Efficacy of low-intensity pulsed ultrasound in the treatment of COVID-19 pneumonia

Wirksamkeit von niedrigenergetischem gepulstem Ultraschall bei der Behandlung von COVID-19-Pneumonien

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ABSTRACT

Purpose As a public health emergency of international concern, coronavirus disease 2019 (COVID-19) still lacks specific antiviral drugs, and symptomatic treatment is currently the mainstay. The overactivated inflammatory response in COVID-19 patients is associated with a high risk of critical illness or even death. Low-intensity pulsed ultrasound (LIPUS) can mitigate inflammation and inhibit edema formation. We
aimed to investigate the efficacy of LIPUS therapy for COVID-19 pneumonia.

**Materials and Methods** 62 patients were randomly assigned to a treatment group (LIPUS treatment area – Group 1; self-control area – Group 2) and an external control group (Group 3). The primary outcomes were the volume absorption rate (VAR) and the area absorption rate (AAR) of lung inflammation in CT images.

**Results** After an average duration of treatment 7.2 days, there were significant differences in AAR and VAR between Group 1 and Group 2 (AAR 0.25 vs 0.12, \( p = 0.013 \); VAR 0.35 vs 0.11, \( p = 0.005 \)), and between Group 1 and Group 3 (AAR 0.25 vs 0.11, \( p = 0.047 \); VAR 0.35 vs 0.19, \( p = 0.042 \)). Neither AAR nor VAR was statistically different between Group 2 and Group 3. After treatment, C-reactive protein, interleukin-6, leukocyte, and fingertip arterial oxygen saturation (SaO2) improved in Group 1, while in Group 3 only fingertip SaO2 increased.

**Conclusion** LIPUS therapy reduced lung inflammation and serum inflammatory factor levels in hospitalized COVID-19 patients, which might be a major advancement in COVID-19 pneumonia therapy.

**ZUSAMMENFASSUNG**


**Material und Methoden** 62 Patienten wurden nach dem Zufallsprinzip einer Behandlungsgruppe (LIPUS-Bereich – Gruppe 1; Selbstkontroll-Bereich – Gruppe 2) und einer externen Kontrollgruppe (Gruppe 3) zugewiesen. Das primäre Outcome waren die Volumenabsorptionsrate (VAR) und die Flächenabsorptionsrate (AAR) der Pneumonie in CT-Aufnahmen.

**Ergebnisse** Nach einer durchschnittlichen Behandlungsdauer von 7,2 Tagen gab es signifikante Unterschiede bei AAR und VAR zwischen Gruppe 1 und Gruppe 2 (AAR 0,25 vs. 0,12, \( p = 0,013 \); VAR 0,35 vs. 0,11, \( p = 0,005 \)) sowie zwischen Gruppe 1 und Gruppe 3 (AAR 0,25 vs. 0,11, \( p = 0,047 \); VAR 0,35 vs. 0,19, \( p = 0,042 \)). Weder AAR noch VAR unterschieden sich statistisch zwischen Gruppe 2 und Gruppe 3. Nach der Behandlung verbesserten sich in Gruppe 1 die Werte für C-reaktives Protein, Interleukin-6, Leukozyten und die arterielle Sauerstoffsättigung (SaO2) an der Fingerspitze, während in Gruppe 3 nur die SaO2 an der Fingerspitze anstieg.

**Schlussfolgerung** Die LIPUS-Therapie verringerte die Pneumonie und die Konzentration von Entzündungsfaktoren im Serum bei hospitalisierten COVID-19-Patienten, was einen wichtigen Fortschritt in der Therapie der COVID-19-Pneumonie darstellen könnte.

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**Introduction**

Coronavirus disease 2019 (COVID-19) is an acute respiratory infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-COV-2). SARS-COV-2 and its variants are highly infectious, highly transmissible, and have gradually enhanced immune escape ability [1]. Although the current clinical severity and case fatality rate are lower, the absolute number is likely to be much higher due to the sheer incidence of infection and the sizable number of patients [2].

The main clinical manifestations of COVID-19 patients include headache, cough, fever, generalized myalgia and fatigue [3]. The pathological mechanism is mainly based on alveolar exudative inflammation and pulmonary interstitial inflammation. The virus invades alveolar epithelial cells, mediates cellular damage, induces inflammatory response [4], and promotes the release of various pro-inflammatory cytokines, such as interleukin (IL)-6, IL-8, and tumor necrosis factor (TNF)-α, which induces fever and cough symptoms [5]. At the same time, the massive release of inflammatory mediators leads to increased vascular permeability, and some patients experience increased sputum, and in severe cases, pulmonary edema, dyspnea, or hypoxemia [6, 7]. In addition, virus-induced immune complexes induce local microthrombosis, leading to a stasis of pulmonary circulation, and further affecting ventilatory
such as acute viral myocarditis [13], synovitis [14], and nerve cell mechanical injury [15] that the above-mentioned inflammatory pathways were significantly inhibited after LIPUS sonication, and inflammatory cytokines such as TNF-α, IL-1β and IL-6 decreased accordingly. The potential of LIPUS to modulate the inflammatory cell phenotype and reduce the number of neutrophils and M1 inflammatory macrophages was also observed in musculoskeletal injury models [16, 17]. Similarly, in human clinical trials, repair of damaged bone tissue and absorption of local edema [18], healing of diabetic ulcers, and reduction of the inflammatory response [19] were also observed after LIPUS treatment. In addition, in the case of acute myocardial infarction, ultrasound can remove microthrombosis, improve myocardial blood perfusion, and thereby reduce the size of the infarct area [20]. It is suggested that LIPUS therapy may also play a certain role in reducing the microthrombotic state and improving ventilatory function in patients with COVID-19 pneumonia. Although the treatment principle has not been fully clarified, the comprehensive and synergistic effects of LIPUS in alleviating inflammation, promoting tissue repair, inhibiting edema formation, and stimulating angiogenesis are of great significance in the field of clinical treatment.

At present, the positive effect of LIPUS in animal experiments and clinical treatment has been confirmed, but the application in the treatment of pneumonia has not been reported, so we aimed to study the therapeutic effect of wearable LIPUS on COVID-19 pneumonia.

Methods

Study design and objectives

This study was an individually randomized and controlled trial to evaluate the efficacy of LIPUS therapy in patients hospitalized with COVID-19 pneumonia and was approved by the ethics committee in our hospital.

Participants

Adult patients from ages 20 to 85 with COVID-19 pneumonia confirmed by pharyngeal swab polymerase chain reaction (PCR) and lung CT were included in the study. The inclusion criteria were as follows: (1) diagnosis of COVID-19 based on a positive PCR test; (2) aged 20 to 85 years; (3) pneumonia confirmed by chest CT; (4) willingness to cooperate with all examinations during the clinical study and signed informed consent; (5) no participation in other clinical trials during the study period.

The exclusion criteria were as follows: (1) bronchiectasis, COPD, or lung malignancies; (2) local skin injury on the chest cannot wear the LIPUS device; (3) pregnancy or lactation; (4) contraindications to therapeutic US, including dermatological conditions, local abnormal sensations in the chest or back, epilepsy, etc.; (5) mental illness or inability to communicate properly.

Randomization

62 patients were randomly assigned to a treatment group and an external control group (Group 3) with a computer random number generator (1:1). The treatment group was then divided into two areas according to the location of inflammation on lung CT images, and one area was randomly selected as the LIPUS sonication area (Group 1), and the other area was used as the self-control area (Group 2). Inflammatory lesions in Group 3 close to the diseased lung lobes in Group 1 were used as external control areas.

Two members of the research team were responsible for recruiting and registering subgroup information. The patients and clinicians who performed LIPUS therapy were not blinded to the grouping results and the course of treatment. Researchers performed the image processing and statistics were masked to the grouping result.

Procedures

LIPUS sonication

The wearable LIPUS therapeutic apparatus (UT – HP 21, Shanghai, China) consists of two movable ultrasound probes and a central device (Supplementary Figure 1). The operator attached the ultrasound probes to the patient’s chest or back and adjusted the position of the probes according to the shape and scope of the lung lesion to perform vertical or parallel sonication therapy (Supplementary Figure 2). The operating parameters of the ultrasound probes were chosen to be a pulse frequency of 572 kHz, a pulse repetition frequency of 50 Hz, an intensity of 820 mW/cm², and a duty cycle of 50% (1 s inter-stimulus interval), and the probe alternately transmitted sound waves (Video 1). During hospitalization, patients received 30-minute treatments at 8:00 am and 2:00 pm daily.

Treatment group

Patients allocated to this group were to receive localized LIPUS sonication. If the lesions were located in bilateral lungs, LIPUS treatment was randomly performed on one side, namely Group 1, and the other side was considered as self-control (Group 2); if the lesions were confined to one side, one area was randomly selected for LIPUS sonication (Group 1), and the other area was defined as self-control (Group 2). First, CT examination was performed to locate the body surface of the inflammatory exudative area. Then...
operators attached the wearable LIPUS therapeutic apparatus to the chest or back of the patient and conducted ultrasonic therapy.

**External control group**

Patients allocated to this group did not receive LIPUS treatment. Other symptomatic and supportive treatment methods were the same as in the LIPUS group. All patients underwent chest CT (Lia-nying-uCT 510 scanner) examinations before and after treatment. The standard lung window (window position 600HU, window width 1255HU) was adopted and Pair software was used to mark and 3D reconstruct the target area to record the changes in pulmonary inflammation. Two fellowship-trained radiologists independently interpreted the lung images. In the case of any non-concurrence, interpretation was finalized by consensus.

All participants underwent a standardized interview to obtain demographic and clinical information, including age, sex, disease history, symptoms (e.g., cough, sputum, muscle pain, etc.), and laboratory results. Temperature, blood pressure, blood sugar, and other indicators were obtained from the patient’s medical records. Hypertension was defined as a history of hypertension, systolic blood pressure ≥ 140 mmHg, diastolic blood pressure ≥ 90 mmHg, or the use of antihypertensive medications. Diabetes was diagnosed if the subject had a history and was currently using insulin or oral hypoglycemic agents or had a fasting blood glucose level ≥ 126 mg/dL.

**Outcomes**

The primary outcomes were the volume absorption rate (VAR) and the area absorption rate (AAR) of lung inflammation on CT images. VAR is defined as \( \frac{(\text{target site inflammation volume before treatment} - \text{target site inflammation volume after treatment})}{\text{target site inflammation volume before treatment}} \times 100 \% \). AAR is defined as \( \frac{(\text{target site inflammation area before treatment} - \text{target site inflammation area after treatment})}{\text{target site inflammation area before treatment}} \times 100 \% \).

Secondary outcomes included serum leukocyte and inflammatory factor levels, arterial partial pressure of oxygen (\( \text{PaO}_2 \)), arterial partial pressure of carbon dioxide (\( \text{PaCO}_2 \)), fingertip arterial oxygen saturation (\( \text{SaO}_2 \)), and symptom improvement before and after treatment.

During treatment, researchers also recorded whether the patients had adverse effects, including local swelling, spotting bleeding, enhanced local pain response, hemoptysis, aggravation of symptoms, etc., until the end of the study.
Statistical analysis

Normally distributed data were expressed as the mean (standard deviation), whereas data not normally distributed were expressed as the median (interquartile range). The independent sample test was used for the comparison between groups, and the paired sample test was used for the comparison within the group before and after treatment. Categorical variables were expressed as percentages. A χ² test or Fisher’s exact test was used to compare categorical data. A p-value < 0.05 was considered statistically significant. Statistical analysis was carried out using SPSS software, version 26.

Results

62 (82.7 %) of 75 patients enrolled in the LIPUS therapy trial were eligible for random assignment (▶ Fig. 1). 42 patients were randomly allocated to the treatment group and 20 were randomly allocated to the external control group. In the treatment group, the inflammation site of each patient was randomly divided into the LIPUS treatment area and the internal control area. All patients were Asian, the median age was 68.5 years (IQR, 60.8–75.3); sex distribution was 26 (61.9 %) men versus 16 (38.1 %) women in the treatment group and 12 (60.0 %) versus 8 (40.0 %) in the external control group. At baseline, there was no statistically significant difference between the two groups (▶ Table 1).

After an average of 7.2 days of treatment, the area and volume of lung inflammation in the three groups were reduced (p < 0.05) (▶ Fig. 2), but the AAR and VRR in Group 1 were higher than those in Group 2 (AAR 0.25 vs. 0.12, p = 0.013; VAR 0.35 vs. 0.11, p = 0.005) and in Group 3 (AAR 0.25 vs. 0.11, p = 0.047; VAR 0.35 vs. 0.19, p = 0.042) (▶ Table 2, ▶ Fig. 3), and so was the volume absorption difference (▶ Table 2, ▶ Fig. 4). However, there was no statistically difference between Group 2 and Group 3 (AAR, p = 0.957; VRR, p = 0.392).

Before and after treatment, some laboratory results, clinical symptoms, and signs of patients in Group 1 and Group 3 were improved, but the effectiveness in Group 1 was more obvious (▶ Table 3). After LIPUS treatment, CRP, IL-6, leukocyte and neutrocyte were decreased compared with before treatment (CRP 19.1 vs. 19.3, p = 0.744; IL-6 6.0 vs. 5.8, p = 0.744; Leukocyte 9.5 vs. 9.3, p = 0.744; Neutrocyte 7.5 vs. 7.3, p = 0.744).

Table 1 Baseline demographics and clinical characteristics of all patients with COVID-19.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Total</th>
<th>LIPUS treatment area (n = 42)</th>
<th>External control group (n = 20)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age, median (IQR), y</td>
<td>68.5 (60.8–75.3)</td>
<td>67.0 (59.8–76.0)</td>
<td>70.0 (61.8–75.0)</td>
<td>0.729</td>
</tr>
<tr>
<td>Sex, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>38 (61.2 %)</td>
<td>26 (61.9 %)</td>
<td>12 (60.0 %)</td>
<td>0.886</td>
</tr>
<tr>
<td>Female</td>
<td>24 (38.7 %)</td>
<td>16 (38.1 %)</td>
<td>8 (40.0 %)</td>
<td></td>
</tr>
<tr>
<td>Target site of inflammation, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The right lung</td>
<td>40 (64.5 %)</td>
<td>28 (66.7 %)</td>
<td>12 (60.0 %)</td>
<td>0.608</td>
</tr>
<tr>
<td>The left lung</td>
<td>22 (35.5 %)</td>
<td>14 (33.3 %)</td>
<td>8 (30.0 %)</td>
<td></td>
</tr>
<tr>
<td>Area of lung inflammation, median (IQR), mm²</td>
<td>632.9 (305.7–1643.1)</td>
<td>543.4 (302.6–1643.1)</td>
<td>927.0 (308.6–1643.1)</td>
<td>0.436</td>
</tr>
<tr>
<td>Volume of lung inflammation, median (IQR), mm³</td>
<td>36.2 (13.5–58.2)</td>
<td>37.6 (17.1–58.6)</td>
<td>29.3 (8.6–49.2)</td>
<td>0.233</td>
</tr>
<tr>
<td>Smoking, n (%)</td>
<td>14 (22.5 %)</td>
<td>12 (28.5 %)</td>
<td>2 (10.0 %)</td>
<td>0.102</td>
</tr>
<tr>
<td>Vaccination</td>
<td>23 (37.0 %)</td>
<td>19 (45.2 %)</td>
<td>4 (20.0 %)</td>
<td>0.054</td>
</tr>
<tr>
<td>Previous diseases, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>39 (62.9 %)</td>
<td>27 (64.2 %)</td>
<td>12 (60.0 %)</td>
<td>0.744</td>
</tr>
<tr>
<td>Diabetes</td>
<td>25 (40.3 %)</td>
<td>17 (40.4 %)</td>
<td>8 (40.0 %)</td>
<td>0.971</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>17 (27.4 %)</td>
<td>10 (23.8 %)</td>
<td>7 (35.0 %)</td>
<td>0.753</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>14 (22.6 %)</td>
<td>9 (21.4 %)</td>
<td>5 (25.0 %)</td>
<td>1.000</td>
</tr>
<tr>
<td>Symptomatic treatment, n (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough suppressants</td>
<td>23 (37.1 %)</td>
<td>15 (35.7 %)</td>
<td>8 (40.0 %)</td>
<td>0.744</td>
</tr>
<tr>
<td>Expectorants</td>
<td>18 (29.0 %)</td>
<td>11 (26.2 %)</td>
<td>7 (35.0 %)</td>
<td>0.475</td>
</tr>
<tr>
<td>Anti-inflammatory drugs</td>
<td>16 (25.8 %)</td>
<td>10 (23.8 %)</td>
<td>6 (30.0 %)</td>
<td>0.603</td>
</tr>
<tr>
<td>Immunomodulatory drugs</td>
<td>12 (19.4 %)</td>
<td>8 (19.0 %)</td>
<td>4 (20.0 %)</td>
<td>0.929</td>
</tr>
</tbody>
</table>

Data not normally distributed were expressed as the median (interquartile range). Categorical variables were expressed as percentages.
The target lung inflammation area and volume of the CT image were marked and 3D reconstructed using pair software. (Red represents the area with LIPUS treatment, and purple represents the area without LIPUS treatment). a The LIPUS treatment area and the self-control area in the treatment group were located in different lungs. (a1 represents before treatment, a2 represents after treatment). The inflammation area with LIPUS treatment (red) was reduced 42.7 % (543.01/311.14 mm²). The inflammation volume with LIPUS treatment (red) was reduced 66.2 % (32.17/10.87 mm³). The inflammation area without LIPUS treatment (purple) was reduced 13.9 % (411.68/354.45 mm²). The inflammation volume without LIPUS treatment (purple) was reduced 8.4 % (38.24/35.03 mm³).

b The LIPUS treatment area and the self-control area in the treatment group were located in the same lungs. (b1 represents before treatment, b2 represents after treatment.) The inflammation area with LIPUS treatment (red) was reduced 40.2 % (9.14/5.46 mm²). The inflammation volume with LIPUS treatment (red) was reduced 56.0 % (0.84/0.37 mm³). The inflammation area without LIPUS treatment (purple) was reduced 33.4 % (384.47/256.05 mm²). The inflammation volume without LIPUS treatment (purple) was reduced 41.4 % (31.20/18.28 mm³).

Table 2
Comparisons of changes in the area and volume of pneumonia on CT images before and after treatment in the LIPUS treatment area, self-control area, and external control group.

<table>
<thead>
<tr>
<th>Variable</th>
<th>LIPUS treatment area (n = 42)</th>
<th>Self-control area (n = 42)</th>
<th>External control group (n = 20)</th>
<th>p&lt;sub&gt;a&lt;/sub&gt; value</th>
<th>p&lt;sub&gt;b&lt;/sub&gt; value</th>
<th>p&lt;sub&gt;c&lt;/sub&gt; value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of lung inflammation, median (IQR), mm²</td>
<td>Before treatment 543.4 (302.6–1643.1)</td>
<td>500.7 (290.2–1766.1)</td>
<td>927.0 (308.6–1643.1)</td>
<td>0.837</td>
<td>0.436</td>
<td>0.330</td>
</tr>
<tr>
<td></td>
<td>After treatment 344.8 (210.0–1103.7)</td>
<td>372.8 (221.7–1374.4)</td>
<td>631.3 (288.8–1489.6)</td>
<td>0.570</td>
<td>0.159</td>
<td>0.290</td>
</tr>
<tr>
<td>Volume of lung inflammation, median (IQR), mm³</td>
<td>Before treatment 37.6 (17.1–58.6)</td>
<td>38.4 (12.0–59.5)</td>
<td>29.3 (8.6–49.2)</td>
<td>1.000</td>
<td>0.233</td>
<td>0.286</td>
</tr>
<tr>
<td></td>
<td>After treatment 20.3 (5.4–42.4)</td>
<td>29.9 (8.3–50.0)</td>
<td>20.8 (6.9–46.3)</td>
<td>0.168</td>
<td>0.708</td>
<td>0.418</td>
</tr>
<tr>
<td>Area absorption difference, median (IQR), mm²</td>
<td>132.0 (54.3–340.7)</td>
<td>62.1 (22.1–233.4)</td>
<td>129.2 (17.0–288.4)</td>
<td>0.027</td>
<td>0.354</td>
<td>0.625</td>
</tr>
<tr>
<td>Area absorption rate, median (range)</td>
<td>0.25 (0.10–0.49)</td>
<td>0.12 (0.06–0.26)</td>
<td>0.11 (0.04–0.26)</td>
<td>0.013</td>
<td>0.047</td>
<td>0.957</td>
</tr>
<tr>
<td>Volume absorption difference, median (IQR), mm³</td>
<td>10.0 (3.0–29.2)</td>
<td>3.3 (1.3–10.4)</td>
<td>3.1 (1.9–9.1)</td>
<td>0.039</td>
<td>0.038</td>
<td>0.646</td>
</tr>
<tr>
<td>Volume absorption rate, median (range)</td>
<td>0.35 (0.13–0.71)</td>
<td>0.11 (0.06–0.37)</td>
<td>0.19 (0.11–0.28)</td>
<td>0.005</td>
<td>0.042</td>
<td>0.392</td>
</tr>
</tbody>
</table>

Data not normally distributed were expressed as the median (interquartile range). Categorical variables were expressed as percentages. The p<sub>a</sub> value represents the statistical significance of the difference between the LIPUS treatment area and the self-control area. The p<sub>b</sub> value represents the statistical significance of the difference between the LIPUS treatment area and the external control group. The p<sub>c</sub> value represents the statistical significance of the difference between the internal control area and the external control group.
Fig. 3  Comparison of VAR and AAR in LIPUS area (Group 1), self-control area (Group 2), and external control group (Group 3). There was a statistically significant difference in VAR between Group 1 and Group 2 (0.35 vs. 0.11, p = 0.005), and also between Group 1 and Group 3 (0.35 vs. 0.19, p = 0.042), but not between Group 2 and Group 3. AAR was also statistically different between Group 1 and Group 2 (0.25 vs 0.12, p = 0.013), and also between Group 1 and Group 3 (0.25 vs 0.11, p = 0.047), but not between Group 2 and Group 3. VAR = the volume reduction rate, AAR = the area reduction rate.

Fig. 4  Comparison of the volume of lung inflammation and the volume absorption difference in the LIPUS area (Group 1), self-control area (Group 2), and external control group (Group 3) before and after treatment. a There was a statistically significant difference in the volume of lung inflammation before and after treatment in Group 1 (37.6 vs. 20.3, p < 0.001), Group 2 (38.4 vs 29.9, p < 0.001), and Group 3 (29.3 vs 20.8, p < 0.001). b There was a statistically significant difference in the volume absorption difference before and after treatment between Group 1 and Group 2 (10.0 vs. 3.3, p = 0.039), and between Group 1 and Group 3 (10.0 vs. 3.1, p = 0.038), but not between Group 2 and Group 3 (3.3 vs. 3.1, p = 0.646).
3.7 mg/L, p = 0.000; IL-6 9.7 vs. 2.8 pg/mL, p = 0.000; leukocyte 7.6 vs. 6.6 mg/L, p = 0.026; neutrocyte 5.0 vs. 4.3 mg/L, p = 0.047), but there was no significant difference in Group 3. The fingertip SaO2 increased (96.0 % vs. 99.0 %, p = 0.000) and body temperature decreased (36.9 vs. 36.5°C, p = 0.000) in Group 1, while in the external control group, only the fingertip SaO2 (98.0 vs. 99.0 %, p = 0.026) increased.

### Table 3 Comparison of laboratory results and symptoms before and after treatment between the LIPUS treatment group and the external control group.

<table>
<thead>
<tr>
<th>Variable</th>
<th>LIPUS treatment area (n = 42)</th>
<th>External control group (n = 20)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before treatment</td>
<td>After treatment</td>
<td>p-value</td>
</tr>
<tr>
<td>Leukocyte count×10^9, mean (SD), /L</td>
<td>7.6 (3.9)</td>
<td>6.6 (3.2)</td>
<td>0.026</td>
</tr>
<tr>
<td>Lymphocyte count×10^9, median (IQR), /L</td>
<td>1.1 (0.7–1.9)</td>
<td>1.0 (0.7–1.6)</td>
<td>0.324</td>
</tr>
<tr>
<td>Monocyte count×10^9, mean (SD), /L</td>
<td>0.5 (0.2)</td>
<td>0.7 (1.6)</td>
<td>0.499</td>
</tr>
<tr>
<td>CRP, median (IQR), mg/L</td>
<td>19.1 (3.9–67.8)</td>
<td>3.7 (1.5–9.6)</td>
<td>0.000</td>
</tr>
<tr>
<td>Neutrophil count×10^9, median (IQR), /L</td>
<td>5.0 (2.9–7.5)</td>
<td>4.3 (2.6–6.0)</td>
<td>0.047</td>
</tr>
<tr>
<td>IL-6, median (IQR), pg/mL</td>
<td>9.7 (2.6–37.7)</td>
<td>2.8 (1.3–12.2)</td>
<td>0.000</td>
</tr>
<tr>
<td>Serum lactate, median (IQR), mmol/L</td>
<td>1.5 (1.0–2.5)</td>
<td>1.4 (0.9–2.9)</td>
<td>0.603</td>
</tr>
<tr>
<td>PaCO2, mean (SD), mmHg</td>
<td>36.9 (5.4)</td>
<td>38.3 (6.2)</td>
<td>0.253</td>
</tr>
<tr>
<td>PaO2, mean (SD), mmHg</td>
<td>94.2 (22.1)</td>
<td>95.5 (31.6)</td>
<td>0.868</td>
</tr>
<tr>
<td>Fingertip SaO2, median (IQR), %</td>
<td>96.0 (93.8–98.8)</td>
<td>99.0 (98.0–99.4)</td>
<td>0.000</td>
</tr>
<tr>
<td>Body temperature, median (IQR), °C</td>
<td>36.9 (36.5–38.4)</td>
<td>36.5 (36.4–37.0)</td>
<td>0.000</td>
</tr>
<tr>
<td>Fever, n (%)</td>
<td>20 (47.6)</td>
<td>3 (7.1)</td>
<td>0.000</td>
</tr>
<tr>
<td>Cough, n (%)</td>
<td>20 (47.6)</td>
<td>10 (23.8)</td>
<td>0.023</td>
</tr>
<tr>
<td>Expectoration, n (%)</td>
<td>24 (57.1)</td>
<td>8 (19.0)</td>
<td>0.000</td>
</tr>
<tr>
<td>Sore throat, n (%)</td>
<td>3 (7.3)</td>
<td>1 (2.4)</td>
<td>0.360</td>
</tr>
<tr>
<td>Headache, n (%)</td>
<td>3 (7.3)</td>
<td>1 (2.4)</td>
<td>0.360</td>
</tr>
<tr>
<td>Muscular ache, n (%)</td>
<td>17 (40.5)</td>
<td>1 (2.4)</td>
<td>0.000</td>
</tr>
<tr>
<td>Number of days since Hospitalization, mean (SD), days</td>
<td>11.4 (5.0)</td>
<td>17.7 (7.7)</td>
<td>0.002</td>
</tr>
</tbody>
</table>

Normally distributed data were expressed as the mean (standard deviation). Data not normally distributed were expressed as the median (interquartile range). Categorical variables were expressed as percentages. CRP = C-reactive protein, IL-6 = interleukin-6, PaCO2 = arterial partial pressure of carbon dioxide, PaO2 = arterial partial pressure of oxygen; SaO2 = arterial oxygen saturation.
During LIPUS treatment, no adverse events such as local swelling, spotting bleeding, increased local pain response, and hemoptysis occurred.

Discussion

The results of this randomized trial demonstrate that LIPUS is an effective therapy for hospitalized patients with COVID-19 pneumonia. Following the treatment of soft tissue and musculoskeletal diseases with LIPUS, our study is the first clinical trial to use LIPUS to conduct an exploratory intervention in COVID-19 pneumonia, and no safety problems and side effects occurred during the treatment.

We found that after LIPUS treatment, the volume and area of local pneumonia in COVID-19 patients were reduced, showing a positive effect compared with those without LIPUS treatment. At the same time, the serum inflammatory factors CRP and IL-6 of the patients were decreased compared with those before treatment, suggesting that the anti-inflammatory biological effects of LIPUS are also applicable to patients with pulmonary inflammation. For CRP in particular, early clinical studies in COVID-19 pneumonia reported its correlation with severity and prognosis [21, 22].

After an average of 7.2 days of treatment, the patient’s pulmonary symptoms were improved, and fingertip SaO2 increased, but a similar result was also seen in the external control group, so it is difficult to explain the independent effect of LIPUS, and large-scale blank control clinical studies still need to be carried out. In addition, the working principle and optimal working mode of LIPUS in clinical treatment have not been fully elucidated. Prada et al. have proposed the idea of applying LIPUS to the clinical treatment of COVID-19 [23], but no relevant clinical trials have been reported and the selection of the optimal working mode and treatment parameters is a difficult point. Based mainly on previous research on LIPUS in mitigating soft tissue inflammation, we chose this working parameter. However, the optimal parameters of LIPUS for lung treatment need to be further explored and verified.

Chest CT is currently considered the main reference standard for the imaging diagnosis of pneumonia. Therefore, we quantitatively calculated the area and volume of lung inflammation to evaluate the effect of LIPUS treatment. In recent years, the clinical value of lung ultrasound (LUS), which is favored for its convenience, real-time, reliability, and lack of radiation, has gradually been confirmed. In particular, early clinical studies in COVID-19 pneumonia reported its correlation with severity and prognosis [21, 22].

Two studies in the population [27], and its accessibility should be evaluated before ultrasound localization and treatment, so as to select patients suitable for LIPUS therapy. Due to the existence of sound attenuation, whether there is a difference in the efficacy of LIPUS in the treatment of deep and superficial lung lesions requires more clinical research. No side effects such as pulmonary hemorrhage and hemoptysis were found during the treatment. The ultrasound intensity of LIPUS is far lower than that used in most clinical diagnoses and treatments, and its reliability has been demonstrated by many researchers in both animal and clinical studies [14, 15, 16, 19, 20, 21]. However, various frequencies and intensities of LIPUS application to the lungs need to be established and validated. The underlying cellular and molecular mechanisms underlying the biological effects of LIPUS on inflammation remain to be further explored.

Our study had several limitations. First, this was a single-center and small-sample exploratory clinical study. Due to the limited number of wearable LIPUS devices and control of the local epidemic, the study was terminated, and the data were analyzed. Secondly, all participants enrolled in our study were infected with Omicron, and the effect of LIPUS in reducing pulmonary inflammation may currently only be applicable to this type of virus infection. Whether LIPUS has a role in other types of viral infections or bacterial pneumonia needs further study. Finally, the study did not compare whether there were differences in treatment effects between different disease groups. Due to the limited number of patients included, we randomly assigned lung lobes with different lesions, and there was no statistical difference between the LIPUS treatment area and the self-control area before treatment. Subsequent multi-center large-sample studies will further analyze whether there are differences in the efficacy of inflammation in different locations.

Conclusion

This clinical trial has shown for the first time that LIPUS is effective in mitigating inflammation in COVID-19 pneumonia. In addition, combined with the therapeutic mechanism, it is speculated that LIPUS may be more extensive than limited to COVID-19 pneumonia, and may play a certain role in the treatment of other viral and even bacterial types of pneumonia. However, large-scale clinical trials are still needed for further verification.

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Clinical Trial

Registration number (trial ID): ChiCTR2200059550 | Trial registry: Chinese Clinical Trial Registry (http://www.chictr.org/) | Type of Study: Randomized
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Conflict of Interest

The authors declare that they have no conflict of interest.

References