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


Affiliations below.

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Trial registration: ChiCTR2200059550, Chinese Clinical Trial Registry (http://www.chictr.org/), Randomized

Abstract:
Purpose As a public health emergency of international concern, the 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. Material and methods 62 patients were randomly assigned into a treatment group (LIPUS treatment area - Group 1; self-control area - Group 2) and an external control group (Group 3). Primary outcomes were the volume absorption rate (VAR) and the area absorption rate (AAR) of lung inflammation in CT images. Results Average 7.2 days of treatment, 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 advance in COVID-19 pneumonia therapy.

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

Introduction

Coronavirus disease 2019 (COVID-19) is an acute respiratory infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-COV-2). The 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, inducing fever and cough symptoms \(^5\). At the same time, the massive release of inflammatory mediators leads to increased vascular permeability, and some patients are accompanied by increased sputum, and in severe cases, pulmonary edema, dyspnea or hypoxemia \(^6\-7\). In addition, virus-induced immune complexes induce local
microthrombosis, leading to stasis of pulmonary circulation, and further affecting ventilation functions \[8\]. Patients with advanced age or underlying diseases may experience more severe symptoms and are prone to secondary infection and severe ventilation dysfunction \[9\].

Different from bacterial pneumonia, specific antiviral drugs are still lacking, and symptomatic treatment is the main method. Reducing pulmonary inflammation and improving clinical symptoms is the focus of current treatment.

Low-intensity pulsed ultrasound (LIPUS), a therapeutic ultrasound technique that has emerged in recent years, has been approved by the US Food and Drug Administration (FDA) for the treatment of soft tissue and musculoskeletal injuries \[10\]. It is delivered with low intensity (<3 W/cm\(^2\)) in the mode of medium frequency (0.7-3.0 MHz) pulse wave, which can not only exert physical stimulation but also carry out biological therapy \[11\]. In many preclinical studies, LIPUS has been shown to help reduce local inflammation and promote tissue repair, and its anti-inflammatory effects involve multiple mechanisms, including inhibiting the expression of inflammatory factors, up-regulating the expression of anti-inflammatory genes and the regulatory factors of immunosuppressive cells, and reducing inflammatory cell infiltration, etc \[12\].

The mitogen-activated protein kinase (MAPK) and nuclear factor-kappa B (NF-κB) signaling pathways are classic inflammatory response pathways. It has been observed in many animal models 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 \cite{16-17}. Similarly, in human clinical trials, repair of damaged
bone tissue and absorption of local edema \cite{18}, healing of diabetic ulcers, and reduction of the
inflammatory response \cite{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 \cite{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. Inclusion
criteria were the following: (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.

Exclusion criteria were the following: (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 into 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 in 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 05 21, Shanghai,
China) consists of two movable ultrasound probes and a central device (Supplementary Figure 1). The operator fixed the ultrasound probes on 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% (1s inter-stimulus interval), and the probe alternately transmitted sound waves (Supplementary 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 fixed the wearable LIPUS therapeutic apparatus on the chest or back of the patient and conducted ultrasonic therapy.

**External control group:** Patients allocated to this group did not receive LIPUS treatment, and other symptomatic and supportive treatment methods were the same as the LIPUS group. All patients underwent chest CT (Lianying-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 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 in CT images. VAR is defined as \[(\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 \[(\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 (PaO\(_2\)), arterial partial pressure of carbon dioxide (PaCO\(_2\)), fingertip arterial oxygen saturation (SaO\(_2\)) and symptom improvement before and after treatment.

During the 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 closure 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 by 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 (Tab. 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 VAR 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) (Tab. 2, Fig. 3), and so was the volume absorption difference (Tab. 2, Fig. 4). However, there was no statistically difference between the 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 (Tab. 3). After LIPUS treatment, CRP, IL-6, leukocyte and neutrocyte were decreased compared with those before treatment (CRP 19.1 vs 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 SaO\textsubscript{2} increased (96.0% vs 99.0%, p=0.000) and body temperature decreased (36.9 vs 36.5\textdegree C, p=0.000) in Group 1, while in the external control group, only the fingertip SaO\textsubscript{2} (98.0 vs 99.0%, p=0.026) increased.

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 hospitalised 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 relieved, and fingertip \(\text{SaO}_2\) 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 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) has gradually been confirmed, which is favored for its convenience, real-time, reliability, and radiation-free. Nazerian et al. \[^{[24]}\] and Soldati et al. \[^{[25]}\] compared the value of chest CT and LUS in the diagnosis of lung lesions qualitatively and semi-quantitatively, and found that the two had a good consistency and were significantly better than chest
radiographs. And we conducted LUS follow-up in a small number of COVID-19 pneumonia patients and found that the LUS score decreased significantly after LIPUS treatment (median: 12 vs 2, p<0.001) (Supplementary Figure 3). Lugarà et al.\textsuperscript{[26]} performed LUS scores and high-resolution CT scores on 99 patients with COVID-19 pneumonia, and the results also showed a significant correlation and synergy between the two in the diagnosis and the assessment of disease severity. It can be seen that LUS combined with chest CT for pneumonia diagnosis, localization and guidance of LIPUS treatment will further improve the curative effect.

However, there are differences in the distribution of lung lesions in the population\textsuperscript{[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\textsuperscript{[14-16, 19-21]}. 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 the control of local epidemic, the study was terminated and the data were analyzed. Secondly, all

\textsuperscript{14-16, 19-21}
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 diseased lobes. 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.

Conclusions

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.

References


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-)</td>
<td>543.4</td>
<td>927.0</td>
<td>0.436</td>
</tr>
<tr>
<td>Volume of lung inflammation, median (IQR), mm³</td>
<td>1643.1</td>
<td>(302.6-1643.1)</td>
<td>(308.6-1643.1)</td>
<td></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.

Table 2. Comparisons of changes in the area and volume of pneumonia in CT images before and after
treatment in 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;sup&gt;a&lt;/sup&gt;</th>
<th>p&lt;sup&gt;b&lt;/sup&gt;</th>
<th>p&lt;sup&gt;c&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Area of lung inflammation, mm&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Before</td>
<td></td>
<td></td>
<td>543.4 (302.6-1643.1)</td>
<td>500.7 (290.2-1766.1)</td>
<td>927.0 (308.6-1643.1)</td>
</tr>
<tr>
<td></td>
<td>After</td>
<td></td>
<td></td>
<td>344.8 (210.0-1103.7)</td>
<td>372.8 (221.7-1374.4)</td>
<td>631.3 (288.8-1489.6)</td>
</tr>
<tr>
<td>Volume of lung inflammation, mm&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Before</td>
<td></td>
<td></td>
<td>37.6 (17.1-58.6)</td>
<td>38.4 (12.0-59.5)</td>
<td>29.3 (8.6-49.2)</td>
</tr>
<tr>
<td></td>
<td>After</td>
<td></td>
<td></td>
<td>20.3 (5.4-42.4)</td>
<td>29.9 (8.3-50.0)</td>
<td>20.8 (6.9-46.3)</td>
</tr>
<tr>
<td>Area absorption difference, mm&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></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>
</tr>
<tr>
<td>Volume absorption difference, mm&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></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>
</tr>
<tr>
<td>Area absorption rate, median (%)</td>
<td></td>
<td></td>
<td></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>
</tr>
<tr>
<td>Volume absorption rate, median (%)</td>
<td></td>
<td></td>
<td></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>
</tr>
</tbody>
</table>

Data not normally distributed were expressed as the median (interquartile range).
Categorical variables were expressed as percentages.
The p<sup>a</sup> value represents the statistical significance of the difference between the LIPUS treatment area and the self-control area.
The p<sup>b</sup> value represents the statistical significance of the difference between the LIPUS treatment area and the external control group.
The p<sup>c</sup> value represents the statistical significance of the difference between the internal control area and the external control group.

Table 3. Comparison of laboratory results and symptoms before and after treatment between LIPUS treatment group and 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>
<th>Before treatment</th>
<th>After treatment</th>
<th>p value</th>
<th>Before treatment</th>
<th>After treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leukocyte count×10⁹, mean (SD), /L</td>
<td>7.6 (3.9)</td>
<td>6.6 (3.2)</td>
<td>0.026</td>
<td>7.8 (3.4)</td>
<td>7.5 (2.5)</td>
<td>0.746</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphocyte count×10⁹, median (IQR), /L</td>
<td>1.1 (0.7-1.9)</td>
<td>1.0 (0.7-1.6)</td>
<td>0.324</td>
<td>0.9 (0.7)</td>
<td>1.0 (0.6)</td>
<td>0.546</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monocyte count×10⁹, mean (SD), /L</td>
<td>0.5 (0.2)</td>
<td>0.7 (1.6)</td>
<td>0.499</td>
<td>0.8 (0.3)</td>
<td>0.6 (0.3)</td>
<td>0.055</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CRP, median (IQR), mg/L</td>
<td>19.1</td>
<td>3.7</td>
<td>0.000</td>
<td>28.4</td>
<td>11.2</td>
<td>0.099</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutrophil count×10⁹, median (IQR), /L</td>
<td>5.0 (2.9-7.5)</td>
<td>4.3 (2.6-6.0)</td>
<td>0.047</td>
<td>5.5 (4.1-6.5)</td>
<td>5.2 (3.5-8.7)</td>
<td>0.094</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IL-6, median (IQR), pg/mL</td>
<td>9.7</td>
<td>2.8</td>
<td>0.000</td>
<td>32.9</td>
<td>20.4</td>
<td>0.472</td>
<td></td>
<td></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>
<td>1.4 (1.1-1.9)</td>
<td>1.4 (1.2-2.4)</td>
<td>0.075</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PaCO₂, mean (SD), mmHg</td>
<td>36.9</td>
<td>38.3 (6.2)</td>
<td>0.253</td>
<td>36.0 (6.24)</td>
<td>40.2 (6.0)</td>
<td>0.024</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PaO₂, mean (SD), mmHg</td>
<td>94.2</td>
<td>95.5 (31.6)</td>
<td>0.868</td>
<td>106.4 (38.1)</td>
<td>132.1 (58.7)</td>
<td>0.090</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fingertip SaO₂, median (IQR), %</td>
<td>96.0</td>
<td>99.0</td>
<td>0.000</td>
<td>98.0</td>
<td>99.0</td>
<td>0.026</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Body temperature, median (IQR), ºC</td>
<td>36.9</td>
<td>36.5</td>
<td>0.000</td>
<td>36.6</td>
<td>36.6</td>
<td>0.796</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fever, n (%)</td>
<td>20 (47.6%)</td>
<td>3 (7.1%)</td>
<td>0.000</td>
<td>3 (15.0%)</td>
<td>1 (5.0%)</td>
<td>0.605</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cough, n (%)</td>
<td>20 (47.6%)</td>
<td>10 (23.8%)</td>
<td>0.023</td>
<td>12 (60.0%)</td>
<td>2 (10.0%)</td>
<td>0.002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expectoration, n (%)</td>
<td>24 (57.1%)</td>
<td>8 (19.0%)</td>
<td>0.000</td>
<td>11 (55.0%)</td>
<td>2 (10.0%)</td>
<td>0.006</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore throat, n (%)</td>
<td>3 (7.3%)</td>
<td>1 (2.4%)</td>
<td>0.360</td>
<td>0</td>
<td>0</td>
<td>..</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headache, n (%)</td>
<td>3 (7.3%)</td>
<td>1 (2.4%)</td>
<td>0.360</td>
<td>0</td>
<td>0</td>
<td>..</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Muscular ache, n (%)</td>
<td>Number of days since Hospitalisation, mean (SD), days</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
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<td>-------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17 (40.5%)</td>
<td>11.4 (5.0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 (2.4%)</td>
<td>17.7 (7.7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0.000</td>
<td>0.002</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></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, PaCO$_2$=arterial partial pressure of carbon dioxide, PaO$_2$=arterial partial pressure of oxygen; SaO$_2$=arterial oxygen saturation.
75 Participants assessed for eligibility

63 Randomized

42 Randomized to treatment group

42 Randomized to receive LIPUS treatment

42 target areas were treated with LIPUS irradiation

42 included in the primary analysis

42 Randomized to self-control area

42 non-target areas were not treated with LIPUS irradiation

42 included in the primary analysis

21 Randomized to external control group

20 received routine nutritional support and symptomatic treatment

20 included in the primary analysis

12 Excluded:
8 Did not meet eligibility criteria
4 Withdrawn

1 withdrew consent