ABO blood groups and severe outcomes in COVID-19: A meta-analysis

Similar to the SARS-CoV experience,¹ a possible link between ABO blood groups with COVID-19 susceptibility and severity has been shown in multiple observational studies.²-⁴ Gérard et al⁵ have further noted that people with B and/or O blood groups were less represented among COVID-19 patients, thereby highlighting the possible beneficial role of anti-A antibodies in COVID-19 susceptibility. In fact, it was known that anti-A antibodies can block the adhesion of SARS-CoV S-protein to ACE2 expressing cell lines.⁶ Given the genomic similarity between SARS-CoV-2 and SARS-CoV, it might be prudent to hypothesise a protective role of anti-A antibodies against COVID-19 severity as well. However, existing clinical evidence in this regard is controversial. Hoiland et al⁷ had reported that critically ill COVID-19 patients with blood groups A and AB (lacking anti-A antibodies) were more likely to require mechanical ventilation and prolonged intensive care compared with patients with B/O (with anti-A antibodies). However, a genomewide association study of severe COVID-19 patients showed that those with blood group A had a higher risk of severe disease, while blood group O had a protective effect.⁸ Other studies found no association between ABO blood groups and COVID-19 severity/mortality.⁹-¹¹ We aimed to summarise the available literature and provide a pooled analysis of the effect of A/AB (without anti-A antibodies) on clinical outcomes in COVID-19 patients compared with B/O (with anti-A antibodies) blood groups.

This meta-analysis was conducted and reported according to the Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA) statement.¹² We (SB and MB) independently performed a systematic search of the literature across the PubMed database from inception till 30 November 2020, using the following keywords interposed with appropriate Boolean operators: “COVID-19” OR “SARS-CoV-2” AND “ABO blood groups”. Observational studies of case-control or cohort design were selected. Studies reporting the absolute rate of occurrence of severe outcomes (number of patients requiring intubation or number of patients with dyspnoea where intubation data not reported) or intubation and/or deaths or deaths among confirmed COVID-19 patients with A/AB versus B/O blood groups were included in analysis. Studies conducted only in critically ill patients with COVID-19 were excluded. Reviews, commentaries, articles in non-English language, non-peer-reviewed articles/preprints and studies with incomplete data were also excluded. Any discrepancy was solved by a discussion with a third reviewer (RP). Study quality was assessed using the Newcastle-Ottawa scale.

Statistical analysis was performed using the RevMan V5.4 software following data extraction. Being a dichotomous variable, the difference in the rate of occurrence of the reported clinical outcomes (events) in COVID-19 patients with A/AB versus B/O blood groups were calculated using the OR with 95% CIs after implementation of the Mantel-Haenszel (M-H) fixed-effects model. Heterogeneity was quantified as I². Statistical significance was assessed using the α level of 0.05. We fixed the number of patients with A/AB versus B/O blood groups requiring intubation or number of patients with dyspnoea related to COVID-19 in patients with blood groups A/AB (with no anti-A antibodies) as compared with B/O groups (with anti-A antibodies). However, in the meta-analysis performed among Spanish and Italian cohorts after adjusting for age and gender, odds for having severe COVID-19 disease (defined by respiratory failure) was higher in A/AB groups compared with B/O groups (OR 1.09; 95% CI 0.93 to 1.24, p=0.35, 1²=0%, fixed-effects model) (figure 2).

We found no significant differences in the unadjusted mortality and/or severity outcomes (defined by intubation or dyspnoea) related to COVID-19 in patients with blood groups A/AB (with no anti-A antibodies) as compared with B/O groups (with anti-A antibodies). However, in the meta-analysis performed among Spanish and Italian cohorts after adjusting for age and gender, odds for having severe COVID-19 disease (defined by respiratory failure) was higher in A/AB groups compared with B/O groups (OR: 1.51, 95% CI 1.25 to 1.83). Nevertheless, no difference in ABO blood groups was observed among patients requiring any form of mechanical ventilation.⁸

The present study findings do have certain limitations. Most of the studies included in the meta-analysis had a retrospective design. Adjustment for age, gender and comorbidities were either not reported, or reported for each blood group separately. Hence, pooled analysis using adjusted ORs could not be done. Besides, the clinical outcomes reported across the included studies were variable, ranging from dyspnoea to intubation to...
death. However, we did perform a sensitivity analysis with mortality being the sole severe outcome. Finally, the relationship between COVID-19 severity and anti-A antibodies is indeed far from simple. Several other factors can act as potential confounders, including the immunoglobulin subtype of antibodies, presence of ACE1/C3 polymorphisms and variable levels of factor VIII/VWF levels.

In conclusion, this preliminary, yet updated meta-analysis negates the possible significant association between the lack of anti-A antibodies (A/AB blood group), and poor clinical outcomes in patients with COVID-19. However, further studies on predefined endpoints in hospitalised patients (especially with critical COVID-19 disease), adjusting for possible covariates, are warranted to provide a reliable estimate of the risk.

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