Original Study - Brief Report

The Effect of Age on Mortality in Patients With COVID-19: A Meta-Analysis With 611,583 Subjects

Clara Bonanad MD, PhD, Sergio García-Blas MD, PhD, Francisco Tarazona-Santabalbina MD, PhD, Juan Sanchis MD, PhD, FESC, Vicente Bertomeu-González MD, PhD, FESC, Lorenzo Fálica MD, PhD, Albert Ariza MD, PhD, Julio Nuñez MD, PhD, FESC, Alberto Cordero MD, PhD, FESC,*

**a** Cardiology Department, Hospital Clínico Universitario, Valencia, Spain
**b** Instituto de Investigación Sanitaria (INCLIVA), Hospital Clínico Universitario de Valencia, Spain
**c** Centro de Investigación Biomédica en Red de Enfermedades Cardiovasculares (CIBERCV), Spain
**d** Servicio de Geriatría, Hospital Universitario de la Ribera, Alzira, Valencia, Spain
**e** Cardiology Department, Hospital Universitario de San Juan, Alicante, Spain
**f** Cardiology Department, Hospital General Universitario de Valencia, Spain
**g** Cardiology Department, Hospital Clínico Universitario Bellvitge, Hospital De Llobregat, Barcelona, Spain

**Keywords:** COVID-19, coronavirus, older adults, mortality

**Abstract**

Objectives: Initial data on COVID-19 infection has pointed out a special vulnerability of older adults.

Design: We performed a meta-analysis with available national reports on May 7, 2020 from China, Italy, Spain, United Kingdom, and New York State. Analyses were performed by a random effects model, and sensitivity analyses were performed for the identification of potential sources of heterogeneity.

Setting and participants: COVID-19 positive patients reported in literature and national reports.

Measures: All-cause mortality by age.

Results: A total of 611,1583 subjects were analyzed and 141,745 (23.2%) were aged ≥80 years. The percentage of octogenarians was different in the 5 registries, the lowest being in China (3.2%) and the highest in the United Kingdom and New York State. The overall mortality rate was 12.10% and it varied widely between countries, the lowest being in China (3.1%) and the highest in the United Kingdom (20.8%) and New York State (20.9%). Mortality was <1.1% in patients aged <50 years and it increased exponentially after that age in the 5 national registries. As expected, the highest mortality rate was observed in patients aged ≥80 years. All age groups had significantly higher mortality compared with the immediately younger age group. The largest increase in mortality risk was observed in patients aged 60 to 69 years compared with those aged 50 to 59 years (odds ratio 3.13, 95% confidence interval 2.61-3.76).

Conclusions and Implications: This meta-analysis with more than half million of COVID-19 patients from different countries highlights the determinant effect of age on mortality with the relevant thresholds on age ≥50 years and, especially, ≥60 years. Older adult patients should be prioritized in the implementation of preventive measures.

© 2020 AMDA — The Society for Post-Acute and Long-Term Care Medicine.
among patients older than 80 years. Therefore, older adults seem to have a higher proportion of severe cases of COVID-19 and fatal outcome. The present study aims to analyze the available data of mortality in the older adult population compared with its younger counterparts.

**Methods**

We performed a systematic search [using PubMed, Embase, and Cochrane Central Register of Controlled Trials (CENTRAL), and Google Scholar], without language restriction, for papers using the Medical Subject Headings terms “Coronavirus,” “Covid-19,” “Mortality,” “Clinical outcomes” and “Clinical course” up to May 7, 2020. We also searched for national reports in the official health services’ website of all European Countries. Primary outcome was all-cause death. As a result, of the 17 studies that reported clinical features of patients who died vs survivors, most were hospital registries,4,7,9 4 were national reports (from China,4 Italy,5 and Spain,6 and United Kingdom10), and 1 was a publication from Northwell Health, the largest academic health system in New York State.11 Hospital registries did not include age distribution and, therefore, could not be included. Older adult patients were defined as those aged 80 years or older.

We performed a meta-analysis in line with recommendations from the Cochrane Collaboration and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Statement.12 Clinical features and mortality rates were available in all studies. Relative

**Table 1**

<table>
<thead>
<tr>
<th></th>
<th>China</th>
<th>Italy</th>
<th>Spain</th>
<th>New York State</th>
<th>United Kingdom</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>44,672</td>
<td>214,103</td>
<td>220,375</td>
<td>2634</td>
<td>129,799</td>
<td>611,583</td>
</tr>
<tr>
<td>Age, y, mean</td>
<td>79.5</td>
<td>61</td>
<td>61</td>
<td>63</td>
<td>62</td>
<td>64.9</td>
</tr>
<tr>
<td>Fatality, n (%)</td>
<td>1623 (2.29)</td>
<td>27,955 (13.06)</td>
<td>17,489 (7.94)</td>
<td>553 (20.99)</td>
<td>27,008 (20.81)</td>
<td>74,028 (12.10)</td>
</tr>
<tr>
<td>Sex, male</td>
<td>22,981</td>
<td>99,667</td>
<td>96,297</td>
<td>3437</td>
<td>60,104</td>
<td>132,682</td>
</tr>
<tr>
<td>Hypertension</td>
<td>2683</td>
<td>23,962</td>
<td>23,962</td>
<td>1366</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>1102</td>
<td>19,850</td>
<td></td>
<td></td>
<td></td>
<td>757</td>
</tr>
<tr>
<td>Age groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt;29</td>
<td>4584</td>
<td>16,007</td>
<td>13,795</td>
<td>131</td>
<td>12,081</td>
<td>46,598</td>
</tr>
<tr>
<td>Fatality</td>
<td>8 (0.2)</td>
<td>12 (0.1)</td>
<td>28 (0.2)</td>
<td>4 (0.3)</td>
<td>67 (0.6)</td>
<td>119 (0.3)</td>
</tr>
<tr>
<td>Age 30-39</td>
<td>7600</td>
<td>16,189</td>
<td>20,755</td>
<td>211</td>
<td>211</td>
<td>13,193</td>
</tr>
<tr>
<td>Fatality</td>
<td>18 (0.2)</td>
<td>54 (0.3)</td>
<td>57 (0.3)</td>
<td>8 (3.8)</td>
<td>134 (1.0)</td>
<td>271 (0.5)</td>
</tr>
<tr>
<td>Age 40-49</td>
<td>8571</td>
<td>27,553</td>
<td>32,208</td>
<td>432</td>
<td>15,712</td>
<td>84,476</td>
</tr>
<tr>
<td>Fatality</td>
<td>38 (0.4)</td>
<td>246 (0.9)</td>
<td>186 (0.6)</td>
<td>22 (5.1)</td>
<td>454 (2.9)</td>
<td>946 (1.1)</td>
</tr>
<tr>
<td>Age 50-59</td>
<td>10,008</td>
<td>38,299</td>
<td>39,355</td>
<td>515</td>
<td>19,436</td>
<td>107,613</td>
</tr>
<tr>
<td>Fatality</td>
<td>130 (1.3)</td>
<td>993 (2.6)</td>
<td>569 (1.4)</td>
<td>53 (10.2)</td>
<td>1518 (7.8)</td>
<td>3263 (2.0)</td>
</tr>
<tr>
<td>Age 60-69</td>
<td>8583</td>
<td>29,252</td>
<td>32,175</td>
<td>533</td>
<td>14,815</td>
<td>85,358</td>
</tr>
<tr>
<td>Fatality</td>
<td>309 (3.6)</td>
<td>2976 (10.2)</td>
<td>1543 (4.8)</td>
<td>84 (15.7)</td>
<td>3161 (21.3)</td>
<td>8073 (9.5)</td>
</tr>
<tr>
<td>Age 70-79</td>
<td>3918</td>
<td>31,627</td>
<td>30,844</td>
<td>451</td>
<td>18,273</td>
<td>85,113</td>
</tr>
<tr>
<td>Fatality</td>
<td>312 (8.0)</td>
<td>7849 (24.8)</td>
<td>4325 (14.02)</td>
<td>145 (32.2)</td>
<td>6765 (37.0)</td>
<td>19,396 (22.8)</td>
</tr>
<tr>
<td>Age &gt;80</td>
<td>1408</td>
<td>55,020</td>
<td>50,504</td>
<td>441</td>
<td>34,372</td>
<td>141,745</td>
</tr>
<tr>
<td>Fatality</td>
<td>208 (14.8)</td>
<td>15,825 (28.8)</td>
<td>10,781 (21.3)</td>
<td>237 (53.7)</td>
<td>14,907 (43.4)</td>
<td>41,958 (29.6)</td>
</tr>
</tbody>
</table>

![Fig. 1. Histogram of patients according to age groups and crude mortality rates.](image-url)
risk reductions and percentage incidences were used. The study-specific standard errors for the estimated odds ratio were used to model the within-study variation. The percentage of variability across studies attributable to heterogeneity beyond chance was estimated using the $I^2$ statistic. Once heterogeneity was observed and assuming that the study effect sizes were different as well as that the collected studies represented a random sample from a larger population, all the analyses were performed by a random effects model. Sensitivity analyses were performed for the identification of potential sources of heterogeneity between studies with meta-regression analyses and the Harbord test to assess the small-study effects. All analyses were performed using Stata, release 14.3 (StataCorp LP, College Station, TX).

Fig. 2. Forest plots showing the pooled odds ratio (OR) with 95% confidence intervals of mortality for each age group.
Results

A total of 611,583 subjects were analyzed; the mean age was 61.3 years and 192,786 (31.5%) were male (Table 1). A total of 141,745 patients (23.2%) were ≥80 years old; the percentage of older adults was different in the 5 reports, the lowest being in China and the highest in the United Kingdom and New York State. The overall mortality rate was 12.1% and it varied widely between countries, the lowest being in China and the highest in the United Kingdom and New York State.

According to age, mortality was <1% in patients aged <50 years, and it increased exponentially after that age (Figure 1). As expected, the highest mortality rate was observed in patients aged ≥80 years. All age groups had significantly higher mortality compared to the immediately younger age group (Figure 2). The largest increase in mortality risk was observed in patients aged 60 to 69 years compared to 50 with 59 years. Patients aged ≥80 years had 60% higher risk of death compared to patients with age 70 to 79 years but it was 6-fold higher (odds ratio: 6.25, 95% confidence interval 5.38–7.25; P < .001) if they were compared to all patients aged <80 years.

Significant heterogeneity (P < .001) was observed. The funnel plot is presented in Figure 2. Meta-regression identified sample size (P = .002), countries (P = .001), and mean age (P = .001) as significant sources of heterogeneity; the small-effect study was also observed (Habor test, P = .013).

Discussion

The meta-analysis of currently available national and regional reports of patients with COVID-19 infection highlights the effect of age on mortality. These results have important clinical implications such as on specific preventive measures and the clinical management of COVID-19 patients.

Since the start of the pandemic, age has been outlined as the key predictor determinant in COVID-19 patients. Based on the early statistical data of China, the case-fatality rate (CFR) increases markedly from the age of 60, reaching 14.8% in those older than 80 years. Initial data from Italian patients also described that mortality increased significantly in septuagenarian patients and almost tripled in octogenarians. In a Chinese cohort study, age was identified as an independent predictor of mortality, with an odds ratio of 1.1 (95% confidence interval 1.03, 1.17) for each year. Our analysis of 611,583 patients shows a mortality increase related to age; this is evident in patients aged ≥60 years, increasing significantly in each decade of life. Therefore, the highest mortality occurs in the patients aged ≥80 years in whom it was 6 times higher than in younger patients.

These findings are consistent with a higher susceptibility to the infection and severe clinical manifestations observed in older adult patients. This fact could be influenced by both the physiologic aging process and, especially, the greater prevalence in older adult patients of frailty and comorbidities that contribute to a decrease in functional reserve that reduces intrinsic capacity and resilience and hinders the fight against infections. In this line of thought, comorbidities such as cardiovascular disease, hypertension, and diabetes are highly prevalent in older adults and have been associated with worse outcomes in COVID-19. Many mechanisms underlying this worse prognosis in older adults with COVID-19 might explain our results that might lead to further research.

Our study has several limitations, mainly derived from the data source. National reports might be designed and performed with different methodologies in each country. Population characteristics might also be quite different, especially between Europe and China. Specifically, in older adults the percentage of infected and dead in nursing homes and socio-sanitary centers is not published, therefore the real incidence and mortality of COVID-19 may be underestimated.

Future studies are necessary to analyze the factors that, beyond age, make this population especially susceptible and vulnerable to having a serious infection with complications and a higher mortality rate.

Conclusions and Implications

The meta-analysis of currently available data suggest a determinant effect of age on mortality of COVID-19 patients with a relevant threshold on age >50 and especially >60. Nevertheless, more clinical and basic research is needed to elucidate the mechanism involved in the COVID-19 infection in older adults and to develop strategies to improve outcomes in these patients.

Acknowledgments

Investigators received the support of the Centro de Investigación Biomédica en Red de Enfermedades Cardiovasculares (CIBERCV CB16/11/00226-CB16/11/00420), the national Spanish National Network for Biomedical Investigation on Cardiovascular Disease.

References