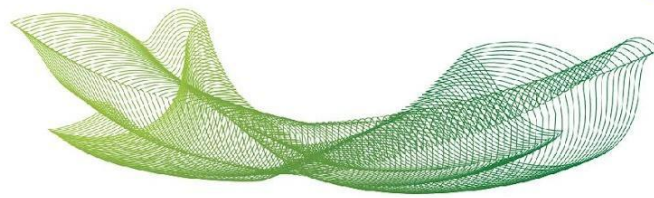


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| Resumo                    | <p>Abstract: Background: Brazil is a multiracial country with five major official races: White, Black, individuals with multiracial backgrounds, Asian, and Indigenous. Brazil is also one of the epicentres of the Coronavirus Disease (COVID)-19 pandemic. Thus, we evaluated how the races of the Brazilian population contribute to the outcomes in hospitalized individuals with COVID-19, and we also described the clinical profile of the five official Brazilian races.</p> <p>Methods: We performed an epidemiological analysis for the first 67 epidemiological weeks of the COVID-19 pandemic in Brazil (from February 22, 2020, to April 04, 2021) using the data available at OpenDataSUS of the Brazilian Ministry of Health, a data set containing data from Brazilian hospitalized individuals. We evaluated more than 30 characteristics, including demographic data, clinical symptoms, comorbidities, need for intensive care unit and mechanical ventilation, and outcomes.</p> <p>Results: In our data, 585 655 hospitalized individuals with a positive result in SARS-CoV-2 real-time chain reaction (RT-PCR) were included. Of these total, 309 646 (52.9%) identified as White, 31 872 (5.4%) identified as Black, 7108 (1.2%) identified as Asian, 235 108 (40.1%) identified as individuals with multiracial background, and 1921 (0.3%) identified as Indigenous. The multivariate analysis demonstrated that race was significative to predict the death being that Black (OR = 1.43; 95% CI = 1.39-1.48),</p> |



individuals with multiracial background (OR = 1.36; 95% CI = 1.34-1.38), and Indigenous (OR = 1.91; 95% CI = 1.70-2.15) races were more prone to die compared to the White race. The Asian individuals did not have a higher chance of dying due to SARS-CoV-2 infection compared to White individuals (OR = 0.99; 95% CI = 0.94-1.06). In addition, other characteristics contributed as such as being male (OR = 1.17; 95% CI = 1.16-1.19), age (mainly, +85 years old - OR = 23.02; 95% CI = 20.05-26.42) compared to 1-year-old individuals, living in rural areas (OR = 1.22; 95% CI = 1.18-1.26) or in peri-urban places (OR = 1.25; 95% CI = 1.11-1.40), and the presence of nosocomial infection (OR = 1.91; 95% CI = 1.82-2.01). Among the clinical symptoms, the main predictors were dyspnoea (OR = 1.25; 95% CI = 1.23-1.28), respiratory discomfort (OR = 1.30; 95% CI = 1.28-1.32), oxygen saturation <95% (OR = 1.40; 95% CI = 1.38-1.43). Also, among the comorbidities, the main predictors were the presence of immunosuppressive disorder (OR = 1.44; 95% CI = 1.39-1.49), neurological disorder (OR = 1.21; 95% CI = 1.17-1.25), hepatic disorder (OR = 1.41; 95% CI = 1.34-1.50), diabetes mellitus (OR = 1.40; 95% CI = 1.37-1.42), cardiopathy (OR = 1.13; 95% CI = 1.11-1.14), hematologic disorder (OR = 1.34; 95% CI = 1.24-1.43), Down syndrome (OR = 1.61; 95% CI = 1.43-1.81), renal disease (OR = 1.15; 95% CI = 1.11-1.18), and obesity (OR = 1.18; 95% CI = 1.15-1.21). Individuals on intensive care unit (OR = 2.25; 95% CI = 2.22-2.29) and on invasive (OR = 10.92; 95% CI = 10.66-11.18) or non-invasive (OR = 1.33; 95% CI = 1.30-1.35) mechanical ventilation were more prone to die.

Conclusions: Alongside several clinical symptoms and comorbidities, we associated race with an enhanced risk of death in Black individuals, individuals with multiracial backgrounds, and Indigenous peoples.

Fomento

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