Indirectly, immune-mediated, post-infectious effects include pathologies such as Guillain-Barre syndrome (GBS), transverse myelitis, and optic neuritis [5,6].

A range of neurologic manifestations of SARS-CoV-2 have been reported during and after infection (Table 1 and Table 2). The prevalence of neurological disorders among all hospitalized patients with COVID-19 was 13.5%, and these included toxic-metabolic encephalopathy (51% of those with neurological disorders), stroke (14%), and seizures (12%) among others [7].

The incidence of encephalopathy in hospitalized patients with COVID-19 ranges widely from 7-69%. Although the vast majority of patients experience an improvement in mentation following medical management, COVID-19 associated encephalopathy is associated with an increased risk of mortality [8].

Stroke is one of the most commonly reported acute effects of COVID-19. At one institution, 2.4% of hospitalized patients with COVID-19 had ischemic stroke while 0.9% had intracranial hemorrhage [9]. Other studies demonstrated an ischemic stroke rate in hospitalized patients with COVID-19 of 0.5% to 1.6% [7]. Moreover, patients with COVID-19 suffer more severe strokes, with higher mortality than their non-infected counterparts (39.3% vs. 16.1%)--though this was likely subject to potential bias in early reporting [10].

Table 2: Pooled prevalence of select neurological sequelae after COVID-19 infection based on meta-analyses.

Neurological Symptoms/Diagnoses	Pooled Prevalence
Sleep disturbance	11-27.4% [38-40]
Olfactory dysfunction	7-15.1% [39,40]
Dizziness	2.9-9.7% [38,39]
Headache	6.6-44% [37,38,41]
Fatigue	23-58% [38-42]
Cognitive impairment	14-22% [38-40,42]

Acute, symptomatic seizures are reported in fewer than 1% of patients with COVID-19, indicating that the risk of seizures is rarer than with other viral diseases such as SARS (Severe Acute Respiratory Syndrome) or MERS (Middle East Respiratory Syndrome) [11]. However, in a meta-analysis of hospitalized COVID-19 patients there was a 20.3% prevalence of epileptiform discharges on EEG, an indication of seizure potential. COVID-19 may also affect the seizure frequency of those with underlying seizure disorders but the extent to which it does remains uncertain [8,12].

These acute and severe neurological manifestations of COVID-19 clearly impact clinical outcomes and prognosis. In a study of hospitalized patients with COVID-19, in-hospital mortality was 15.3% in patients who presented with COVID-19 and associated neurological manifestations. Moreover, patients with severe neurological manifestations, including encephalopathy or stroke, experienced a mortality rate of 37.4% compared to 11.9% in those who had minor neurologic manifestations during infection [7]. The relationship between acute COVID-19 associated neurological symptoms and mortality, in addition to respiratory failure and ICU admission, was confirmed in other reports [13]. However, sepsis from other infections with concomitant neurologic symptoms portends a poorer prognosis, too [14]. Thus, it is not clear how specific this connection between neurologic symptoms and poor prognosis is to COVID-19 compared to other infectious sources.

In addition to the neurological manifestations seen during acute COVID-19 infection, some patients develop less severe, yet distressing, neurologic sequelae from the virus which can last beyond the infectious period. Headache is one of the most common neurologic manifestations in COVID-19, reported in nearly half of patients with the virus [5,15]. Olfactory and gustatory dysfunction as well as cognitive and mental health difficulties have also been reported [16]. Anosmia and hyposmia were reported by 48.23% of COVID-19 patients in one study while 83.38% had decreased taste sensation within 4 weeks from the onset of infection [15]. The incidence of anosmia or gustatory dysfunction also varies depending on the circulating variant. Indeed, the reported risk of olfactory dysfunction ranges from 5-98% [5]. Most patients do recover these senses partially if not wholly over the course of weeks [17]. Cognitive symptoms are common and widely documented, too. In patients with symptoms 4 months after COVID-19 infection, 67% demonstrated 1 or more abnormally low cognitive scores, with processing speed being the most common deficit [18]. In a prospective case-control study, cognitive status using the MoCA (Montreal Cognitive Assessment) at 6 months was worse among survivors of COVID-19 than age, sex, and ICU status-matched controls [19].

Many COVID-19-associated neurological symptoms persist long after the respiratory process passes. One year after COVID-19 infection, persistent neurological sequelae were reported in 12% of patients; symptoms included fatigue, concentration difficulties, forgetfulness, sleep disturbances, limb weakness, and headache in descending order of prevalence [20]. A year following severe COVID-19, 87% of patients had ongoing abnormalities in functional, cognitive, or neurological quality of life metrics [21]. Nevertheless, the natural history of COVID-19 neurological sequelae is still being written and is further complicated by subjective symptom reporting [22].

Conclusion

Neurological manifestations of COVID-19, both direct and indirect, are critical to the clinical impact of the virus. Patients who contract the virus, particularly those that are hospitalized, have an increased risk of stroke, encephalopathy, headache, dizziness, loss of smell and taste, and cognitive sequelae. And while the quality of the studies pointing to these risks vary based on their methodology and design, there seems to be some connection between COVID-19 and neurological symptoms. Moreover, those who develop neurological symptoms or have an underlying neurological disease have an increased risk of poor outcomes, including death [7]. Furthermore, the COVID-19 pandemic significantly strained systems of acute neurologic care and such impacts extend beyond the peak period of the pandemic [23-25]. Potential solutions to reduce this impact have been proposed, but their effectiveness has yet to be demonstrated [26-28]. Thus, while we collect more epidemiological data to parse out quantitative risk for symptoms and outcomes in the population, we ought to look for proven methods to mitigate that risk and the resultant adverse outcomes.

Indeed, there is much that is required from clinical research to improve neurological outcomes in COVID-19 patients. We need further investigation into the relationship between COVID-19 and neurology. But we also need to understand how to treat neurological sequelae and how our approach to COVID-19, our antiviral therapies, and even our vaccines, affect neurological outcomes. This presents the next challenge for neurology patients in the fight against COVID-19.

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