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A 57-Year-Old African American Man with Severe COVID-19 Pneumonia Who Responded to Supportive Photobiomodulation Therapy (PBMT): First Use of PBMT in COVID-19

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Data Collection B
Statistical Analysis C
Data Interpretation D
Manuscript Preparation E
Literature Search F
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Conflict of interest: None declared

Patient: Male, 57-year-old
Final Diagnosis: COVID-19
Symptoms: Shortness of breath • hypoxia
Medication: —
Clinical Procedure: Photobiomodulation therapy (PBMT)
Specialty: Infectious Diseases • Pulmonology

Objective: Unusual or unexpected effect of treatment

Background: Coronavirus disease 2019 (COVID-19) is associated with lung inflammation and cytokine storm. Photobiomodulation therapy (PBMT) is a safe, non-invasive therapy with significant anti-inflammatory effects. Adjunct PBMT has been employed in treating patients with lung conditions. Human studies and experimental models of respiratory disease suggest PBMT reduces inflammation and promotes lung healing. This is the first time supportive PBMT was used in a severe case of COVID-19 pneumonia.

Case Report: A 57-year-old African American man with severe COVID-19 received 4 once-daily PBMT sessions by a laser scanner with pulsed 808 nm and super-pulsed 905 nm modes for 28 min. The patient was evaluated before and after treatment via radiological assessment of lung edema (RALE) by CXR, pulmonary severity indices, blood tests, oxygen requirements, and patient questionnaires. Oxygen saturation (SpO₂) increased from 93–94% to 97–100%, while the oxygen requirement decreased from 2–4 L/min to 1 L/min. The RALE score improved from 8 to 5. The Pneumonia Severity Index improved from Class V (142) to Class II (67). Additional pulmonary indices (Brescia-COVID and SMART-COP) both decreased from 4 to 0. CRP normalized from 15.1 to 1.23. The patient reported substantial improvement in the Community-Acquired Pneumonia assessment tool.

Conclusions: This report has presented supportive PBMT in a patient with severe COVID-19 pneumonia. Respiratory indices, radiological findings, oxygen requirements, and patient outcomes improved over several days and without need for a ventilator. Future controlled clinical trials are required to evaluate the effects of PBMT on clinical outcomes in patients with COVID-19 pneumonia.

MeSH Keywords: Anti-Inflammatory Agents • COVID-19 • Laser Therapy • Respiratory Distress Syndrome, Adult

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Background

Coronavirus disease 2019 (COVID-19) is caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). The presentation of COVID-19 includes dyspnea, lung edema, and pneumonia. Morbidity and mortality are associated with Acute Respiratory Distress Syndrome (ARDS) and cytokine storm. Hospitalized COVID-19 patients are classified as severe if they require intensive care unit (ICU) admission [1,2]. Here, we report the first case of the use of supportive or adjunctive photobiomodulation therapy (PBMT) in a patient with severe COVID-19 pneumonia.

PBMT is an emerging alternative modality with demonstrated anti-inflammatory effects in pain management, lymphedema, wound healing, and musculoskeletal injuries. Additional terms for PBMT include low-level laser (or light) therapy (LLLT), cold laser, and photobiostimulation [3]. The effects of PBMT differ from the thermal effects produced by the high-power lasers used in cosmetic and surgical procedures to destroy the tissue [4,5]. PBMT utilizes non-ionizing, non-thermal light sources in the visible and infrared spectra (400–1000 nm) [3]. In PBMT, light is applied over damaged tissues and the light energy absorbed by intracellular chromophores or biomolecules starts a cascade of molecular reactions that improve cell function and enhance the body's healing process [4]. In effect, light stimulates healing, modulates the immune system, and reduces inflammation, edema, and pain [4]. PBMT is non-invasive, cost-effective, and has no known adverse effects.

Empirical use of PBMT in children, adults, and elderly patients with pneumonia, asthma, chronic bronchitis, or pulmonary fibrosis resulted in reduced chest pain and heaviness, normalization of respiratory function, shortened recovery times, and improved immunological and radiological parameters. In these patients, PBMT used in combination with conventional medical treatment was safe and appeared to produce a synergistic effect in healing [6–10]. Recent publications recommend the use of supportive PBMT in COVID-19 patients [11–13]. ARDS is a critical complication of COVID-19 infection and supportive PBMT can ameliorate ARDS and promote lung healing [11,13–18]. Animal models of acute inflammation of the respiratory system suggest that transcutaneous PBMT over the lungs is effective against cytokine storm and ARDS via its anti-inflammatory action at multiple levels [14–18].

The theory of supportive PBMT for COVID-19 is based on laser light reaching lung tissue, which relieves inflammation and promotes healing. The World Association for Laser Therapy recommended treatment doses for low-level laser therapy, or PBMT for superficial to deep tissue lesions in musculoskeletal disorders in 2010 [19].

The minimum observed therapeutic dose for a bio-stimulatory effect of red and near-infrared (NIR) lasers is 0.01 J/cm² [20]. NIR Laser light at a power of 1 W/cm² projected through bovine tissue ranging in thickness from 1.8 to 9.5 cm resulted in effective power densities at 3.4 cm and 6.0 cm [21]. In veterinary practice, feline and canine pneumonia is frequently treated with laser doses of 6–10 J/cm² [22]. These animals have a thicker chest wall and furry skin, making penetration more challenging than in humans. Therefore, the range used in cats and dogs approximates an effective dose for humans.

Our previous experience in treating asthma [23] and musculoskeletal pain and injuries suggested that the anti-inflammatory effects of PBMT could benefit the severe inflammatory condition in COVID-19 patients. The laser machine used in this case is an US Food and Drug Administration (FDA)-cleared system for pain management and inflammation reduction in deep joints of the body. The combination of 808 and 905 nm, both NIR wavelengths, provides penetration to depths of 4–5.4 cm. This laser machine is used for deeper tissues like hips and pelvic joints that are surrounded by thick muscles. The therapeutic dose with this machine is 4.5 J/cm² over the skin to reach these deep targets of the pelvis. Based on our calculations, we used 7.2 J/cm² over the skin to deliver just over 0.01 J/cm² of laser energy to the lung. The 7.2 J/cm² dosage penetrates the chest wall (1.6 to 6 cm in humans) and reaches the lung tissue with sufficient energy for bio-stimulation. Scapular protraction in the prone position reduces the bone and muscle tissue the laser must penetrate, thereby increasing laser energy to the lung fields.

Here, we report the first use of PBMT as a supportive treatment in a severe case of COVID-19 pneumonia.

Case Report

A 57-year-old African American man with a history of hypertension and asthma presented with shortness of breath, severe dehydration, acute renal failure, and *C. difficile*-positive diarrhea. A physical examination revealed labored breathing, weakness, and fatigue. Chest X-rays demonstrated worsening bilateral lung infiltrates. Oxygen requirements in the hospital ranged from 2 to 6 L/min oxygen. The patient had been in the ICU for respiratory depression with SpO₂ of 80% requiring 48 h on 6 L/min oxygen. The diagnosis of SARS-CoV-2 was confirmed for this patient by reverse transcription-polymerase chain reaction by nasopharyngeal swab on an Abbott ID system. Patient consent was obtained for an FDA-guided and International Review Board-approved trial of laser treatment for COVID-19 (Lowell General Hospital Federal-wide Assurance number 0001427). The inclusion criteria consisted of a positive COVID-19 test, the ability to self-prone, and requiring at least 1 L/min oxygen.

Table 1. Laser parameters for COVID-19 pneumonia patients.

	808 nm (GaAlAs) diode	905 nm (GaAs) diode
Mode of radiation	Pulsed	Pulsed
Frequency	1500 Hz, (Duty Cycle 50%) (1 Hz±2 kHz)	1500 Hz (90 kHz Modulated at 1 Hz±2 kHz)
Pulse duration	333 µs (500 ms±250 µs)	100 ns
Peak power	3 W	75W×3
Average power	1.5 W	11.25×3=33.75 mW
Spot size	19.625 cm ²	
Area	On each lung 25×10=250 cm ²	
Dose	7.1–7.2 J/cm ²	
Distance from the skin	20 cm	
Treatment time	14 minutes each lung	
Total energy	3600 J 1794.24 each lung	
Total time	28 minutes	
Sessions	Once daily for 4 days	

The table explains the technical parameters for the dosage of laser energy and treatment time used in this case report. GaAlAs – Gallium Aluminum Arsenide Diode; GaAs – Gallium Arsenide Diode. The two diodes are part of a single laser system, the Multiwave Locked System (MLS). For patients with dark skin color, there is a pigment adjustment selection button on the laser console. When the pigment selection is activated, laser intensity is reduced by 50% and the software automatically recalculates the required dose.

The patient was treated with an FDA-cleared Multiwave Locked System (MLS) Therapy Laser (ASA Laser, Italy.) The MLS laser utilizes a mobile scanner with 2 synchronized laser diodes, one in pulse mode (adjustable to 1–2000 Hz), emitting at 905 nm, and another in pulsed mode emitting at 808 nm. The 2 laser beams work simultaneously and synchronously. This laser is used in pain centers for treatment of musculoskeletal pain and inflammation. Laser parameters were set as outlined in Table 1 and Figure 1. The laser scanner was adjusted to 20 cm above the skin, as recommended by the manufacturer. Each lung was scanned for 14 min from apex to base over 250 cm² of the posterior thorax (Table 1, Figures 1, 2).

Specific prone positioning was used with the patient's hands under his head for maximal scapular protraction. The laser field was focused to the medial border of the scapula opening the

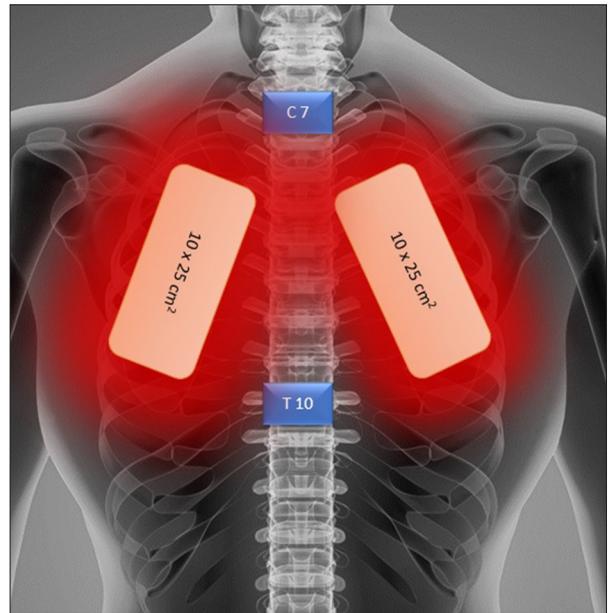


Figure 1. Orientation of the laser beams during laser treatment while in the prone position. The apex of the lung lies above the first rib. The lungs extend from the C7 to T10 vertebra, which is also from the apex of the lung to the inferior border. Laser parameters with both diodes operating synchronously and simultaneously, and the propagation axes are coincident. 1) 808 nm (GaAlAs) diode: Peak Power: 3 W, Laser Mode: Pulsed, Frequency: 1500 Hz, Pulse Duration: 333 µs, Scanning Area: 25×10=250 cm², Dose: 7.2 J/cm²; 2) 905 nm (GaAs) diode: Peak Power: 75 W×3, Laser Mode: Pulsed, Frequency: 1500 Hz, Pulse Duration: 100 ns, Area: 25×10=250 cm², Dose: 113.4 mJ/cm²; Total Energy: 3600 J. Treatment Time: (28 minutes), 14 minutes each lung, Sessions: Once daily for 4 days. Therapeutic Protocol: PBMT-COVID-19 By Dr. S. Mokmeli.

lung fields, thereby minimizing the chest wall thickness for theoretical improvement of laser penetration to lung tissue.

Prior to laser treatment, the patient was bedridden, with SpO₂ 92–95% on 2–4 L/min oxygen. He had completed his antibiotic course and was not receiving any pharmacotherapeutic or IV support. He experienced severe paroxysmal coughing episodes and had failed a physical therapy trial. The patient tolerated the prone position for laser treatment for a total of 28 min. Within 5 min of laser treatment, his oxygen saturation rose from 94% to 100% in the first session. Following treatment, he returned to his bed and resumed the semi-sitting position and SpO₂ remained at 98% for the rest of the day.

The patient tolerated all 4 daily treatments and noted significant improvement in breathing immediately after each treatment. Paroxysmal coughing spells resolved after the third treatment. Upon completion of the fourth treatment, the patient was able

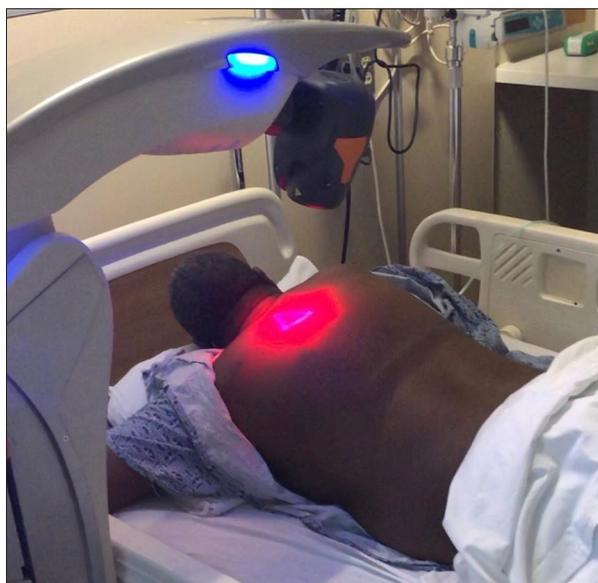


Figure 2. Laser scanner configuration while the patient is in the prone position with scapular protraction. The laser scanner was adjusted 20 cm above the skin as per manufacturer's guidelines. The patient is shown here with his hands under his head for maximum scapular protraction. The red light is the laser machine's guide beam on the skin. Infrared lasers with wavelengths of 808 and 905 nm are not visible to human eyes. The 2 sources are coupled in a single system in the MLS laser system.

to ambulate in the room with physical therapy. On the day following his final treatment, the patient was discharged to an acute rehabilitation facility on 1 L/min oxygen. On the day after arrival to the acute rehabilitation facility, the patient was able to complete 2 trials of stair climbing with physical therapy and was in the process of weaning to room air.

The patient's response to PBMT was evaluated by comparing different scoring tools before and after laser therapy. The patient showed improvement in all evaluation criteria (Table 2).

The Pneumonia Severity Index (PSI) [24] calculates the probability of morbidity and mortality among patients with community-acquired pneumonia (CAP). Prior to treatment, the patient's PSI score was Class V (142), which requires ICU treatment and predicts intubation and ventilator use. After PBMT, PSI decreased to Class II (67), which signifies outpatient treatment.

The SMART-COP score [25], which is an acronym for Systolic blood pressure, Multilobar infiltrates, Albumin, Respiratory rate, Tachycardia, Confusion, Oxygen, and pH, evaluates pneumonia severity and predicts the need for intensive respiratory or vasopressor support (IRVS) in CAP. The pretreatment SMART-COP score was 5, placing him in the high-risk group, and signifying a 1 in 3 chance of needing IRVS. Following PBMT, the

SMART-COP decreased to 2, implying minimal risk for needing IRVS.

The Brescia-COVID Respiratory Severity Scale [26] is a stepwise algorithm for managing patients with confirmed COVID-19. Before treatment, the patient's score was 4 out of 4, which requires a trial of high-flow nasal cannula (HFNC), reassessment, and intubation if the score remains >2. Following PBMT, the patient's Brescia-COVID score was 0, which simply requires patient monitoring.

The CAP tool score [27] is a short and sensitive questionnaire evaluating changes in respiratory symptoms and well-being during the treatment of community-acquired pneumonia. Scores <75% indicate symptomatic distress. The patient's pretreatment CAP score was 36.68% and increased to 82.84% after treatment. His CAP Respiratory Score improved from 67.52%, before treatment to 87.17% at the time of discharge. The CAP Well-Being score increased from 0% before treatment to 73.07% after treatment. This patient demonstrated substantial improvement in all 3 measures of respiratory symptoms.

The Radiographic Assessment of Lung Edema (RALE) score [28,29] evaluates lung edema on CXR in ARDS patients. To quantify the extent of infection, a severity score was calculated [29]. A score of 0 to 4 was assigned to each lung depending on the percent lung consolidation or ground-glass opacity, with 0 signifying no lung involvement, 1 indicating <25% lung involvement, 2 indicating 25–50% lung involvement, 3 indicating 50–75% lung involvement, and 4 indicating >75% involvement. The scores for each lung were added together to produce the final severity score [29]. The RALE score was 8 (>75% involvement of both lungs) and improved to 5 upon treatment completion (Figure 3).

His white blood cell count decreased from 10.7 to 6.5 and his C-reactive protein decreased from 15.1 to 1.23 after treatment. The oxygen requirement before treatment was 2–4 L/min with an oxygen saturation (SpO₂) of 93–94%. The oxygen requirement after treatment improved to 1 L/min with an SpO₂ of 97–100% at the time of discharge.

Discussion

This case report showed that 4 daily sessions of adjunct PBMT were beneficial in a patient with severe COVID-19 symptoms. The patient's positive response to treatment was supported by radiological findings, pulmonary severity scores, oxygen requirements, blood and inflammatory markers, and patient questionnaires. On follow-up, his clinical recovery in total was 3 weeks, whereas the median time for COVID-19 is typically 6–8 weeks [30].

Table 2. Evaluation criteria before and after photobiomodulation therapy in a COVID-19 patient.

Parameters	Before treatment	After treatment	Normal range or evaluation criteria
PSI	Class V (142)	Class II (67)	Risk Class (Points): Disposition Class I (<50): Outpatient Class II (51–70): Outpatient Class III (71–90): Outpatient/brief Inpatient Class IV (91–130): Inpatient Class V (>130): Inpatient
SMART-COP	5	2	0 points: Very low risk of needing IRVS 1 point: Low risk (1 in 20) of needing IRVS 2 points: Moderate risk (1 in 10) of needing IRVS 3 points: High risk (1 in 6) of needing IRVS ≥4 points: High risk (1 in 3) of needing IRVS; Consider ICU admission
Brescia-COVID	4	0	0 – monitor 1 – add O ₂ and monitor 2 – CXR, ABG, O ₂ therapy, monitor >2 – HFNC and reassess. If still >2, intubate.
CAP total	36.68	82.82	Calculated based on (CAP) score questionnaire: 75–100%
CAP respiratory	67.52	87.17	75–100%
CAP well-being	0.0	73.07	75–100%
RALE	8	5	Lungs score dependent on extent of involvement based on consolidation or ground-glass opacities for each lung, total score is the sum of the score of the lungs: 0 – no involvement; 1 – <25% of lung involved; 2 – 25–50% of lung involved; 3 – 50–75% of lung involved; 4 – >75% of lung involved.
WBC	10.7	6.5	4.5–11
CRP	15.1	1.23	3 mg/mL
O ₂ Requirement	2–3 L/min	1 L/min	0 L/min
SpO ₂	93–94%	100%	≥94%

PSI – Pneumonia Severity Index; SMART-COP – Systolic blood pressure, Multilobar infiltrates, Albumin, Respiratory rate, Tachycardia, Confusion, Oxygen, and pH; CAP – Community-Acquired Pneumonia; RALE – Radiographic Assessment of Lung Edema; SpO₂ – Oxygen saturation; WBC – White Blood Cells; CRP – C-Reactive Protein; IRVS – Intensive Respiratory or Vasopressor Support; CXR – Chest x-ray; ABG – Arterial Blood Gas; HFNC – High-Flow Nasal Cannula.

The therapeutic effects of PBMT on pneumonia are thought to occur via local and systemic effects that reduce inflammatory cytokines, cellular infiltrates, edema and fibrosis, and increase anti-inflammatory cytokines and processes, and promote healing. Local PBMT affects the entire body when photoproducts are distributed via the vasculature to reach distant targets. Activated photoproducts lead to alleviation of inflammation and immunomodulatory effects, and stimulate wound healing and tissue regeneration [4]. Animal studies illustrate the potency of PBMT.

Transcutaneous PBMT in murine models for pulmonary fibrosis and ARDS significantly reduced pro-inflammatory cytokines,

inflammatory cells, and collagen fiber deposition in lung parenchyma [14–18]. In contrast, the anti-inflammatory cytokine interleukin-10, serum monocytes, and lung macrophages were significantly increased following PBMT [15,17]. The molecular basis of MLS laser anti-inflammatory effects has been demonstrated in murine and *in vitro* models [31–33]. In particular, it has been shown to inhibit inflammasome activation, inhibiting interleukin-1β and interleukin-18, whose downstream signaling induces the production of interleukin-6, interleukin-8, tumor necrosis factor α (TNF-α), and interferon-γ, which are implicated in ARDS caused by COVID-19 infection [14–18,31–33].

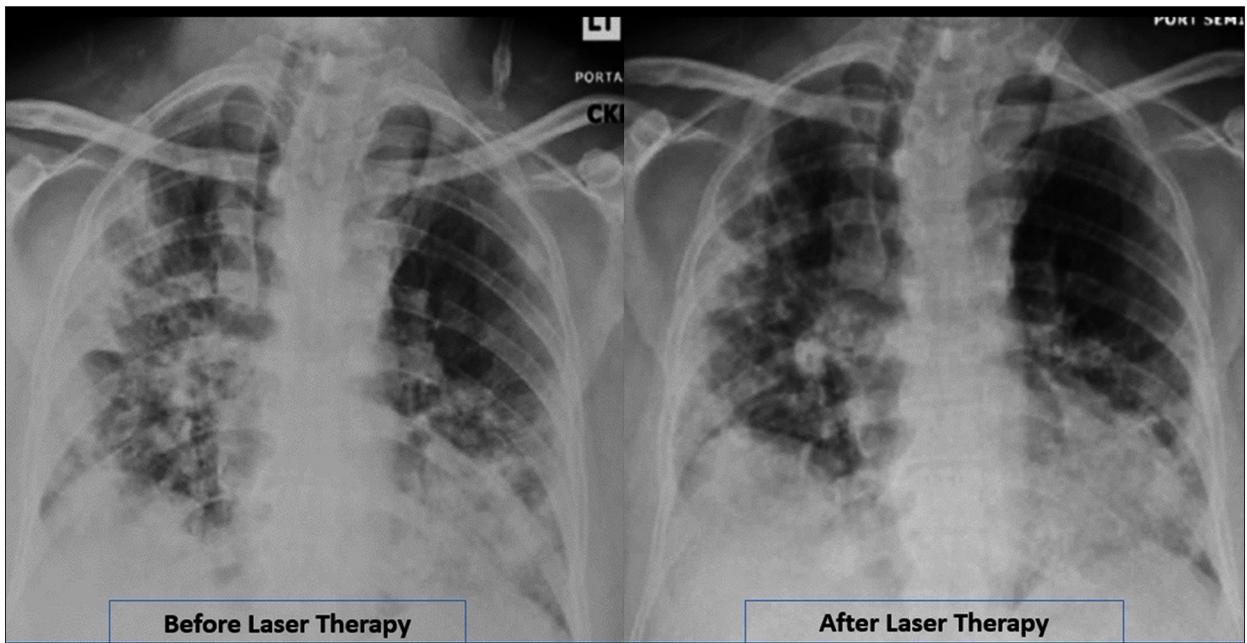


Figure 3. Radiographic Assessment of Lung Edema (RALE) by CXR showed reduced ground-glass opacities and consolidation following PBMT. Lung radiographic score is dependent on extent of involvement based on consolidation or ground-glass opacities for each lung. Total score is the sum of both lungs. Scores classification: 0 – no involvement; 1 – <25% of lung involved; 2 – 25–50% of lung involved; 3 – 50–75% of lung involved; 4 – >75% of lung involved. RALE score before laser therapy (04-27-2020)=8. Laser therapy started on (04-29-2020). RALE score after laser therapy (05-03-2020)=5.

Human trials have shown local and systemic effects of PBMT when applied to quadriceps muscle in patients with chronic obstructive pulmonary disease [10]. Beneficial effects extended beyond improved muscular performance, to statistically significant reductions in dyspnea and fatigue [10]. Our patient also reported subjective feelings of improved respiratory function and strength.

Our patient was only placed in the prone position for the duration of laser treatment. Treatments lasted exactly 28 min for each of the 4 days. Physiological evidence and clinical trial data support the use of prone position ventilation in selected patients with moderate-to-severe ARDS. For patients to benefit, the use of long prone positioning sessions of 12 h to 18 h per session are necessary [34,35]. An increase in SpO₂ from 94% to 100% occurred within the first 5 min of treatment, and the patient maintained good saturation thereafter. This finding shows the rapid effect of PBMT treatment on oxygen saturation. It is unlikely that prone positioning alone was the reason for improved oxygenation, given the minimal time in that position.

A strength of this case report is that we collected patient symptom data before and after treatment. All 4 pulmonary scoring tools and the 3 patient questionnaires demonstrated the benefit of treatment. To the best of our knowledge, this was the first time that PBMT was used as adjunctive treatment for

pneumonia in a COVID-19 patient. Irradiation over the posterior projection of the lungs, using the scanning method, has no risk of contamination since the scanning laser does not physically touch the patient. A deficiency of our study is the lack of inflammatory markers and blood tests. Future studies should include measurements before and after treatment of interleukin-6, interleukin-10, TNF- α , as well as additional inflammatory markers. A limitation of this case report is that this is a single patient and we were unable to carry out any statistical analysis.

Conclusions

This report has presented a patient with severe COVID-19 pneumonia associated with ARDS who was given supportive treatment with PBMT. Based on this case report, as well as clinical experience of PBMT in respiratory tract diseases in humans, we consider PBMT to be a feasible adjunct modality for the treatment of COVID-19. There is published experimental work demonstrating the anti-inflammatory effect of PBMT on lung tissue. We suggest that the use of adjunct PBMT in the early stages of severe ARDS seen in COVID-19 patients can enhance healing and reduce the need for prolonged ventilator support and ICU stay. The urgent current medical situation calls for PBMT pilot studies and clinical trials to evaluate its effect on COVID-19 pneumonia. This patient is part of an ongoing investigational randomized controlled trial.

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Adjunct low level laser therapy (LLLT) in a morbidly obese patient with severe COVID-19 pneumonia: A case report

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S. A. Sigman, S. Mokmeli, M. A. Vetrici. Adjunct low level laser therapy (LLLT) in a morbidly obese patient with severe COVID-19 pneumonia: A case report *Can J Respir Ther* 2020;56:52–56. doi: 10.29390/cjrt-2020-022.

Introduction: COVID-19 poses a higher risk of complications in obese patients due to low respiratory system compliance, increased inflammatory cytokines, and an activated immune system secondary to excess adiposity. Low level laser therapy (LLLT) has significant anti-inflammatory effects and reduces inflammatory cytokines. It is noninvasive and approved for pain management and musculoskeletal injuries. Data from human and experimental animal models of respiratory tract disease suggests that LLLT reduces inflammation and promotes lung healing.

Case and outcomes: A morbidly obese 32-year-old Asian female with severe COVID-19 received four consecutive once-daily LLLT sessions via a laser scanner. Pulsed 808 nm and 905 nm laser beams were delivered over the posterior chest for 28 min. The patient was evaluated before and after LLLT by radiological assessment of lung edema (RALE) on chest X-ray, oxygen requirements and saturation, pneumonia severity indices (SMART-COP and Brescia-COVID), blood inflammatory markers (interleukin-6, ferritin, and C-Reactive protein (CRP)). Prior to treatment, oxygen saturation (SpO₂) via pulse oximetry was 88%–93% on 5–6 L oxygen. Following LLLT, SpO₂ increased to 97%–99% on 1–3 L oxygen. Reductions in RALE score from 8 to 3, Brescia-COVID from 4 to 0, and SMART-COP from 5 to 0 were observed. Interleukin-6 decreased from 45.89 to 11.7 pg/mL, ferritin from 359 to 175 ng/mL, and CRP from 3.04 to 1.43 mg/dL. Post-treatment, the patient noted appreciable improvement in respiratory symptoms.

Conclusion: Following LLLT our patient showed improvement over a few days in respiratory indices, radiological findings, inflammatory markers, and patient outcomes. This report suggests that adjunct LLLT can be safely combined with conventional treatment in patients with severe COVID-19 and morbid obesity.

Key Words: COVID-19; low level laser therapy, LLLT; anti-inflammatory; photobiomodulation; morbid obesity.

INTRODUCTION

COVID-19 patients with underlying conditions are at higher risk of morbidity and mortality, secondary to the cytokine storm and Acute Respiratory Distress Syndrome (ARDS). The World Health Organization advises that patients with obesity experience more severe symptoms and complications [1], and severe cases of COVID-19 typically require 3–6 weeks for recovery [2].

Obesity leads to mechanical compression of the diaphragm, lungs, and chest cavity, creating restrictive pulmonary damage. Excess fatty tissue decreases respiratory system compliance, while pulmonary resistance is increased, and respiratory muscle strength is decreased [3]. Excess adiposity is associated with elevated inflammatory cytokines and an activated immune system [4]. Severe cases of COVID-19 are characterized by respiratory rates >30, oxygen saturation ≤93%, and >50% involvement of lungs by chest X-ray (CXR). Significantly higher levels of plasma pro-inflammatory factors such as interleukin-6 (IL-6), ferritin, and C-reactive protein (CRP) predict possible intensive care unit (ICU) admission [5–7]. Serum ferritin levels were found to be most closely related to the severity of COVID-19 [6].

Low level laser therapy (LLLT), also known as photobiomodulation therapy (PBMT) is a noninvasive, safe modality with significant anti-inflammatory effects confirmed by meta-analyses [8]. It is approved

for pain management, tissue healing, and lymphedema reduction. In LLLT, transcutaneous application of low-intensity monochromatic light of 400–1000 nm produces intracellular photochemical reactions that activate biomolecules to restore normal cell function and enhance the tissue's healing processes [9].

Adjunct LLLT in human respiratory conditions, including pneumonia, asthma, and chronic obstructive pulmonary disease (COPD), has been shown to reduce respiratory symptoms, normalize respiratory function, shorten recovery times, and improve blood, immunological, and radiological parameters [10–13].

Experimental studies suggest that LLLT modulates the cytokine storm and ARDS via its anti-inflammatory action. Murine models of acute airway and lung inflammation show that LLLT reduces pulmonary microvascular leakage, IL-1β, IL-6, and intracellular reactive oxygen species [14–17]. LLLT reduces inflammation at multiple levels and may be an effective strategy to control cytokine storm [14–17]. The use of adjunctive LLLT or PBMT has been recommended as a potential treatment modality to reduce cytokine storm, ARDS, and the need for ventilators in COVID-19 [18, 19].

Here we report the effect of LLLT on CXR, pulmonary severity indices, and select inflammatory markers in a patient with severe COVID-19 and morbid obesity.

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CASE DESCRIPTION

A morbidly obese 32-year-old Asian female with a body mass index of 52 and a history of meningioma excision and asthma, presented to the emergency room (ER) with a positive COVID-19 test and shortness of breath, cough, and diarrhea. She was hypoxic with oxygen saturation via pulse oximetry (SpO₂) of 88% on room air, tachypneic with respiratory rate of 35, febrile with temperature of 100.5 F, pulse rate 89, and blood pressure 106/84. CXR demonstrated bilateral basal multifocal infiltrates. She was admitted on 5 L/min of O₂. The patient experienced symptoms 7 days prior to presenting to the ER. Upon admission, the patient was confirmed to be SARS-CoV-2 positive by nasopharyngeal swab and reverse transcription-polymerase chain reaction with an Abbott ID system. The patient was started on Ceftriaxone and Azithromycin for potential superimposed bacterial infection. She was considered high risk due to morbid obesity, asthma, low oxygen saturation, infiltrates on CXR, and tachypnea. Her condition worsened despite antibiotics and supportive therapy and was evaluated for ICU admission on hospital day 3. Consent was obtained for the institutional review board (IRB)-approved randomized clinical trial of LLLT for COVID-19. LLLT treatment started on hospital day 3 while antibiotics continued. The patient was not receiving any antiviral or steroid medications.

Pretreatment clinical findings

The patient's response to LLLT was evaluated via SMART-COP [20] (systolic blood pressure, multilobar infiltrates, albumin, respiratory rate, tachycardia, confusion, oxygen, and pH) and Brescia-COVID [21] prediction tools, CXR radiographic assessment of lung edema (RALE) [14], and blood markers of inflammation (Table 2).

The SMART-COP Score [20] evaluates pneumonia severity and predicts the need for intensive respiratory or vasopressor support (IRVS) in community-acquired pneumonia. The pretreatment SMART-COP score was 5, indicating potential serious progressive complications, rapid referral to the ICU, and the need for a ventilator. The Brescia-COVID Respiratory Severity Scale [21] is a stepwise algorithm for managing patients with confirmed COVID-19. Pretreatment score was 4, which predicted ICU and ventilator support.

The RALE score [22, 23] evaluates lung edema by CXR in ARDS patients. To quantify the extent of infection, a severity score was calculated by adapting and simplifying RALE score [15]. A score of 0–4 was

assigned to each lung depending on the extent of involvement by consolidation or ground glass opacities (0 = no involvement; 1 = <25%; 2 = 25%–50%; 3 = 50%–75%; 4 = >75% involvement). The scores for each lung were summed up to produce the final severity score [23]. Before treatment, the RALE score was 8, consistent with 100% involvement of the lungs.

Prior to LLLT, the patient had significant tachypnea and complained of “terrible shortness of breath” with activities of daily living.

Intervention

The multiwave locked system (MLS) scanner-equipped laser utilized in this study was deemed a nonsignificant risk device by the US Food and Drug Administration (FDA) prior to obtaining IRB approval. An FDA-cleared laser system (MLS-ASA/Italy) typically used in pain clinics was employed. Two simultaneous and synchronized laser diodes, emitting at 905 and 808 nm, were used in pulsed modes (Table 1). The scanner was positioned 20 cm above the skin, according to the manufacturer specifications. Each lung was scanned for 14 min, from apex to base over 250 cm² of the posterior thorax, (Figure 1). The patient tolerated all four consecutive once-daily LLLT without complication.

Post treatment outcomes

During the first laser treatment, her SpO₂ increased from 92% to 97% on 3 L/min oxygen within 10 min of starting treatment. After the second laser treatment the patient was breathing without dyspnea. Following treatments her respiratory rate returned to normal 19–20 breaths/min. After the fourth treatment, the patient was able to independently ambulate and had improved ability to perform activities of daily living. Patient was discharged 2 days after her last treatment on 1 L/min oxygen. Total hospital stay was 7 days. On follow-up 2 days after discharge, she was weaned to room air. The SMART-COP score decreased from 4 to 1 after treatment, indicating low risk for IRVS and requiring observation only. The Brescia-COVID score decreased from 4 to 0 after treatment, which supports patient monitoring via pulse oximetry and clinical evaluation.

Before treatment, the RALE score was 8, consistent with 100% involvement of the lungs, and it diminished to three after LLLT. The imaging absorption stage for severe COVID-19 is typically seen after ≥14

TABLE 1

Laser multiwave locked system parameters for COVID-19 pneumonia

	808 nm (GaAlAs) diode	905 nm (GaAs) diode
Mode of radiation	Pulsed	Super-pulsed
Frequency	1500 HZ, (Duty Cycle 50%) (1 Hz ÷ 2 kHz)	1500 HZ (90 kHz Modulated at 1 Hz ÷ 2 kHz)
Pulse duration	500 ms ÷ 250 µs (333 µs)	100 ns
Peak power	3 W	75 W × 3
Average power	1.5 W	11.25 × 3 = 33.75 mW
Spot size	19.625 cm ²	19.625 cm ²
Area	25 × 10 = 250 cm ²	25 × 10 = 250 cm ²
Dose	7.2 J/cm ²	113.4 mJ/cm ²
Distance from the skin	20 cm	
Treatment time	14 min each lung	
Total energy	3600 J	
Total time	28 min	
Sessions	Once daily for four consecutive days	

FIGURE 1

Positioning of the laser beams on the posterior thorax.

The apex of the lung lies above the first rib. The posterior border of the lung extends from the C7 to the T10 vertebra. The laser device (MLS) utilizes a scanner which was positioned 20 cm above the skin and scanned 250 cm² over each lung.

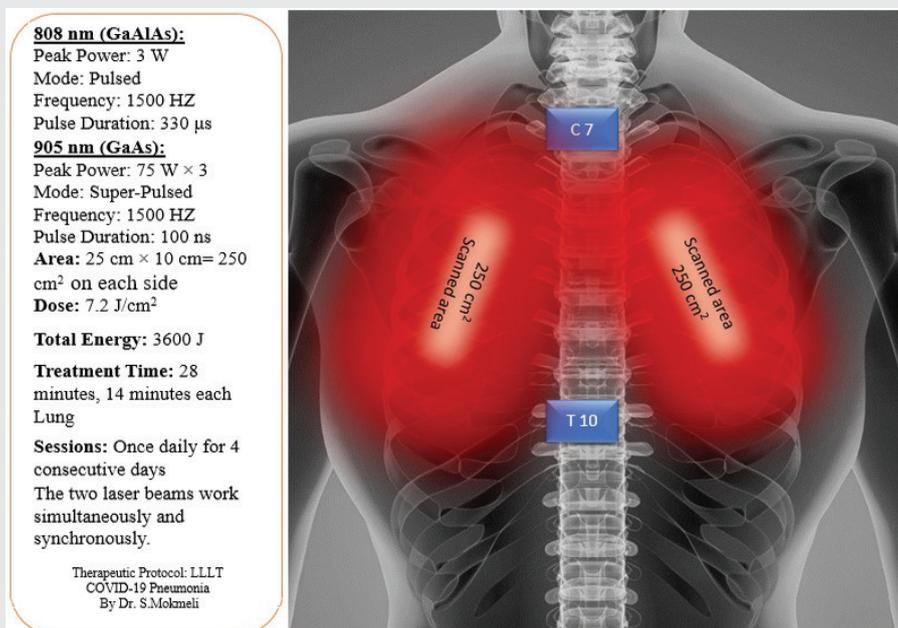
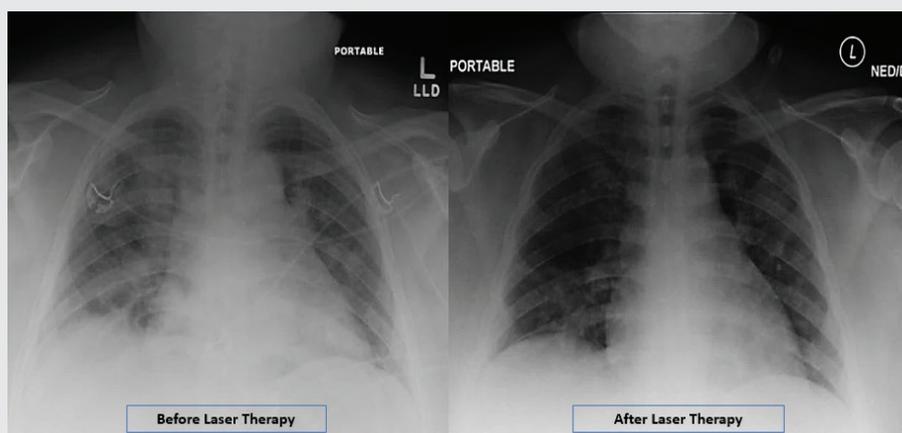


FIGURE 2

Radiographic assessment of lung edema (RALE) by chest X-ray before and after low level laser therapy.

The Radiographic Assessment of Lung Edema (RALE) Scores by Chest-X-Ray confirmed the improvement of the lung involvement after Low Level Laser Therapy for the patient. A score of 0-4 was assigned to each lung, depending on the extent of lung involvement by consolidation or ground glass opacities. 0 = no lung involvement; 1 = <25%; 2 = 25 - 50%; 3 = 50% - 75%; 4 = >75% involvement. The scores for each lung were summed up to calculate the final severity score. The RALE Scores for the patient were 8, before laser therapy, and 3, after laser therapy (6 days later).



days [24], but in this case, the absorption stage is evident at 7 days (Figure 2).

Blood work included pre- and post-LLLT, IL-6, ferritin, and CRP. Immediately after final treatment IL-6 dropped from 45.89 to 11.7 pg/mL, ferritin from 359 to 175 ng/mL, and CRP improved from 3.06 to 1.43 mg/dL (Table 2).

Oxygen requirement before treatment was 3–6 L/min with SpO₂ 88%–93% and improved to 1–3 L/min and SpO₂ 97%–99% after treatment.

At 2 weeks and 6 weeks from discharge the patient reported subjective improvement in respiratory symptoms and well-being. She was satisfied and appreciative of her LLLT experience and treatment outcome.

TABLE 2

Patient assessments/scores pre- and post-treatment (low level laser therapy) during hospitalization

Parameters	Pre-treatment	Post-treatment	Normal range or evaluation criteria
SMART-COP, evaluates pneumonia severity	5	1	0 points: Very low risk of needing IRVS 1 point: Low risk (1 in 20) of needing IRVS 2 points: Moderate risk (1 in 10) of needing IRVS 3 points: High risk (1 in 6) of needing IRVS ≥4 points: High risk (1 in 3) of needing IRVS; consider admission to intensive care unit
Brescia-COVID respiratory severity scale	4	0	0 – monitor 1 – add O ₂ and monitor 2 – chest X-ray, arterial blood gas, O ₂ therapy, monitor >2 – High-flow nasal cannula and reassess. If still >2, intubate.
Radiographic assessment of lung edema	8	2	Lungs score dependent on extent of involvement based on consolidation or ground glass opacities for each lung, total score is the sum of the score of the lungs: 0 = no involvement. 1 = <25%; 2 = 25%–50%; 3 = 50%–75%; 4 = >75%
Interleukin-6	45.89	11.7	<5 pg/mL
C-reactive protein	3.06	1.43	0–0.8 mg/dL
O ₂ requirement	3–6 L/min	0–1 L/min	0 L/min
Oxygen saturation	88%–93%	97%	≥94%
Ferritin	359	175	11–307 ng/mL, in females
White blood cells	4.4	4.9	4.5–11 K/uL
Hemoglobin	10.6	9.0	12.0–15.5 g/dL
Hematocrit	36	30	37%–48% for women
Albumin	3.7	3.3	3.4–5.4 g/dL

SMART-COP, systolic blood pressure, multilobar infiltrates, albumin, respiratory rate, tachycardia, confusion, oxygen, and pH; IRVS, intensive respiratory or vasopressor support.

DISCUSSION

Animal and human experimental studies demonstrate that LLLT reduces inflammation at the molecular, cellular, and tissue levels. LLLT is effective against both cytokine storm and ARDS while promoting healing and tissue regeneration. Experimental and animal models of pulmonary disease and infection have revealed multiple cellular and molecular effects, which are both local and systemic. LLLT reduces inflammation without impairing lung function in acute lung injuries and is a promising therapeutic approach for lung inflammatory diseases such as COPD [13–17]. The results of our patient evaluation are consistent with the anti-inflammatory effect of LLLT on the lung, cytokine storm, and ARDS.

The strength of this report is that we measured multiple objective and subjective parameters before and after treatment. We believe that the anti-inflammatory effect of LLLT on lung tissue [13–17] may have occurred in this patient as evidenced by the reduction of pro-inflammatory markers IL-6 and ferritin. Another strength of the therapy is that the scanning method of this laser has no risk of contamination because the laser does not contact the patient.

To our knowledge, this was the first time that LLLT was used for the treatment of pulmonary disease in COVID-19 patients. The reduction of inflammatory markers and improved radiography support the clinical improvement of the patient. The lasers currently available in pain and lymphedema clinics may be adjusted to treat the lung inflammation in COVID-19. The laser used in our pain clinic was easily adapted to the management of COVID-19 pulmonary disease in a community hospital.

The patient in this case report is part of an ongoing randomized controlled trial. The urgent need for effective COVID-19 treatments calls for pilot studies and clinical trials to further evaluate the potential healing effects of LLLT.

CONCLUSION

The use of LLLT in the early stage of severe COVID-19 for this patient may have been beneficial and potentially negated the need for

ventilator support that was predicted by both Brescia-COVID and SMART-COP scores. Adjunct LLLT in COVID-19 patients may accelerate recovery and reduce the need for ventilator support and ICU admission. This in turn could significantly reduce length of stay, severity of disease, and the clinical burden in our hospitals.

Contributors

- 1) Scott Sigman, as research director, contributed to planning, coordinating, and administering the research including, obtaining FDA guided IRB approval, patient recruitment and consent, patient screening and assessments, performing the laser therapy, adverse event monitoring, follow-up, collecting the data, discussion, revising, etc.
- 2) Soheila Mokmeli, as scientific supervisor, contributed to study methodologies including, designing the therapeutic protocol, determining the assessment tools, materials, instructions on how to conduct the study, verifying case report forms and monitoring overall progress throughout the study, providing the references and discussion, revising, etc.
- 3) Mariana Vetrici, as scientific advisor, contributed to analyzing data, providing the references, discussion, drafting, and revising the article.

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Competing interests

All authors have completed the ICMJE uniform disclosure form at www.icmje.org/coi_disclosure.pdf and declare: no financial relationships with any organizations that might have an interest in the submitted work in the previous 3 years; no other relationships or activities that could appear to have influenced the submitted work.

Ethical approval

The study was performed under FDA guided IRB approval By Clinical Research Review Committee; Lowell General Hospital, Massachusetts, USA.

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