Hence, we speculated that patients with COVID-19 might benefit from treatments specifically targeting the COVID-19-associated inflammation storm. Indeed, in addition to antiviral medications, numerous immune-modulating medications to regulate inflammatory response are currently being investigated in patients with COVID-19. In clinical practice, glucocorticoid is generally used to inhibit severe inflammation in high-risk patients. Besides, chloroquine, which has been used as an antimalarial agent, blocks virus infection by increasing the endosomal pH required for virus/cell fusion and has been demonstrated in vitro to have inhibitory activity in SARS-CoV-2. Yet, for patients with COVID-19 experiencing an inflammation storm, more evidence is needed to verify the effectiveness of glucocorticoid and immunosuppressive therapy. For us, it may be reasonable to triage patients with COVID-19 according to the presence of underlying CVD and evidence of myocardial injury for prioritized treatment and particularly for treatments specifically targeting on inflammation.

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CORRECTION

Errors in Abstract, Results, and End Matter: The Brief Report “Risk of QT Interval Prolongation Associated With Use of Hydroxychloroquine With or Without Concomitant Azithromycin Among Hospitalized Patients Testing Positive for Coronavirus Disease 2019 (COVID-19),” published online on May 1, 2020, contained 3 errors. The first was a misstated percentage in the Abstract and Results. The phrase “3 patients (3%)” should have said “3 patients (8%).” In addition, a percentage in the Results section was missing a decimal point. The phrase “(26 patients [289%])...” should have said “(26 patients [28.9%]).” Finally, the Corresponding Author information for Howard S. Gold, MD, and Peter J. Zimetbaum, MD, was inadvertently omitted and has been added. The article has been corrected online.


Errors in Table 2: In the Original Investigation titled “Safety and Efficacy of Femoral Access vs Radial Access in ST-Segment Elevation Myocardial Infarction: The SAFARI-STEMI Randomized Clinical Trial,” published in the February issue of JAMA Cardiology, data were incorrectly shown for the type of stent and for 2 of the critical time intervals in Table 2. In the “Radial Access” column, the No./total No. (%) was changed to 912/1043 (87.4%) for drug-eluting stents, 123/1043 (11.8%) for bare metal stents, and 8/1043 (0.8%) for both, and the median (interquartile range) critical time interval was changed to 189 (136-300) minutes for “Symptom onset to first balloon inflation/device” and 48 (36-64) minutes for “Arrival at PCI [percutaneous coronary intervention] center to first balloon inflation/device.” In the “Femoral Access” column, the No./total No. (%) was changed to 952/1076 (88.5%) for drug-eluting stents, 113/1076 (10.5%) for bare metal stents, and 11/1076 (1.0%) for both, and the median (interquartile range) critical time interval was changed to 183 (132-310) minutes for “Symptom onset to first balloon inflation/device” and 46 (34-61) minutes for “Arrival at PCI center to first balloon inflation/device.” Finally, the P value for table footnote c in Table 2 should be changed to P = .003. This article has been corrected online. This article was previously corrected to fix an incorrect degree for the second author in the byline.


Error in Text: The Viewpoint “Fear of Coronavirus Disease 2019—An Emerging Cardiac Risk,” published online July 22, 2020, contained an error in the text. The phrase “there are no specific therapies that are known to decrease mortality” should instead have said “there are as yet no specific therapies broadly accepted to decrease mortality.” The error has been corrected online.