

Immune-Based Prediction of COVID-19 Severity and Chronicity Decoded Using Machine Learning

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Summary: Immunologic Modeling of Severity and Chronicity of COVID-19

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Abbreviations: IL-interleukin; RANTES-regulation on activation, normal T-expressed and secreted; CCR-chemokine receptor; IFN-interferon, TNF-tumor necrosis factor; MIP-macrophage inflammatory protein; GM-CSF-granulocyte-macrophage colony-stimulating factor; VEGF-vascular endothelial growth factor; HIV; human immunodeficiency virus; HCV hepatitis C virus

47 **ABSTRACT**

48

49 Individuals with systemic symptoms long after COVID-19 has cleared represent
50 approximately ~10% of all COVID-19 infected individuals. Here we present a
51 bioinformatics approach to predict and model the phases of COVID so that effective
52 treatment strategies can be devised and monitored. We investigated 144 individuals
53 including normal individuals and patients spanning the COVID-19 disease continuum.
54 We collected plasma and isolated PBMCs from 29 normal individuals, 26 individuals
55 with mild-moderate COVID-19, 25 individuals with severe COVID-19, and 64 individuals
56 with Chronic COVID-19 symptoms. Immune subset profiling and a 14-plex cytokine
57 panel were run on all patients. Data was analyzed using machine learning methods to
58 predict and distinguish the groups from each other. Using a multi-class deep neural
59 network classifier to better fit our prediction model, we recapitulated a 100% precision,
60 100% recall and F1 score of 1 on the test set. Moreover, a first score specific for the
61 chronic COVID-19 patients was defined as **S1 = (IFN- γ + IL-2) / CCL4-MIP-1 β** . Second,
62 a score specific for the severe COVID-19 patients was defined as **S2 = (10*IL-10 + IL-6)**
63 **- (IL-2 + IL-8)**. Severe cases are characterized by excessive inflammation and
64 dysregulated T cell activation, recruitment, and counteracting activities. While chronic
65 patients are characterized by a profile able to induce the activation of effector T cells
66 with pro-inflammatory properties and the capacity of generating an effective immune
67 response to eliminate the virus but without the proper recruitment signals to attract
68 activated T cells.

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90 **INTRODUCTION**

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92 Chronic COVID-19 is a group of previously infected individuals, so called “Long

93 Haulers”, who experience a multitude of symptoms from several weeks to months after

94 recovering from their acute illness and presumably months after viral clearance. These

95 symptoms include joint pain, muscle aches, fatigue, “brain fog” and others. These

96 symptoms can commonly resemble rheumatic diseases such as rheumatoid arthritis,

97 autoimmune disorders, and others such as fibromyalgia and chronic fatigue syndrome

98 (1). Many of these common disorders are caused by inflammation, hyper- and/or auto-

99 immunity and some such as chronic fatigue are associated with viral persistence after

100 an acute infection with pathogens such as Epstein Barr and Cytomegalovirus (2).

101 Recent studies including those from our laboratory have suggested that (CC) may be

102 caused by persistent COVID itself (3). Here, we sought to identify possible immunologic

103 signatures of COVID-19 severity and to determine whether Chronic COVID-19 might

104 represent a distinct immunologic entity compared to mild to moderate (MM) or

105 severe/critical COVID-19. Further, we addressed the question whether the immunologic

106 profile represents an immune response indicative of prolonged or chronic antigenic

107 exposure. Using machine learning, we identified algorithms that allowed for accurate

108 determination of chronic COVID and severe COVID immunotypes. Further, we present

109 a quantitative immunologic score that could be used to stratify patients to therapy and/or

110 non-subjectively measure response to therapy.

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114 **RESULTS**

115 *Immune Profiling*

116 To determine if immunologic abnormalities remain in Long Haulers, we performed high
117 parameter immune cell quantification and characterization in a subset of individuals with
118 preserved peripheral blood mononuclear cells. We determined B-cells, T-cells, and
119 monocytes including subsets and including CD4/CD8 activation and exhaustion. Unlike
120 active COVID-19, the CD4 and CD8 T-cell populations were within normal limits and
121 there was no evidence of T-cell exhaustion (co-expression of PD-1, LAG3, and or
122 CTLA-4). B-cells were significantly elevated compared to normal individuals ($P<0.001$)
123 as was the CD14+, CD16+ monocytic subset ($P<0.001$) (Table 1). Interestingly, these
124 two immune cell populations have been shown to be chronically infected by different
125 viruses. B-cells are infected by Epstein-Barr and the CD14+, CD16+ monocytic subset
126 by HIV-1 and by HCV (4).

127 To further characterize the immune response in Long Haulers, we performed
128 quantitative, multiplex cytokine/chemokine panel on 30 normal individuals to establish
129 the normal range of the assay. We then analyzed 64 long haulers and compared the
130 cytokine/chemokine profile (Table 1). IL-2, IL-4, CCL3, IL-6, IL-10, IFN- γ , and VEGF
131 were all significantly elevated compared to normal control (all $P<0.001$). Conversely
132 GM-CSF and CCL4 were significantly lower than normal controls. Further exacerbating
133 this hyper-immunity was the significant decrease in T regulatory cells compared to
134 normal individuals ($P<0.001$).

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136 *Random Forest Binary and Multi-Class Models for Feature Selection and Prediction*

137 We separated the dataset into a training and test split of 90% training and 10% test.
138 This proportion was used because of the reduced number of instances in the dataset.
139 Also, to ensure reproducible results we set the same random seed for all the models.
140 The first model we constructed was the multi-class predictor. This model attempted to
141 separate the severe, long hauler and non-severe-non-long hauler class. This classifier
142 achieved 97% precision, 97% recall and a F1 score of 0.97 in the training partition. In
143 the test split, it performed slightly better, with a precision of 100%, a recall of 100% and
144 thus and F1 score of 1.00 (Table 2). This model was then analyzed to identify the most
145 relevant or informative features. This resulted in the identification of 6 features with an
146 importance score above the importance median (0.063895) and average (0.07143). The
147 identified features were: IFN- γ , IL-2, IL-6, IL-10, IL-8, CCL4-MIP-1 β , in importance
148 order. The full list of ranked features can be seen in figure 2.

149 Regarding the long hauler and non-long hauler binary classifier, our results were
150 consistent between the training and the test set. In both partitions the precision and the
151 recall were 100% (1.00) and thus the F1 score equaled 1.00. The observation that the
152 model had good metrics in the test split when compared to the train set is a valuable
153 indicator that the model is not overfitting, and that it is capable of generalizing the
154 patterns identified in the training data. The overview of the precision, recall and F1 score
155 for the binary long hauler model can be seen in table 2. Feature importance analysis of
156 the binary model, revealed that the features identified as important for this model were
157 the same features identified as important for the multi-class predictor. This finding

158 suggests there is an important group of characteristics or variables that are influential in
159 the identification of long hauler data points from other instances. These features can be
160 seen in figure 2.

161 The severe binary model, which classified instances between non-severe and severe
162 resulted in high performance metrics for both the training and test splits. As shown in
163 table 2, the performance of this model was an indicator of no potential overfitting. This
164 model is of special interest given the small number of instances in the severe class.
165 Furthermore, the feature importance analysis of this model revealed that the relevant
166 features were also the same as with the multi-class model and with the long hauler
167 binary classifier (Figure 2). This finding reinforces our notion that these group of
168 relevant features could impact classification, or that could have some biological
169 significance worth exploring by means of other analysis like a separation heuristic.

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171 *Deep Neural Network Binary Classifiers using the Full Feature Set*

172 The deep neural network (DNN) classifier was constructed layers of neurons. Each
173 layer transformed the inputs inputs using the rectified linear activation function or ReLU.
174 The DNN model was constructed to have 1 input layer, 3 hidden layers with 10 neurons
175 each, followed by layer with 6 neurons. Finally, the output layer consists of 3 neuros, for
176 the outputs (classes) and the softmax (multi-class) or sigmoid (binary) function. This
177 architecture was used for the multi-class model and the binary models.

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179 The results of the long hauler binary models, revealed differences of ~5% between the
180 metrics of the training and the test set (Table 3). Such difference is not significant to
181 attribute overfitting to the training set. In contrast, the severe binary model had
182 significant differences between the performance metrics of the training and the test set
183 (Table 3). This is evident in the precision score, with 98% in the training set and 75% on
184 the test set, and thus the F1 score with a difference of 20% (0.99 on the training set and
185 0.79 on the test set). A potential explanation could be that the severe class has a limited
186 number of data points, but our random forest classifier for the severe class performed
187 well. These results suggest that the best approach is a multi-class predictor.

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189 *Multi-class Deep Neural Network Classifiers using the Full Feature Set*

190 The multi-class DNN implemented using the full feature set had good metrics (Table 3).
191 The precision, recall and F1 score of 100%, 100% and 1.00 in the test split. This
192 indicates that the model is not overfitting, and validating our notion that this would
193 generalize better than the binary models. The model's performance is supported by its
194 confusion matrix (true class vs predicted) where it is possible to determine how well it
195 can predict the three classes (Figure 3).

196 The potential of a DNN classifier is that it adjusts multiple parameters transform the
197 inputs into outputs. This is very important because the vast number of parameters
198 allows for the model to better identify hidden signals in the data. Also, DNN require
199 hyperparameter tuning, such as learning rate, number of hidden layers and neurons per
200 hidden layer, as well as the optimizer and activation function, which affect the

201 performance of the model. By adjusting these hyperparameters and castrating a model
202 capable of finding the hidden relationships in the data we were able to achieve such
203 high results and construct a predictive multi-class system.

204 *Reduced Feature Multi-class Deep Neural Network Classifiers*

205 The results of the DNN indicated that the multi-class had the highest performance.
206 Based on this, we constructed a DNN using the 6 most important features identified by
207 the random forest variable importance. This model was known as minimal DNN or
208 mDNN. This model was constructed using the same architecture as the full feature set
209 DNN. This model's performance in the training set and the test set (Table 4), revealed a
210 significant difference in both precision and recall, such difference could indicate that
211 although the 6 features were identified as the most relevant, it could be possible that all
212 variables contribute to the hidden pattern that makes up the classification of the
213 instances. This idea is supported by the differences in performance between the mDNN
214 and the full feature classifier in both training and test splits (Tables 3 & 4). This is further
215 supported by the comparison of the confusion matrices, where mDNN (figure 4A)
216 misclassifies more instances than the full feature multi-class DNN (Figure 3).

217 Moreover, we simplified our prediction model by feature engineering of two classification
218 scores based on the top informative features. First, a "Long Hauler Score" was defined
219 as $S1 = (IFN-\gamma + IL-2) / CCL4-MIP-1\beta$. Second, "Severe Score" was defined as $S2 =$
220 $(10*IL-10 + IL-6) - (IL-2 + IL8)$. Using a combined heuristic to first classify the Long
221 Haulers ($S1 > 0.4$) and second the severe COVID-19 patients ($S2 > 0$), we obtained a

222 sensitivity of 97% for Long Haulers with a 100% specificity and a sensitivity of 88% for
223 severe patients with a specificity of 96% (Figure 4B).

224

225 **DISCUSSION**

226

227 Individuals infected with SARS-Cov2 exert distinct severity patterns which have been
228 associated with different immune activation profiles. Interestingly, in some cases longer
229 times are required to experience full recovery, representing a particular pathological
230 type recently described as long-COVID or long haulers (LH). The scientific evidence
231 generated during the last months strongly supports that the different outcomes on
232 COVID-19 patients are determined by the immune mechanisms activated in response to
233 the viral infection.

234 The immune response to SARS-Cov2 induces a release of different molecules with
235 inflammatory properties such as cytokines and chemokines. This event, known as
236 cytokine storm, is an immunopathological feature of COVID-19 and it has been
237 associated with the severity of the disease. The increase in blood concentrations of
238 different cytokines and chemokines such as IL-6, IL-8, IL-10, TNF- α , IL-1 β , IL-2, IP-10,
239 MCP-1, CCL3, CCL4, and CCL5 has been described for COVID-19 patients (5). Some
240 of these molecules have been proposed as biomarkers to monitor the clinical evolution
241 and to determine treatment selection for COVID-19 patients. Nevertheless, it is
242 important to consider that some of these molecules function in a context dependent
243 manner, therefore the clinical relevance of analyzing single cytokine changes is limited.

244 One of the most important challenges during the pandemics is to avoid the saturation of
245 the health systems, therefore the determination of predictive biomarkers that allow a
246 better stratification of the patients is paramount. Even though cytokines such as IL-6
247 and IL-8 have been proposed as indicators of the disease severity, and in some studies
248 they were strong and independent predictors of patient survival (6), their predictive
249 value when analyzed alone is debatable (7). The generation of scores considering blood
250 levels of cytokines and chemokines with different immunological functions incorporates
251 the importance of the context-dependent function of these molecules.

252 In order to predict severe cases, a score was generated considering IL-10, IL-6, IL-2,
253 and IL-8 blood concentrations. In this classification, severe cases are characterized by
254 high IL-6 and IL-10 levels, both cytokines previously attributed to increase the
255 immunopathogenesis of COVID-19 and predictive value in severe cases (6, 8). In
256 different settings, IL-6 has been associated with oxidative stress, inflammation,
257 endothelial dysfunction, and thrombogenesis (9-12) which are characteristic features of
258 severe COVID-19 cases caused by excessive myeloid cell activation (13). Consistently,
259 increased IL-10 levels interfere with appropriate T-cell responses, inducing T-cell
260 exhaustion and regulatory T cell polarization leading to an evasion of the antiviral
261 immune response (14). Furthermore, besides its anti-inflammatory function on T cells, in
262 some settings IL-10 induces STAT1 activation and a pro-inflammatory response in type
263 I IFN-primed myeloid cells (15,16). Therefore, elevated levels of IL-6 and IL-10 promote
264 myeloid cell activation, oxidative stress, endothelial damage, and dampens adequate T
265 cell activation. Additionally, to strengthen the classification, the score presented here,

266 differentiates the severe cases by the subtraction of IL-2 and IL-8, which are cytokines
267 related to proper T cell activation (IL-2) and recruitment (IL-8).

268 According to the score generated for distinguishing LH, these patients are characterized
269 by an increased IFN- γ and IL-2 and a reduced CCL4 production. In the context of a viral
270 infection, the combination of IFN- γ and IL-2 would induce the activation of effector T
271 cells with pro-inflammatory properties and the capacity of generating an effective
272 immune response to eliminate the virus. However, LH are characterized by longer
273 periods of time with clinical signs and symptoms such as fatigue and lung damage. This
274 suggests that the inflammatory context created by these cytokines to induce T cell
275 activation is not enough to generate an adequate anti-viral response without the proper
276 recruitment signals to attract activated T cells. CCL4 signals through the receptor CCR5
277 to attract T cells to the site of inflammation and depending on the immune context, this
278 molecule recruits differently activated T cells (17,18). Moreover, it was recently shown
279 by single cell analysis a down regulation of CCL4 expression in peripheral myeloid cell
280 compartments in patients with mild and severe COVID-19 (19). In LH, IFN- γ and IL-2
281 would create an immune context to induce Th1 polarization, but the low levels of CCL4
282 affect the recruitment of these cells impairing the antiviral response. The effect of
283 increased IFN- γ and IL-2 on T cell activation is evident in the reduction of the
284 percentage of exhausted (CD4+PD1+ / CD8+PD1+) and regulatory T cells (FoxP3+)
285 compared to healthy donors. Interestingly, there is an increase in the percentage of
286 circulating CD4+ and CD8+ T cells expressing CTLA-4 in the LH group compared to
287 healthy donors, which is a molecule that affects antigen presentation in secondary
288 lymphoid organs, but its presence in circulating T cells may reflect a compensatory

289 mechanisms to the low CCL4 levels in the LH group. CTLA-4 induced signaling in T
290 cells upregulates the expression of the CCL4 receptor CCR5 (20, 21), in the LH group
291 CTLA-4 upregulation suggests a failed attempt to increase the sensitivity of IFN- γ /IL-2
292 activated T cells to CCL4. Therefore, proper T cell activation (high IFN- γ +IL-2) but
293 ineffective T cell recruitment (low CCL4) are characteristic features of the failed anti-
294 viral response observed in the LH group supporting virus persistence. Additionally,
295 increased IFN- γ promotes myeloid cell activation which is observed in the augmented
296 percentage of inflammatory CD14+CD16+ monocytes in the LH group compared to
297 healthy donors, supporting lymphopenia and virus persistence in these patients. This is
298 supported by recent findings describing an increased gene expression in response to
299 IFN- γ in mild and severe COVID-19 patients in peripheral myeloid cells (19) and the
300 dysregulation in the balance of monocyte populations by the expansion of the monocyte
301 subsets described in COVID-19 patients (22). Finally, we propose that long-lasting
302 pulmonary damage observed in LH, is caused by a combination of factors including 1)
303 longer virus persistence influenced by LH immune profile characterized by high IFN- γ
304 and IL-2 levels inducing Th1 polarization which is ineffective with low CCL4-induced T
305 cell recruitment, leading to an inflammatory myeloid cell activation; and 2) the
306 immunopathological pulmonary effects consequence of this LH immune profile.
307 Regarding the immunopathological effects of LH immune profile, using murine models it
308 has been shown that high IFN- γ levels could affect the kinetics of the resolution of
309 inflammation-induced lung injury as well as thrombus resolution (23, 24), which could be
310 related to long-lasting symptoms of LH associated to pulmonary coagulopathy and
311 immune-mediated tissue damage.

312 Interestingly, COVID-19 individuals (including LH, mild, severe) show high levels of
313 CCL5, a chemoattractant that like CCL4 signals through CCR5. Indeed, the disruption
314 of the CCL5-CCR5 pathway restores immune balance in critical COVID-19 patients (4).
315 In the specific case of LH, despite the high concentrations of CCL5 a reduction on the
316 CCL4-mediated recruitment of activated T cells is proposed. This could be related to
317 different factors:

318 (1) Reduction of total recruitment signals in LH with low CCL4 concentrations.

319 (2) Different functional responses of CCL4 and CCL5 to polymorphic variants of the
320 CCR5. Distinct functional features have been reported to CCR5 variants regarding
321 binding avidity, receptor internalization, Ca⁺⁺ influx and chemotactic activity (25). Even
322 though, clear mechanistic differences between CCL4 and CCL5 interaction with CCR5
323 are missing, it has been suggested that is important to consider the knowledge gained
324 on CCR5 polymorphisms in HIV/AIDS context (26).

325 (3) Signaling through alternative receptors for CCL5. Besides CCR5, CCL5 can signal
326 through the receptors CCR1 and CCR3 (27) whereas CCL4 effects are restricted to
327 CCL5. It has been shown that CCL4 can bind to CCR1 but is not able to induce the
328 intracellular pathway necessary for activating the chemoattractant stimulus (27,28) .
329 Therefore, CCL4 has been proposed as an antagonist of CCR1 (28), however further
330 analysis of this needs to be performed. Interestingly, CCR1 is expressed on blood
331 myeloid cells such as monocytes and neutrophils (27), and it is upregulated on COVID-
332 19 patients (29). Additionally, high levels of IFN- γ (feature of LH) have been associated
333 with an increase CCR1 expression on human neutrophils (30). Therefore, in LH, high

334 levels of CCL5 (combined with low levels of potential CCR1-antagonist CCL4) leads to
335 a higher recruitment of myeloid cells expressing CCR1.

336

337 **MATERIAL/METHODS**

338 *Patients*

339 Following informed consent, whole blood was collected in a 10 mL EDTA tube and a 10
340 mL plasma preparation tube (PPT). A total of 144 individuals were enrolled in the study
341 consisting of 29 normal individuals, 26 mild-moderate COVID-19 patients, 25 severe
342 COVID-19 patients and 64 chronic COVID (long hauler-LH) individuals. Long Haulers
343 symptoms are listed in Figure 1. Study subjects were stratified according to the
344 following criteria.

345 Mild

- 346 1. Fever, cough, sore throat, malaise, headache, myalgia, nausea, diarrhea, loss of
347 taste and smell
- 348 2. No sign of pneumonia on chest imaging (CXR or CT Chest)
- 349 3. No shortness of breath or dyspnea

350 Moderate:

- 351 1. Radiological findings of pneumonia fever and respiratory symptoms
- 352 2. Saturation of oxygen (SpO₂) ≥ 94% on room air at sea level

353 Severe

- 354 1. Saturation of oxygen (SpO₂) < 94% on room air at sea level

- 355 2. Arterial partial pressure of oxygen (PaO₂)/ fraction of inspired oxygen (FiO₂) <
356 300mmHG
- 357 3. Lung infiltrate > 50% within 24 to 48 hours
- 358 4. HR ≥ 125 bpm
- 359 5. Respiratory rate ≥ 30 breaths per minute

360 Critical

- 361 1. Respiratory failure and requiring mechanical ventilation, ECMO, high-flow nasal
362 cannula oxygen supplementation, noninvasive positive pressure ventilation
363 (BiPAP, CPAP)
- 364 2. Septic Shock- Systolic blood pressure < 90mmHg or Diastolic blood pressure <
365 60 mmHg or requiring vasopressors (levophed, vasopressin, epinephrine
- 366 3. Multiple organ dysfunction (cardiac, hepatic, renal, CNS, thrombotic disease)

367

368 Post-acute COVID-19 (Long COVID)

- 369 1. Extending beyond 3 weeks from the initial onset of first symptoms

370 Chronic COVID-19

- 371 1. Extending beyond 12 weeks from the initial onset of first symptoms (Table 1)

372

373 *High Parameter Immune Profiling/Flow Cytometry*

374 Peripheral blood mononuclear cells were isolated from peripheral blood using

375 Lymphoprep density gradient (STEMCELL Technologies, Vancouver, Canada). Aliquots

376 200 of cells were frozen in media that contained 90% fetal bovine serum (HyClone,
377 Logan, UT) and 10% dimethyl sulfoxide (Sigma-Aldrich, St. Louis, MO) and stored at -
378 70°C. Cells were stained and analyzed as previously described (4) (Patterson) using a
379 17-color antibody cocktail.

380

381 *Multiplex Cytokine Quantification*

382 Fresh plasma was used for cytokine quantification using a customized 14-plex bead
383 based flow cytometric assay (IncellKINE, IncellDx, Inc) on a CytoFlex flow cytometer as
384 previously described using the following analytes: 'TNF- α ', 'IL-4', 'IL-13', 'IL-2', 'GM-
385 CSF', 'sCD40L', 'CCL5 (RANTES)', 'CCL3 (MIP-1 α)', 'IL-6', 'IL-10', 'IFN- γ ', 'VEGF', 'IL-
386 8', and 'CCL4 (MIP-1 β)' (4). For each patient sample, 25 μ L of plasma was used in each
387 well of a 96-well plate. Standard curves with serial 6 point dilutions of antigen were run
388 on each plate for each cytokine. Raw data was analyzed using LegendPlex software
389 (Biolegend, Inc San Diego CA). Samples were run in duplicate.

390

391 *Data Processing*

392 Data was imported and processed using Python 2.7, using the *pandas* library (version
393 1.1.0). and the numeric python module, *numpy* version 1.18.5. Our data consisted of
394 144 instances representing 4 classes (Normal-n=29, Mild-Moderate-n=26, Severe-n=25,
395 Long Hauler-n=64). Each class had 14 columns, representing the different
396 cytokine/chemokine analytes. Each analyte had different measurements which required
397 a normalization process to reduce outlier effect and to facilitate algorithm convergence.

398 Normalization was done using Min-Max and based on a linear transformation of the
399 original data. Min-Max maintains the original relationship between the data, while fitting
400 it within a pre-defined boundary. The Python implementation of min-max calculates the
401 range in such a manner that the range of the features will be defined between 0 and 1.
402 For this reason, min-max normalization is also referred to as 0-1 normalization (or
403 scaling). The typical min-max transformation is given in equation 1:

404

$$405 \quad X = \frac{(X - X_{min})}{X_{max} - X_{min}} \quad [1]$$

406

407

408 *Target Variable Processing*

409 Since Min-max normalization, can only be applied to numeric variables a new variable
410 defined as *targets* was created. The variable *targets* represent the different classes
411 (Long Hauler, Severe, Mild-Moderate, and Normal) for the instances in the dataset. The
412 resulting array has 4 classes for each state. The goal of our analysis is to properly
413 identify/discriminate the instances that belong to the Severe state or the Long-Hauler
414 state compared to other states. This goal can be achieved by building either binary
415 classifiers for the Severe class and for the Long Hauler class, a multi-class predictor.
416 For the construction of both models, it is required to separate the targets to reflect the
417 dosing question: can a predictor discriminate between the Severe, Long Hauler and
418 Other States.

419 To build the models that answer this question, we grouped the M-M and Normal labels
420 in a new class which was distinct from the Severe and Long-Hauler states. We then
421 proceeded to apply filters based on the task (binary or multi-class classification). For the
422 Severe binary predictor, we conditioned the targets to be exactly Severe or else they
423 were assigned to Not-Severe. This same task was done for Long-Haulers, where either
424 an instance label was exactly labelled Long-Hauler or else it would be assigned to the
425 Non-Long Hauler class. The multi-class predictor processing only requires to define
426 three classes: Severe, Long-Hauler and Non-Severe-Non-Long-Hauler which was
427 composed of the Normal and Mild-Moderate cases.

428

429 *One-hot Encoding of Targets*

430 The implementation of one-hot encoding on the target variable, is based on the notion
431 that multiple machine learning algorithms are unable to properly process categorical
432 data. It is possible to use numeric replacements, such as integer values, but this can
433 only be useful if there is an ordinal relationship within the variable. Such use would
434 imply that there exists a vectorial relationship between the labels, for example, in our
435 classes we have Normal, Mild-Moderate, Severe and Long-Haulers. If we assigned a
436 vector of integers from 0 to 4 in their corresponding orders to the classes, it would
437 assume the presence of a vectorial distance between Normal and Long Hauler or $V_0 \rightarrow$
438 V_4 .

439 To properly design an experiment that reflects this, we use one-hot encoding After
440 applying one-hot encoding the labels are substituted with 1 and 0, where 1 represents

441 the presence of the class and 0 the absence. The use of one-hot encoding corrects for
442 the vector-distance assumption of integer or categorical classes, where higher or larger
443 values could be interpreted as better.

444

445 Definition of precision, recall and F1 score

446 The precision (equation 2) is a measure of the percentage of the results that are
447 relevant. The metric Recall measures the percentage of the total relevant results that
448 are correctly classified by the predictor (equation 3). The harmonic mean between these
449 two measures is known as the F1 score and ranges from 0 to 1, the closer to 1, the
450 better the model performs (equation 4). The F1 score for both false positives (FP) and
451 false negatives (FN) as well as for true positives (TP).

452
$$Precision = \frac{TruePositive}{TruePositive+FalsePositive} \quad [2]$$

453
$$Recall = \frac{TruePositive}{TruePositive+FalseNegative} \quad [3]$$

454
$$F1 = \frac{2*Precision*Recall}{Precision+Recall} = \frac{TP}{TP+1/2(FP+FN)} \quad [4]$$

455

456 *Feature Selection and Classification using Random Forest*

457 Data pre-processing, target variable processing and the encoding of targets were
458 performed before classification as above. Feature selection is the process of reducing

459 dimensionality of the dataset by selecting those features or variables that are more
460 informative than those that are not.

461 To perform feature selection, we implemented the RandomForestClassifier method from
462 Sci-kit Learn. Random Forest allows for identification of features that better separate the
463 classes by determining what percentage of the nodes that use those features have a
464 reduction in entropy or impurity (which are measures of how well separated the
465 instances are using a feature).

466 The binary classifier was constructed using the data points and their features with the
467 one-hot encoded target corresponding to: 1) the severe and non-severe model, 2) the
468 long hauler and non-long hauler model and 3) the multiclass model. The model was
469 built with the RandomForestClassifier method from Sci-kit Learn, with the number of
470 trees constructed set to 750, the number of features set as the square root of the
471 feature space, and the node depth equal to 4 to avoid overfitting. These parameters
472 were set for binary and multi-class predictors. Model performance was measured using:
473 precision, recall and the F1 score (see supplementary information).

474

475 *Predictor Construction Using Deep Neural Networks*

476 The deep neural network (DNN) binary and multiclass classifiers were constructed with
477 a basic DNN architecture built on stacks of perceptrons, where each subsequent layer
478 is connected to the previous one. Each layer transformed the inputs inputs using the
479 rectified linear activation function or ReLU. The DNN models were constructed to have

480 1 input layer, 3 hidden layers with 10 neurons each, followed by layer with 6 neurons.
481 Finally, the output layer consists of 3 neurons, for the outputs (classes) and the softmax
482 (multi-class) or sigmoid (binary) function.

483 In order for a DNN to generate the best possible predictions, we minimized the loss
484 function or error of the model using the ADAM optimizer to search for the optimal
485 combination of hyperparameters. When setting the optimizer, we defined the learning
486 rate to 1e-3. The loss function was set to categorical cross entropy because the targets
487 are one-hot encoded.

488

489

490 REFERENCES

491

492 1. L. Chen, H. Deng, H. Cui, J. Fang, Z. Zuo, J. Deng, Y. Li, X. Wang, L. Zhao
493 Inflammatory responses and inflammation-associated diseases in organs. *Oncotarget*
494 **9**, 7204–7218 (2018).

495 2. S. Rasa, Z. Nora-Krukke, N. Henning et al. Chronic viral infections in myalgic
496 encephalomyelitis/chronic fatigue syndrome (ME/CFS). *J Transl Med* **16**, 268 (2018).

497 3. P.A. Mudd, J.S. Turner, A. Day, W.B. Alsoussi, Z. Liu, J.A. O'Halloran, R.M. Presti,
498 B.K. Patterson, S.P.J. Whelen, A. Ellebedy. SARS-CoV-2 viral RNA shedding for more
499 than 87 days in an individual with an impaired CD8+ T-cell response. *Front Immunol* (in
500 press).

501 4. G. Coquillard, B. Patterson. HCV-Infected, Monocyte Lineage Reservoirs Differ in
502 Individuals with or without HIV Co-Infection. *J Infect Dis* **2009**;200:947-954.

503

504 5. B. K. Patterson, H. Seethamraju, K. Dhody, M. J. Corley, K. Kazempour, J. P.,
505 Lalezari, A. P. Pang, C. Sugai, E. B. Francisco, A. Pise, H. Rodrigues, M. Ryou, H. L.
506 Wu, G. M. Webb, B. S. Park, S. Kelly, N. Pourhassan, A. Lelic, L. Kdouh, M. Herrera, E.
507 Hall, E. Aklın, L. Ndhlovu, J. B. Sacha. CCR5 inhibition in Critical COVID-19 Patients
508 Decreases Inflammatory Cytokines, Increases CD8 T-Cells, and Decreases SARS-
509 CoV2 RNA in Plasma by Day 14. *Int J Infect Dis* (2020) doi: 10.1016/j.ijid.2020.10.101

- 510 6. D. M. Del Valle, S. Kim-Schulze, H. H. Huang, N. D. Beckmann, S. Nirenberg, B.
511 Wang, Y. Lavin, T. H. Swartz, D. Madduri, A. Stock, T. U. Marron, H. Xie, M. Patel, K.
512 Tuballes, O. Van Oekelen, A. Rahman, P. Kovatch, J. A. Aberg, E. Schadt, S.
513 Jagannath, M. Mazumdar, A. W. Charney, A. Firpo-Bncourt, D. R. Mendu, J. Jhang, D.
514 Reich, K. Sigel, C. Cordon-Cardo, M. Feldmann, S. Parekh, M. Merad, S. Gnjjatic,. An
515 inflammatory cytokine signature predicts COVID-19 severity and survival. *Nat Med*, **26**,
516 1636-1643 (2020).
517
- 518 7. S. M. Russell, A. Alba-Patiño, E. Barón, M. Borges, M. Gonzalez-Freire, & R. de la
519 Rica. Biosensors for Managing the COVID-19 Cytokine Storm: Challenges Ahead. *ACS*
520 *Sens*, **5**, 1506-1513.
521
522
- 523 8. S. K.Dhar, K, V., S. Damodar, S. Gujar & M. Das, IL-6 and IL-10 as redictors of
524 disease severity in COVID 19 patients: Results from Meta-analysis and Regression.
525 *medRxiv*, (2020). 2008.2015.20175844. <https://doi.org/10.1101/2020.08.15.20175844>
526
- 527 9. T. Hou, Tieu, B. C., S. Ray, A. Recinos Iii, R. Cui, R. G. Tilton, & A. R. Brasier. Roles
528 of IL-6-gp130 Signaling in Vascular Inflammation. *Curr Cardiol Rev*, **4**, 179-192.
529 <https://doi.org/10.2174/157340308785160570>
530
- 531 10. J. Lee, S. Lee, H. Zhang, M. A. Hill, C. Zhang, & Y. Park. Interaction of IL-6 and
532 TNF- α contributes to endothelial dysfunction in type 2 diabetic mouse hearts. *PLoS*
533 *One*, **12**, e0187189. <https://doi.org/10.1371/journal.pone.0187189>
534
- 535 11. V. Roldán, F. Marín, A. D. Blann, A. García, P. Marco, F. Sogorb, & G. Y. Lip.
536 Interleukin-6, endothelial activation and thrombogenesis in chronic atrial fibrillation. *Eur*
537 *Heart J*, **24**, 1373-1380. [https://doi.org/10.1016/s0195-668x\(03\)00239-2](https://doi.org/10.1016/s0195-668x(03)00239-2)
538
- 539 12. S. Wassmann, M. Stumpf, K. Strehlow, A. Schmid, B. Schieffer, M. Böhm, & G.
540 Nickenig. Interleukin-6 induces oxidative stress and endothelial dysfunction by
541 overexpression of the angiotensin II type 1 receptor. *Circ Res*, **94**, 534-541.
542 <https://doi.org/10.1161/01.res.0000115557.25127.8d>
543
- 544 13. D. McGonagle, K. Sharif, A. O'Regan, & C. Bridgewood. The Role of Cytokines
545 including Interleukin-6 in COVID-19 induced Pneumonia and Macrophage Activation
546 Syndrome-Like Disease. *Autoimmun Rev*, **19**, 102537.
547 <https://doi.org/10.1016/j.autrev.2020.102537>
548
- 549 14. J. M. Rojas, M. Avia, V. Martín, & N. Sevilla. IL-10: A Multifunctional Cytokine in
550 Viral Infections. *J Immunol Res*, **2017**, 6104054. <https://doi.org/10.1155/2017/6104054>
551
- 552 15. H. Mühl. Pro-Inflammatory Signaling by IL-10 and IL-22: Bad Habit Stirred Up by
553 Interferons? *Front Immunol*, **4**, 18. <https://doi.org/10.3389/fimmu.2013.00018>
554

- 555 16. M. N. Sharif, I. Tassiulas, Y. Hu, I. Mecklenbräuker, A. Tarakhovsky, & L. B.
556 Ivashkiv. IFN- α priming results in a gain of proinflammatory function by IL-10:
557 implications for systemic lupus erythematosus pathogenesis. *J Immunol*, **172**, 6476-
558 6481. <https://doi.org/10.4049/jimmunol.172.10.6476>
559
- 560 17. J. Y. Liu, F. Li, L. P. Wang, X. F. Chen, D. Wang, L. Cao, Y. Ping, S. Zhao, B. Li, S.
561 H. Thorne, B. Zhang, P. Kalinski, & Y. Zhang. CTL- vs Treg lymphocyte-attracting
562 chemokines, CCL4 and CCL20, are strong reciprocal predictive markers for survival of
563 patients with oesophageal squamous cell carcinoma. *Br J Cancer*, **113**, 747-755.
564 <https://doi.org/10.1038/bjc.2015.290>
565
- 566 18. N. Mukaida, S. I. Sasaki, & T. Baba. CCL4 Signaling in the Tumor
567 Microenvironment. *Adv Exp Med Biol*, **1231**, 23-32. https://doi.org/10.1007/978-3-030-36667-4_3
568
569
- 570 19. G. Xu, F. Qi, H. Li, Q. Yang, H. Wang, X. Wang, X. Liu, J. Zhao, X. Liao, Y. Liu, L.
571 Liu, S. Zhang, & Z. Zhang. The differential immune responses to COVID-19 in
572 peripheral and lung revealed by single-cell RNA sequencing. *Cell Discov*, **6**, 73.
573 <https://doi.org/10.1038/s41421-020-00225-2>
574
- 575 20. K. Knieke, H. Hoff, F. Maszyzna, P. Kolar, A. Schrage, A. Hamann, G. F. Debes, M.
576 C. Brunner-Weinzierl. CD152 (CTLA-4) determines CD4 T cell migration in vitro and in
577 vivo. *PLoS One*, **4**, e5702. (2009). <https://doi.org/10.1371/journal.pone.0005702>
578
- 579 21. K. Knieke, H. Lingel, K. Chamaon, & M. C. Brunner-Weinzierl. Migration of Th1
580 lymphocytes is regulated by CD152 (CTLA-4)-mediated signaling via PI3 kinase-
581 dependent Akt activation. *PLoS One*, **7**, e31391. (2012).
582 <https://doi.org/10.1371/journal.pone.0031391>
583
- 584 22. W. Shi, X. Liu, Q. Cao, P. Ma, W. Le, L. Xie, J. Ye, W. Wen, H. Tang, W. Su, Y.
585 Zheng, & Y. Liu. High-dimensional single-cell analysis reveals the immune
586 characteristics of COVID-19. *Am J Physiol Lung Cell Mol Physiol*.
587 <https://doi.org/10.1152/ajplung.00355.2020>
588
- 589 23. J. R. Mock, M. K. Tune, C. F. Dial, J. Torres-Castillo, R. S. Hagan, & C. M.
590 Doerschuk. Effects of IFN- γ on immune cell kinetics during the resolution of acute lung
591 injury. *Physiol Rep*, **8**, e14368. <https://doi.org/10.14814/phy2.14368>
592
- 593 24. M. Nosaka, Y. Ishida, A. Kimura, Y. Kuninaka, M. Inui, N. Mukaida, & T. Kondo.
594 Absence of IFN- γ accelerates thrombus resolution through enhanced MMP-9 and VEGF
595 expression in mice. *J Clin Invest*, **121**, 2911-2920. <https://doi.org/10.1172/jci40782>
596
- 597 25. H. F. Dong, K. Wigmore, M. N. Carrington, M. Dean, J. A. Turpin, & O. M. Howard.
598 Variants of CCR5, which are permissive for HIV-1 infection, show distinct functional
599 responses to CCL3, CCL4 and CCL5. *Genes Immun*, **6**, 609-619.
600 <https://doi.org/10.1038/sj.gene.6364247>

- 601 26. R. K. Mehlotra. Chemokine receptor gene polymorphisms and COVID-19: Could
602 knowledge gained from HIV/AIDS be important? *Infect Genet Evol*, **85**, 104512.
603 <https://doi.org/10.1016/j.meegid.2020.104512>
604
- 605 27. C. E. Hughes, & R. J. B. Nibbs. A guide to chemokines and their receptors. *Febs j*,
606 **285**, 2944-2971. <https://doi.org/10.1111/febs.14466>
607
- 608 28. H. Gaertner, O. Lebeau, I. Borlat, F. Cerini, B. Dufour, G. Kuenzi, A. Melotti, R. J.
609 Fish, R. Offord, J. Y. Springael, M. Parmentier, & O. Hartley. Highly potent HIV
610 inhibition: engineering a key anti-HIV structure from PSC-RANTES into MIP-1 β /CCL4.
611 *Protein Eng Des Sel*, **21**, 65-72. <https://doi.org/10.1093/protein/gzm079>
612
- 613 29. P. R. Ray, A. Wangzhou, N. Ghneim, M. S. Yousuf, C. Paige, D. Tavares-Ferreira,
614 J. M. Mwirigi, S. Shiers, I. Sankaranarayanan, A. J. McFarland, S. V. Neerukonda, S.
615 Davidson, G. Dussor, M. D. Burton, & T. J. Price. A pharmacological interactome
616 between COVID-19 patient samples and human sensory neurons reveals potential
617 drivers of neurogenic pulmonary dysfunction. *Brain Behav Immun*, **89**, 559-568.
618 <https://doi.org/10.1016/j.bbi.2020.05.078>
619
- 620 30. R. Bonecchi, N. Polentarutti, W. Luini, A. Borsatti, S. Bernasconi, M. Locati, C.
621 Power, A. Proudfoot, T. N. Wells, C. Mackay, A. Mantovani, & S. Sozzani. Up-
622 regulation of CCR1 and CCR3 and induction of chemotaxis to CC chemokines by IFN- γ
623 in human neutrophils. *J Immunol*, **162**, 474-479.
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633 **Author contributions:**

634 R.Y. organized the clinical study and actively recruited patients.
635 B.K.P., A.P., H.R., E.L. performed experiments and analyzed the data.
636 J.G-C., R.A.M., J.M. performed the bioinformatics
637 B.K.P., J.M., J.G-C., R.A.M. wrote the draft of the manuscript and all authors
638 contributed to revising the manuscript prior to submission.
639

640 **Competing interests:**

641 B.K.P., A.P., H.R., E.L. are employees of InCellDx
642

643 **Data and materials availability:**

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645 All requests for materials and data should be addressed to the corresponding author

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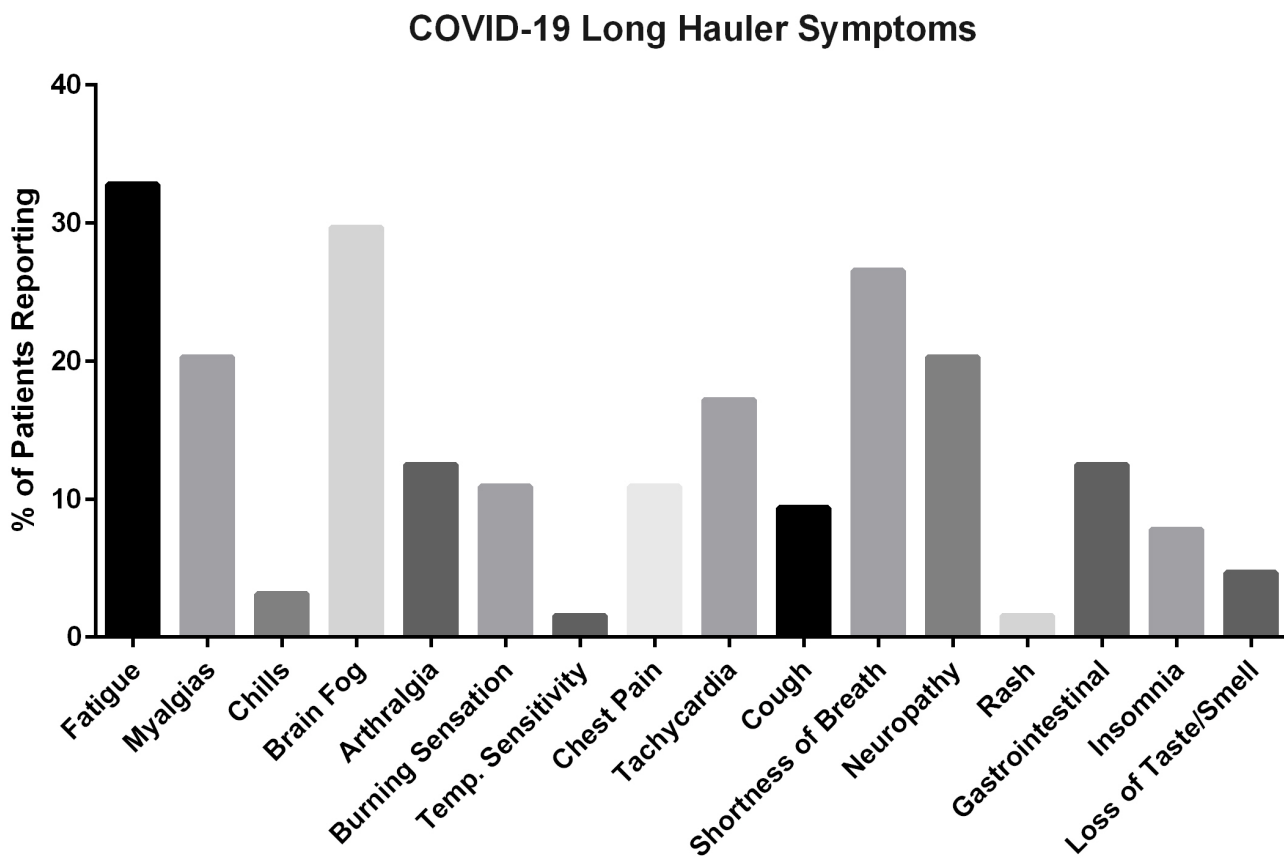
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676 **TABLES and FIGURES**

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678 Figure 1. Symptoms reported by long hauler patients enrolled in the study.



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688 Table 1. Immunologic parameters of study participants

Average	CD3+%	CD4%	CD8%	CD4+PD1+%	CD4+LAG3+%	CD4+CTLA4+%	CD4+FoxP3+%	CD8+PD1+ %	CD8+LAG3+ %	CD8+CTLA4+%	CD19+%	CD14+CD16-%	CD16+CD14+%	CD16+CD14-%
Normals	64.45	53.89	33.83	35.62	0.94	1.51	6.21	43.76	4.35	1.39	6.04	42.79	9.00	32.68
Lower CI	54.39	43.21	27.20	28.36	0.49	0.75	4.54	33.50	2.71	0.74	5.04	34.41	4.60	25.49
Upper CI	74.50	64.57	40.46	42.89	1.39	2.26	7.87	54.01	5.99	2.03	7.04	51.16	13.41	39.86

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Average	CD3+%	CD4%	CD8%	CD4+PD1+%	CD4+LAG3+%	CD4+CTLA4+%	CD4+FoxP3+%	CD8+PD1+ %	CD8+LAG3+ %	CD8+CTLA4+%	CD19+%	CD14+CD16-%	CD16+CD14+%	CD16+CD14-%
Long Hauler	48.98	56.18	35.36	17.78	0.72	4.06	2.58	31.99	0.71	3.11	13.14	19.07	29.30	33.86

690

Average (pg/ml)	TNF- α	IL-4	IL-13	IL-2	GM-CSF	sCD40L	CCL5 (RANTES)	CCL3 (MIP-1 α)	IL-6	IL-10	IFN- γ	VEGF	IL-8	CCL4 (MIP-1 β)
Normals	9.09	4.18	3.94	6.17	51.27	7192.39	10781.84	22.82	2.21	0.67	1.94	9.32	16.87	76.84
Lower CI	7.37	2.17	1.79	5.53	25.72	5148.85	9764.99	13.05	1.65	0.42	0.63	6.36	13.03	61.00
Upper CI	10.81	6.18	6.09	6.82	76.82	9235.92	11798.68	32.60	2.77	0.92	3.26	12.28	20.72	92.67

Long Haulers	7.72	17.03	4.21	16.16	12.46	18302.41	12505.06	97.81	20.47	12.23	86.60	41.03	35.98	35.10
Mild-Mod	6.82	2.33	2.40	5.90	56.13	10673.72	11627.70	18.75	8.74	0.63	1.15	17.39	17.37	94.40
Severe	5.39	2.39	2.26	5.43	20.31	12306.39	11581.47	16.54	144.15	3.10	2.06	25.52	10.87	64.84

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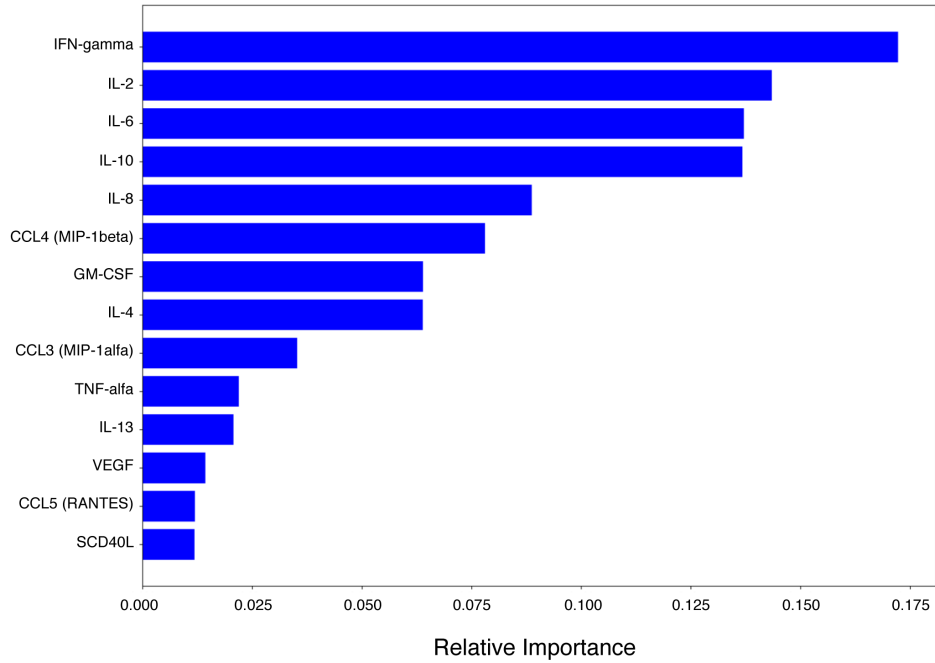
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694 Table 2. Performance Metrics for the Random Forest Classifiers in the test split.

Model	Precision %	Recall %	F1 Score
Long Hauler-Full Features	100	100	1.00
Severe- Full Features	100	100	1.00
Multi-Class-Full Features	100	100	1.00

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696 Figure 2. Feature importance for multi-class classifier using Random Forest predictor.



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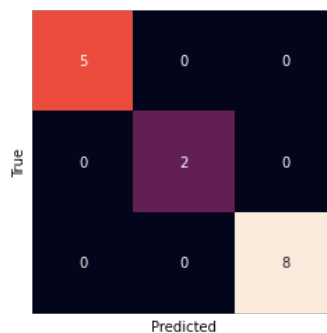
705 Table 3. Performance Metrics of the DNN full feature model in the training and test splits

706

DNN	Precision %	Recall %	F1 Score
Multi-Class - Full Features -Train	99	97	0.98
Long Hauler - Full Features -Train	100	100	1.00
Severe - Full Features - Train	98	100	0.99
Multi-Class - Full Features -Test	100	100	1.00
Long Hauler - Full Features -Test	94	94	0.93
Severe - Full Features - Test	75	92	0.79

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708 Figure 3. Full-feature multi-class DNN model confusion matrix for the test split.



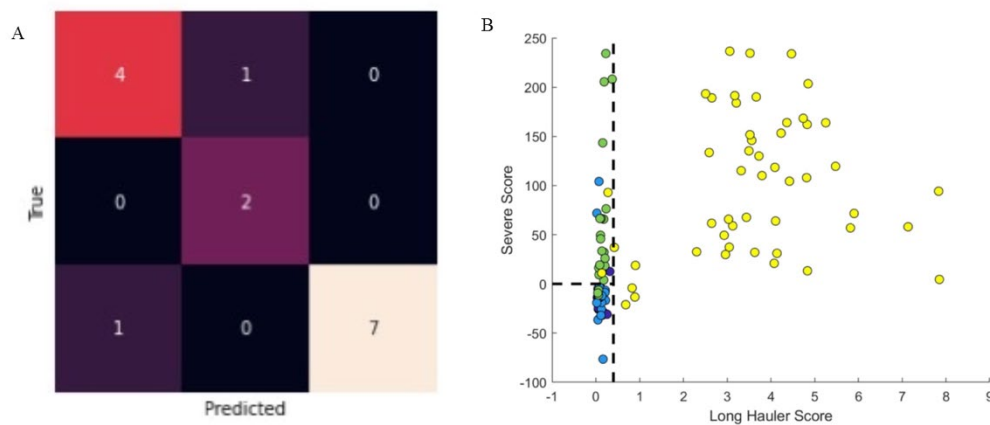
709

710 Table 4. Performance metrics for the minimal deep neural network (mDNN) on the
711 training and test splits.

Model	Precision %	Recall %	F1 Score
mDNN- Training	98	96	0.97
mDNN- Test	82	89	0.84

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714 Figure 4. Classification abilities of the minimal Deep Neural Network (mDNN) and the
715 discrimination heuristic generated using important variables. A) The confusion matrix for
716 the mDNN classifier denoting the presence of false positives for the severe and other
717 classes. B) Discrimination ability of the heuristic with reduced or most important features
718 identified using Random Forest classifier. The dots represent the data points, where
719 yellow are long haulers, green-severe, dark blue-mild/moderate and light blue-normal.

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