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CORRECTION

Correction to: Clinical Characteristics and Multisystem Imaging Findings of COVID-19: An Overview for Orthopedic Surgeons

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The published article listed an incorrect credential for Jose Rodriguez, MD. It is corrected here.

The correct article category should be "Response to COVID-19/Review Article."

The published article also contained two typographic errors in Table 1, neither of which affected the data or findings presented. Table 1 is corrected here.

The online version of the original article can be found at https://doi.org/10.1007/s11420-020-09775-3

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Table 1 Summary of reported COVID-19 most common imaging findings to date

Organ system	Imaging findings
Pulmonary manifestations	Plain radiograph (Fig. 1) • Consolidation and ground glass opacities (GGO) in a peripheral and lower lobe distribution, with predominately bilateral lung involvement• Pulmonary nodules, pleural effusions, lymphadenopathy, and lung cavitation are usually absent Chest CT findings based on time of illness (Figs. 2, 3, and 4)*A*. Early stage (days 0–4) • Subpleural unilateral or bilateral GGO • Negative findings possible in minority of patients *B*. Progressive stage (days 5–8) • Diffuse/multilobe distribution of GGO • Crazy-paving pattern (GGO with superimposed inter- and intralobular septal thickening) • Consolidations without mediastinal lymphadenopathy *C*. Peak stage (days 9–13) • Worsening GGO diffusion and crazy-paving with residual parenchymal bands • ARDS highly likely during this period *D*. Absorption stage (days 14–resolution) • GGO may persist, but crazy-paving resolves • Consolidations decrease over time Other associated chest CT findings (Fig. 7) • Septal thickening • Pleural thickening • Pericardial effusion • Bronchiectasis • CT Halo sign • Acute pulmonary embolism (screen for deep vein thrombosis on duplex ultrasound)
Cardiovascular manifestations	Gadolinium-enhanced cardiac MRI and echocardiographs **(**Figs. 5 and 6**)** • Acute myopericarditis: curvilinear delayed enhancement in the subepicardial wall and adjacent pericardium • Acute myocardial infarction: delayed transmural enhancement within ventricle • Generalized increase in heart wall thickness • Diffuse biventricular hypokinesis • Severe left ventricular dysfunction • Biventricular myocardial interstitial edema • Pericardial effusion (mostly around the right cardiac chambers)
Musculoskeletal and neurologic manifestations	CT brain (Figs. 8 and 9) • Acute large vessel cerebral infarcts (could be thromboembolic in nature) • Acute cerebral hemorrhage • Leukoencephalopathy, including CT hypoattenuation of the bilateral cerebral hemispheric white matter and corpus callosum MRI (with or without IV contrast) (Figs. 10, 11, and 12) • Encephalitis with leptomeningeal enhancement • Meningoencephalitis • Guillain-Barré syndrome (GBS) • Acute ischemic stroke with frontotemporal hypoperfusion abnormalities • Intracranial hemorrhage • Cerebral venous thrombosis • Multiple sclerosis plaque exacerbation • Miller-Fisher syndrome

	• Posterior reversible encephalopathy syndrome (PRES) • Acute necrotizing encephalopathy (ANE) • Leukoencephalopathy with diffuse confluent white matter T2/FLAIR hyperintensities, scattered micro-hemorrhage in the corpus callosum, and posterior circulation hyperperfusion, without diffusion restriction or abnormal enhancement • Myositis
Gastrointestinal manifestations	CT and US abdomen (Figs. 13 and 14) • Small and large bowel wall thickening, due to gastroenteritis or ischemia • Bowel and mesenteric infarction and necrosis, with associated non-enhancing bowel, pneumatosis, portal venous gas, and bowel perforation • Portal vein thrombosis • Distended gallbladder containing sludge suggestive of cholestasis • Solid organ inflammation and infarction, including the pancreas (pancreatitis), liver (hepatitis), kidneys, and spleen

CT computed tomography, *MRI* magnetic resonance imaging