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The protease inhibitor lopinavir, boosted with ritonavir, as treatment for COVID-19: a rapid review

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Abstract

Background: The HIV protease inhibitor lopinavir, boosted with ritonavir, has been used off-label to treat COVID-19. We aimed to synthesise the clinical evidence for lopinavir/ritonavir as a treatment for COVID-19.

Methods: We performed a rapid review by searching databases including PubMed, GoogleScholar, medRxiv, ClinicalTrials.gov and the Cochrane COVID-19 Study Register, for COVID-19 studies comparing outcomes between patients who did and did not receive lopinavir/ritonavir. The quality of evidence was assessed using the GRADE criteria.

Results: We identified five completed randomised controlled trials (RCTs) and 14 retrospective cohort studies. Two large RCTs of 5040 and 2771 hospitalised adults with COVID-19 found no evidence that lopinavir/ritonavir influenced the primary outcome of mortality, or secondary outcomes including progression to mechanical ventilation or time to discharge. Results remained similar in all sub-group analyses including by age, gender, baseline ventilation and time since symptom onset. Results from one of these trials were only available as a pre-print. The three smaller RCTs (n=86-199) also found no evidence of a benefit in the primary outcomes of time to clinical improvement or time to viral clearance. The 14 observational studies included between 50 and 415 participants, and were limited by a lack of adjustment for potential confounding variables. The majority of these studies found no evidence that lopinavir/ritonavir was associated with improved mortality or other clinical outcomes, although results regarding viral clearance were mixed.

Conclusions: Good evidence from large clinical trials does not support using lopinavir/ritonavir to treat COVID-19 amongst hospitalised patients.

Accepted 5 February 2021, published online 11 March 2021
Running head: Rapid review of lopinavir/ritonavir for COVID-19
Introduction

The severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), which causes novel coronavirus disease 2019 (COVID-19), is known to have infected over 51 million people globally at the time of writing, with over 1.2 million reported deaths [1]. Due to limited SARS-CoV-2 testing, the true numbers of cases are likely far higher. Currently, there are few effective treatments for COVID-19 that have been rigorously tested in randomised controlled trials. The rapid spread of the pandemic and urgent need for effective treatments has led to interest in re-purposing currently available drugs for immediate use [2]. The antiretroviral drug lopinavir is a protease inhibitor, which is widely used for the treatment of HIV and is a potential candidate for treatment of COVID-19. Lopinavir is formulated in combination with another protease inhibitor, ritonavir (lopinavir/ritonavir, branded as Kaletra or Aluvia). Ritonavir inhibits the metabolising enzyme cytochrome P450 3A and thereby increases the half-life of lopinavir [3].

There is preliminary clinical evidence of effectiveness of lopinavir/ritonavir against other coronaviruses such as severe acute respiratory syndrome coronavirus (SARS-CoV) and Middle East respiratory syndrome coronavirus (MERS-CoV). During the SARS-CoV outbreak in 2003, an open-label, non-randomised study found reduced risk of severe hypoxia or death in 41 SARS-CoV patients who were treated with lopinavir/ritonavir and ribavirin, compared to 111 historical controls treated with ribavirin alone [4]. However, there has been no evidence from randomised clinical trials to demonstrate the efficacy of lopinavir/ritonavir in treating SARS-CoV or MERS-CoV.

Potential mechanism of action

The SARS-CoV-2 virus is a single-stranded RNA-enveloped beta-coronavirus, similar to SARS-CoV and MERS-CoV. These viruses enter host cells and replicate, producing strands of the viral RNA which are translated by host cell ribosomes into polypeptides [2,5]. The enzyme 3-chymotrypsin-like protease (3CLpro) cleaves these polypeptides into non-structural proteins. These then replicate and transcribe the viral genome, prior to assembly and release of new progeny viruses [5–7]. As lopinavir is a protease inhibitor, it may inhibit the action of 3CLpro, which would in turn disrupt the process of viral replication and release from host cells [6,7]. Lopinavir has antiviral activity against SARS-CoV [4] and MERS-CoV [8] and, has in vitro activity against SARS-CoV-2 with a half-maximal effective concentration (EC50) at 26.63 µM [9]. However, this indicates that SARS-CoV-2 is less susceptible to lopinavir than HIV, as the EC50 for lopinavir against HIV is between 0.01-0.03 µM [3]. One reason for the reduced potency may be that coronavirus proteases like 3CLpro do not contain a C2-symmetric pocket, which is the target of HIV protease inhibitors [8,10]. Darunavir, another HIV protease inhibitor, was not active against SARS-CoV-2 in an unpublished in vitro study [11]. A recent study using in vitro and mouse models found stronger evidence for anti MERS-CoV activity for another antiviral, the RNA-dependent RNA polymerase inhibitor remdesivir, compared to lopinavir/ritonavir [8].
Dosing, safety, side effect profile and drug interactions

The recommended dose of lopinavir/ritonavir for HIV treatment is 400mg/100mg twice daily [3]. For COVID-19, the same dose has commonly been used, generally for 14 days [2]. Lopinavir/ritonavir is contraindicated in porphyria and caution is advised in patients with haemophilia, cardiac conduction disorders, pancreatitis, structural heart disease and those with increased risk of cardiovascular disease [12]. Common side effects include gastrointestinal disturbance, in particular diarrhoea, which is often worse in the first few weeks and can be treated with loperamide. Dyslipidaemia, diabetes mellitus, pancreatitis and hepatic disorders have also been reported, but these complications are usually only experienced after several months of therapy [12,13]. Drug interactions with lopinavir/ritonavir are common due to their inhibition of cytochrome P450, which can lead to increased levels of co-administered drugs that are metabolised by this enzyme. Drugs that interact with lopinavir/ritonavir and are commonly used in primary care include the lipid lowering simvastatin, combined oral hormonal contraceptives, anti-epileptic drugs and the inhaled corticosteroid fluticasone [14].

Global use and price

Lopinavir/ritonavir is currently recommended by the World Health Organisation as a second-line treatment of HIV, and is used by approximately 580,000 people globally for this indication [15]. With the current interest in repurposing its use for COVID-19, there have been concerns regarding ensuring adequate supply for people living with HIV. Currently, a two week course costs approximately £140 (USD 170) in the UK [12], and approximately £6.50 (USD 8) in certain low and middle income countries under pooled patent agreements [15].

    Here, we used rapid review methods [16] to synthesise the evidence for the use of lopinavir/ritonavir as a treatment for COVID-19.

Methods

We adhered as closely as possible to the PRISMA guidelines for systematic reviews [17]. We searched for clinical trials or observational studies comparing the efficacy of lopinavir/ritonavir against standard care or other drugs, for the treatment of COVID-19 in humans. We excluded studies which had fewer than 15 participants in either the lopinavir/ritonavir or the comparator group, as these studies were unlikely to have statistical power to detect any difference in treatment outcomes. We did not use any language restrictions and included pre-prints. Systematic reviews were used as a point of reference.

Search strategy and selection criteria

We conducted electronic searches in PubMed, GoogleScholar, the Cochrane COVID-19 Study Register, ClinicalTrials.gov and medRxiv on the 13th October 2020. We excluded articles published before 2019. We used search terms including coronavirus*, COVID-19, SARS-CoV-2, lopinavir and Kaletra. Full search terms are listed in the appendix. We searched the reference lists of identified
articles to find further relevant articles. After removing duplicates, one author conducted title, abstract and full text searches, with any uncertainties checked by a second author. We used the Population, Intervention, Comparator, Outcomes, Study design (PICOS) framework to extract relevant data from selected articles using a standardised form (Table 1) [18]. We assessed the quality of the evidence using the GRADE criteria [19].

Results

We identified a total of 879 records, including 386 through PubMed, 85 through medRxiv, 264 through the Cochrane COVID-19 Study Register, 87 through ClinicalTrials.gov and 57 through GoogleScholar. From these, 175 duplicates were identified, and a further 631 records were excluded through title and abstract screening. Fifty-four studies were further excluded in the full-text screening, including 45 studies that did not compare clinical outcomes between patients receiving lopinavir/ritonavir and those not receiving lopinavir/ritonavir, and nine studies with sample sizes too small to allow meaningful comparisons. We finally included 19 studies, including five completed clinical trials and 14 observational studies (Table 2). Two of the clinical trials provided good quality evidence, one provided moderate quality evidence, and the other included studies were assessed as being at high risk of bias, mainly due to small sample sizes and the lack of adjustment for potential confounders. We present our findings in narrative format as heterogeneity of outcomes and study designs made quantitative synthesis inappropriate.

Clinical trial findings

The RECOVERY trial is an open-label, randomised platform trial of patients hospitalised with clinically suspected or laboratory confirmed SARS-CoV-2 infection in 176 UK hospitals [20]. As part of this study, 5040 patients were randomised to receive either usual care plus lopinavir/ritonavir 400mg/100mg twice daily for ten days (n=1616), or usual care alone (n=3424). Median days from symptom onset to enrolment was similar in both arms (lopinavir/ritonavir eight days (IQR 5-12), usual care eight days (IQR 4-12). There was no difference between the two groups in the primary outcome of mortality by 28 days (rate ratio 1.03, 95% CI 0.91-1.17, p = 0.60). Analyses of pre-specified subgroups by age, sex, ethnicity, time since symptom onset, respiratory support at randomisation and baseline predicted risk also found no evidence of benefit. Secondary outcomes of hospital discharge (risk ratio [RR] 0.98, 95% CI 0.91–1.05, p=0.53) and a composite of mechanical ventilation or death by 28 days (RR 1·09, 95% CI 0·99–1·20, p=0·092), were similar between groups. There was one serious adverse event of elevated serum alanine aminotransferase in the lopinavir/ritonavir group, although the authors note that they did not record non-serious adverse reactions.

The SOLIDARITY trial, led by the World Health Organization, is a large, international, randomised platform trial of adults admitted with COVID-19 to 405 hospitals in 30 countries [21]. Interim results have been reported in a pre-print, in which 1399 participants randomised to receive lopinavir/ritonavir 400mg/200mg twice daily for 14 days, were compared to 1372 participants who were randomised to receive usual care. The primary outcome of in-hospital mortality was similar in
both groups (148/1399 vs 146/1372, RR 1.00, 95% CI 0.79-1.25, p=0.97), and there were no differences in sub-group analyses stratified by age or ventilation status at randomisation. Proportions achieving the secondary outcome of progression to requiring ventilation were similar in the lopinavir/ritonavir group (9.6%) and the control group (9.5%). The proportion remaining in hospital at 7 and 14 days (68% vs 59%, 31% vs 22% respectively) was higher in the lopinavir/ritonavir arm, but the authors hypothesise that this was due to patients being asked to remain in hospital to complete the lopinavir/ritonavir treatment course, and this resolved by 21 days (12% versus 11%). 95% CIs and p values were not presented for secondary outcomes. Serious adverse events were not reported, but there were no deaths from hepatic failure in the lopinavir/ritonavir arm.

Cao et al conducted an open-label randomised controlled trial at a single hospital in Wuhan, China at the peak of the epidemic there [22]. They enrolled 199 hospitalised adults with a positive SARS-CoV-2 reverse transcriptase polymerase chain reaction (RT-PCR) test, pneumonia and oxygen saturations ≤ 94% on ambient air, and randomised them to receive lopinavir/ritonavir 400mg/100mg twice a day for 14 days (n=99) or standard care (n=100). Median time from onset of illness to randomisation was 13 days [interquartile range (IQR) 11-16]. Baseline characteristics were similar between the two groups. The median age was 58 years (IQR 49-68). Most patients (55%) were enrolled >12 days after symptom onset, and were severely unwell, requiring urgent clinical attention. After 28 days, intention to treat (ITT) analysis revealed no difference in the primary outcome of time to clinical improvement between the two arms (16 days in both groups; hazard ratio 1.31; 95% CI: 0.95 to 1.85; p=0.09). Restricting the analysis to patients enrolled within 12 days of symptom onset did not alter results. When modified ITT analysis was conducted, in which three patients who died within 24 hours of randomization and did not receive lopinavir/ritonavir were excluded, there was weak evidence of a small improvement in the time to clinical improvement with lopinavir/ritonavir [median of 15 days versus 16 days, respectively; hazard ratio 1.39 (95% CI: 1.00 to 1.91)]. There was no effect of lopinavir/ritonavir on the proportion of patients with clinical improvement at 28 days, time from randomization to death, nor duration of oxygen therapy or mechanical ventilation. There was also no difference in viral clearance between groups. Gastrointestinal symptoms were more common in the lopinavir/ritonavir arm, and 13.8% of patients stopped treatment early due to adverse events. Overall, serious adverse events were higher in the usual care arm (32 versus 19 events), largely due to a higher frequency of acute respiratory distress syndrome (27 versus 12 events).

Li et al report findings from a single-blind randomised controlled trial in China [23]. The investigators initially aimed to enrol 125 adults with laboratory confirmed SARS-CoV-2, but due to control of the epidemic, the trial was limited to 86 participants. Patients with mild or moderate clinical status (with or without signs of pneumonia) were suitable for inclusion. The mean age of was 49.4 years (range 19-79). Thirty-four participants were randomised to receive lopinavir/ritonavir for 14 days, 35 to receive umifenovir (a fusion inhibitor [24]) and 17 to standard care with no antiviral. There was no difference in the primary outcome of mean time to negative pharyngeal SARS-CoV-2 PCR test between the lopinavir/ritonavir, umifenovir and control groups (9.0 (standard deviation [SD] 5.0), 9.1 (SD 4.4) and 9.3 (SD 5.2) days, respectively). There were no differences in pyrexia, cough or lung computed tomography (CT) scan findings at 7 and 14 days. 12 (35.3%) patients in the
lopinavir/ritonavir group experienced adverse events (gastrointestinal and deranged liver function), compared to five (14.3%) in the umifenovir group and zero patients in the control group.

Huang et al conducted a single-site, open-label, randomised controlled trial amongst 101 adults hospitalised with laboratory confirmed SARS-CoV-2 infection and mild to moderate COVID-19, defined as respiratory rate <30 breaths per minute, oxygen saturations >93% and FiO2 > 39.9 kPa [25]. Participants were randomised to receive ribavirin plus interferon-α (n=33), or lopinavir/ritonavir plus interferon-α (n=36), or lopinavir/ritonavir plus ribavirin plus interferon-α (32). There was no evidence of a difference in the primary outcome of time to SARS-CoV-2 negativity between the groups (13 vs 12 vs 15 days respectively, p=0.23). Secondary outcomes of proportions who were SARS-CoV-2 negative by day 14 (51.5% vs 61.1% vs 46.9% respectively, p value not given), and progression to severe disease (3.0% vs 5.6% vs 6.3%, p=0.58) were similar between the three groups.

Observational study findings

We identified 14 observational studies that provided some empirical data for the association of lopinavir/ritonavir with outcomes in patients with COVID-19 (Table 2). These studies were characterised by high risk of bias with respect to the question posed by this review. All studies were among hospitalised patients, with two studies restricted to patients in intensive care units [26,27], and one study limited to ‘non-severe’ cases (defined as not hypoxic) [28]. Seven studies reported time from symptom onset as being a median of seven days or longer, while two studies reported a median of less than 7 days. Outcomes reported included mortality (n=6 studies) [26,27,29–32], clinical deterioration in COVID-19 severity (n=3 studies) [26,27,32], clinical improvement (n=4 studies) [32–35] and SARs-CoV-2 RT-PCR clearance (n=11 studies) [27,28,31–39]. Only five studies adjusted for potential confounders [26,30,37,38].

Most studies found no association between lopinavir/ritonavir treatment and COVID-19 outcomes. Lopinavir/ritonavir use was not associated with a change in mortality outcomes in five studies [26,27,30–32], or with preventing clinical deterioration in three studies [26,27,32], nor with clinical improvement in three studies [32,33,35]. One Chinese study found that amongst patients receiving lopinavir/ritonavir (n=28) a higher proportion developed unfavourable outcomes, including death or disease progression (53.6% versus 21.4%, p<0.001), compared to those not on lopinavir/ritonavir (n=295) [29]. However, patients with critical disease severity at baseline were more likely to receive lopinavir/ritonavir compared with those with non-severe and severe disease (p<0.001), meaning that the worse outcomes amongst those receiving lopinavir/ritonavir could be explained by this bias. Another Chinese study found an association between receiving lopinavir/ritonavir and faster resolution of lung involvement on computed tomography (CT) scan, but patients receiving lopinavir/ritonavir were also more likely to have influenza co-infection, and the scheduling of CT scans was not clear [34]. Regarding clearance of SARS-CoV-2 in RT-PCR testing, results were more mixed. Of the 11 studies, six found no association between lopinavir/ritonavir use and SARS-CoV-2 clearance [27,28,31–33,36], while lopinavir/ritonavir was associated with better SARS-CoV-2 clearance in three studies [34,35,38], and worse clearance in two studies [37,39]. The
two studies with shorter time since symptom onset did not find an association between lopinavir/ritonavir use and shorter time to viral clearance [28,35]. Three studies reported increased side effects (gastrointestinal disturbances) [32] and adverse events (liver and renal function derangement) [26,32,35] among patients receiving lopinavir/ritonavir.

Discussion

We identified five randomised clinical trials, including 8197 hospitalised patients, which assessed lopinavir/ritonavir as a treatment for COVID-19. Two of these studies provided good quality evidence due to their large sample size and objective primary outcome [20,21], although neither were placebo controlled and results from one of these trials had not yet been peer-reviewed. The remaining three trials had a higher risk of bias; none were blinded and two were under-powered. No randomised trial found a benefit from lopinavir/ritonavir with regard to their primary outcomes which included mortality, time to clinical improvement and negative pharyngeal SARS-CoV-2 PCR test. There was no clear benefit in secondary outcomes, nor in sub-analyses broken down by patients who received treatment earlier in the course of the disease. Gastrointestinal side effects were more common in patients treated with lopinavir/ritonavir compared with controls. We also reviewed 14 observational studies including 2549 patients, of whom 1003 received lopinavir/ritonavir. There was no association between use of lopinavir/ritonavir and reduced mortality nor clinical improvement. Results regarding viral shedding were mixed, and in general were unadjusted for potential confounders such as disease severity or concomitant treatments.

Comparison with existing literature

We did not find any other published systematic reviews reporting results of recent, large trials of lopinavir/ritonavir for COVID-19. Our rapid review, containing five RCTs and 14 observational studies, therefore provides an important update.

Strengths and Limitations

We used a broad search strategy, and rapid, pragmatic approach that allowed identification of emerging evidence in the evolving COVID-19 pandemic. We adhered as closely as possible to the PRISMA checklist for systematic reviews. We specifically searched for and included pre-prints, because much of the current evidence is being made available in this form in the interest of data sharing during this pandemic. This allowed us to include the recent results from the SOLIDARITY trial, although as this one included preprint has yet to be peer reviewed, the overall quality of reporting could be less rigorous. We did not apply language restrictions in order to capture COVID-19 related research being conducted in China. Due to the rapid nature of the review, we did not attempt to contact authors, meaning we were unable to clarify or confirm data where we had queries.

Limitations of the current evidence

We did not find any randomised trials of lopinavir/ritonavir use among patients with COVID-19 in the community, where earlier treatment may be more effective. However, amongst hospitalised patients,
there was no evidence of a benefit in sub-group analyses among those treated with lopinavir/ritonavir earlier in the course of the disease. Our review included a large number of observational studies which, by virtue of their design, are more prone to bias. None of the included studies adjusted their analyses for concomitant medication use or COVID-19 severity, which are likely to have affected outcomes. Lack of adjustment for important co-variates (potential confounders) can increase risk of bias. We also excluded many cohort studies from this analysis as they did not specifically describe the number of patients treated with lopinavir/ritonavir for COVID-19, or did not describe a comparator group. This represents a missed opportunity to increase the evidence base to identify treatment strategies for COVID-19.

Implications for research and clinical practice

Ongoing platform randomised trials should continue to assess alternative treatments for COVID-19 in order to determine safety and efficacy [40–42]. Ideally, these would be double blinded, but the urgency and constraints of conducting research in pandemic settings means this has not always been possible [42–44]. These studies are mainly focused on hospital inpatients, and trials of treatments in primary care, where patients are likely to present earlier, should also be prioritised. Developing studies in community settings would allow assessment of whether earlier treatment with repurposed drugs such as lopinavir/ritonavir could prevent the development of serious complications of COVID-19 [45]. Treatments that are hypothesised to have an antiviral effect may be more likely to work earlier during the replicative phase of SARS-CoV-2 infection, rather than later during the inflammatory stage of COVID-19.

Conclusions

In this rapid review, we found evidence that lopinavir/ritonavir should not be used to treat COVID-19 amongst hospitalised patients. Further trials of community-based lopinavir/ritonavir treatment may be warranted.

Disclosure statement

JD and OG are funded by the Wellcome Trust PhD Programme for Primary Care Clinicians (216421/Z/19/Z and 203921/Z/16/Z respectively). For the purpose of Open Access, the author has applied a CC BY public copyright licence to any Author Accepted Manuscript version arising from this submission. TC is funded by the British Heart Foundation (BHF) PhD Studentship (FS/19/13/34235). GH is funded by an NIHR Advanced Fellowship. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care. We have no conflicts of interest to declare.

References


Coronavirus Disease 2019: Results of a Randomized, Open-Labeled Prospective Study. Front Pharmacol 2020; 11:1071.


45. Butler CC, Ogburn E, Allen J, Bongard E, Swazy H, Tonner D. ISRCTN86534580: A trial evaluating treatments for suspected coronavirus infection in people aged 50 years and above with

Table 1: PICOS items to guide data extraction

<table>
<thead>
<tr>
<th>PICOS item</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Population</td>
<td>People with suspected or confirmed SARS-CoV-2 infection</td>
</tr>
<tr>
<td>Intervention</td>
<td>Lopinavir/ritonavir</td>
</tr>
<tr>
<td>Comparisons</td>
<td>No treatment, or other treatments</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Clinical outcomes including but not limited to death, intensive care admission, ventilation, hospitalisation, oxygen use, clinical signs and symptoms, SARS-CoV-2 viral shedding</td>
</tr>
<tr>
<td>Study designs</td>
<td>Randomised controlled trials, observational studies</td>
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</table>
Table 2: Completed clinical studies of lopinavir/ritonavir treatment for COVID-19 patients

<table>
<thead>
<tr>
<th>No</th>
<th>Study details</th>
<th>Location</th>
<th>Study population</th>
<th>Design</th>
<th>Interventions</th>
<th>Results</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RECOVERY Collaborative Group 2020 [20] NCT04381936</td>
<td>Multi-site, UK</td>
<td>5040 hospitalised patients with COVID-19. Mean age 66.2 years (SD 15.9). 26% no oxygen, 70% oxygen only, 4% mechanical ventilation. Median 8 days (IQR 4-12) since symptom onset.</td>
<td>Open-label RCT</td>
<td>1. Standard care (n=3424) 2. LPV/r 400/100 twice a day for 10 days (n=1616)</td>
<td>Primary outcome: 374 (23%) died by 28 days in LPVr arm vs 767 (22%) in usual care arm, rate ratio 1.03 (95% CI 0.91-1.17, p=0.60). No differences in subgroup analyses by age, gender, ethnicity, time since symptom onset, respiratory support at randomisation or baseline risk. Secondary outcomes: No difference in time to discharge (median 11 days in both groups), nor composite outcome of mechanical ventilation or death (risk ratio 1.09, 95% CI 0.99-1.2, p = 0.092)</td>
<td>Good quality due to large sample size and objective primary outcome.</td>
</tr>
<tr>
<td>2</td>
<td>SOLIDARITY trial consortium [21] PREPRINT NCT04315948</td>
<td>Multi-site, all 6 WHO regions</td>
<td>2771 adults ≥18 years old hospitalised with COVID-19. 28% no oxygen, 63% oxygen only, 8% ventilated.</td>
<td>Open-label RCT</td>
<td>1. Standard care (n=1372) 2. LPV/r 400/100 twice a day for 14 days (n=1399)</td>
<td>Primary outcome: 148 (10.6%) died during admission in LPVr arm vs 146 (10.6%) in usual care arm (rate ratio, 1.00, 95% CI 0.79-1.25, p=0.97). No difference in subgroup analyses by age, ventilation at admission, geographic region, corticosteroid use. Secondary outcomes: No difference in progression to ventilation (9.6% in lopinavir/ritonavir group vs 9.5% in control group, 95% CIs and p values not presented).</td>
<td>Good quality due to large sample size and objective primary outcome.</td>
</tr>
<tr>
<td>3</td>
<td>Cao 2020 [22] NCT02845843</td>
<td>Single site, China</td>
<td>199 hospitalised adults ≥18 years with laboratory confirmed SARS-CoV-2, pneumonia and oxygen saturation &lt; 94%. 55% enrolled &gt;12 days after symptom onset. Median age 58, 60.3% men median NEWS (National Early Warning Score) = 5.</td>
<td>Open-label RCT</td>
<td>1. Standard care (n=100) 2. LPV/r 400/100 twice a day for 7 days (n=99)</td>
<td>Primary outcomes: Time to clinical improvement was median of 16 days in each arm. No difference in analysis restricted to those initiated within 12 days of symptom onset. No difference in NEWS score or clinical deterioration. Secondary outcomes: Mortality at 28 days lower in LPV/r vs SOC: 19.2% vs. 25.0% (difference, −5.8%; 95% CI, −17.3 to 5.7). Clinical improvement at 14 days 15% higher in LPV/r vs SOC (95% CI 2.2-28.8), but no difference at 7 or 28 days. Time in ICU (-5 days, 95% CI -9-0) and time to discharge (-1 day, 95% CI -3-0) shorter in LPV/r arm vs SOC arm. No difference in proportion with clinical improvement at 28 days, time from randomization to death, or duration of oxygen therapy and duration of mechanical ventilation. Virology: No difference in viral RNA over time</td>
<td>Moderate quality due to small sample size, subjective nature of primary end-point, open-label design.</td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Study Design</td>
<td>Setting</td>
<td>Participants</td>
<td>Intervention</td>
<td>Primary Outcome</td>
<td>Secondary Outcomes</td>
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<td>Huang 2020 [25]</td>
<td>2020</td>
<td>Single site, China</td>
<td>Single site, China</td>
<td>101 adults aged 18-65 with mild/moderate, laboratory confirmed SARS-CoV-2. Median 4 days (IQR 1.5-7.0) since symptom onset</td>
<td>Open label RCT</td>
<td>1. RBV+IFN-α (n=33) 2. LPV/r +IFN-α (n=36) 3. RBV + LPV/r +IFN-α (n=32)</td>
<td>Primary outcome: Time to negative SARS-CoV-2 PCR test similar in three arms (13, 12 and 15 days respectively, p=0.23) Secondary outcomes: Proportion with negative SARS-CoV-2 test at 14 days similar in both arms (51.5% (17/33), 61.1% (22/36), and 46.9% (15/32) respectively). Progression to severe disease also similar between arms (3.0% (1/33) vs 5.6% (2/36), vs 6.3%, 2/32 respectively).</td>
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<tr>
<td>Li 2020 [23]</td>
<td>2020</td>
<td>Single site, China</td>
<td>Single site, China</td>
<td>86 adults aged 18-80 years with mild/moderate, laboratory confirmed SARS-CoV-2. Mean age 49.4, range 19-79. Median 3.5 days (IQR 2-6) since symptom onset in LPVr arm.</td>
<td>Open label RCT</td>
<td>1. LPV/r (n=34) 2. Umifenovir (35) 3. No antiviral (17)</td>
<td>Primary outcome: Time to negative pharyngeal SARS-CoV-2 RNA test in LPV/r, umifenovir and control groups was 9.0 (SD 5.0), 9.1 (SD 4.4) and 9.3 (SD 5.2) days respectively, p=0.981. Secondary outcomes: No differences in pyrexia, cough or CT scan improvement at 7 and 14 days. In LPV/r arm, 23.5% deteriorated to severe/critical clinical status, compared to 8.6% in the umifenovir arm and 11.8% in the control arm (p=0.186)</td>
</tr>
<tr>
<td>Grimaldi 2020 [26]</td>
<td>2020</td>
<td>Multi-site, Belgium &amp; France</td>
<td>Multi-site, Belgium &amp; France</td>
<td>415 patients with moderate to severe laboratory confirmed COVID-19 ARDS receiving mechanical ventilation. Median 8 days (IQR 7-10) since symptom onset in LPVr group</td>
<td>Prospective cohort study</td>
<td>1. No treatment (n=85) 2. Hydroxychloroquine (n=220) 3. LPV/r (n=57) 4. Other treatments (n=53)</td>
<td>No difference between LPVr group and no treatment group in proportions alive and extubated by day 28, after adjustment for age, sex, co-morbidity, and ventilatory requirements (OR 0.48, 95% CI 0.18-1.25). Need for renal replacement therapy higher in LPVr group versus no treatment group (39% vs 17%).</td>
</tr>
<tr>
<td>Hu 2020 [29]</td>
<td>2020</td>
<td>Single site, China</td>
<td>Single site, China</td>
<td>323 hospitalised adults with laboratory/radiologic</td>
<td>Retrospective cohort study</td>
<td>1. LPV/r (n=28) 2. No LPV/r</td>
<td>Mortality/severe disease 53.6% in LPV/r exposed versus 21.4% in unexposed (calculated from data presented in paper. P value and confidence intervals</td>
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<tr>
<td>Reference</td>
<td>Setting</td>
<td>Study Design</td>
<td>Intervention</td>
<td>Comparator</td>
<td>Outcome</td>
<td>Note</td>
<td>Risk of Confounding</td>
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<tr>
<td>Cai 2020 [36]</td>
<td>Single site, China</td>
<td>Retrospective cohort study</td>
<td>1. LPV/r (n=229)</td>
<td>2. Favipiravir (n=30)</td>
<td>Mortality (overall 0) and ICU admission (overall 10.7%) not described by drug treatment. Median time to viral clearance was similar amongst those who received antivirals (15 days, IQR 10-19) vs those with no antivirals (14 days, IQR 10-19).</td>
<td>Very low due to risk of confounding</td>
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<tr>
<td>Chen 2020 [37]</td>
<td>Single site, China</td>
<td>Retrospective cohort study</td>
<td>1. LPVr (n=75)</td>
<td>2. No LPVr (n=192)</td>
<td>Time to viral clearance was longer in LPVr group (14.0 days, IQR 10.0-19.0) vs median 12.0 days, (IQR 8.0-16.0) in control group. Similarly, the hazard of viral clearance was lower in LPVr group in adjusted analysis taking into account age, disease severity and other clinical factors (aHR 0.70 (0.52–0.94), p=0.017)</td>
<td>Very low due to risk of confounding</td>
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<tr>
<td>Rivera-Izquierdo [30]</td>
<td>Single site, Spain</td>
<td>Retrospective cohort study</td>
<td>1. LPVr (n=191)</td>
<td>2. No LPVr (n=47)</td>
<td>No difference in mortality between LPVr and no LPVr groups (HR 0.87, 95% CI 0.44-1.73) when adjusted by calendar time, age, sex, comorbidities and clinical status on admission.</td>
<td>Very low due to risk of confounding</td>
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<tr>
<td>Zhou 2020 [31]</td>
<td>Two sites, China</td>
<td>Retrospective cohort study</td>
<td>1. LPV/r (n=41)</td>
<td>2. No LPV/r (n=150)</td>
<td>Mortality 29.3% in LPV/r exposed and 28% in unexposed, p=0.87. Median time to viral clearance was similar amongst those who received LPV/r (19 days, IQR 17–22, n=29) vs the whole study population (20 days, IQR 17-24).</td>
<td>Very low due to risk of confounding</td>
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<tr>
<td>Wen 2020 [33]</td>
<td>Single site, China</td>
<td>Retrospective cohort study</td>
<td>1. LPVr (n=59)</td>
<td>2. Umifenovir (n=36)</td>
<td>Days to SARS-CoV-2 clearance was similar across all groups (LPVr = 10.20 ± 3.49, Umifenovir = 10.11 ± 4.68, LPVr+Umifenovir = 10.86 ± 4.74, no antiviral = 8.44 ± 3.51. There were no differences between groups in time to improvement of clinical symptoms or lung CT changes.</td>
<td>Very low due to small sample size &amp; risk of confounding</td>
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<td>ID</td>
<td>Study Year</td>
<td>Study Design</td>
<td>Setting</td>
<td>Country</td>
<td>Participants</td>
<td>Methodology</td>
<td>Comparator Groups</td>
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<tr>
<td>13</td>
<td>Gao 2020</td>
<td>Single site, China</td>
<td>129 adults hospitalised with non-severe, laboratory confirmed COVID-19. Median 5 (IQR 3–7) days from symptom onset.</td>
<td>Gao 2020 [28]</td>
<td>Retrospective cohort study</td>
<td>1. Standard care (n=59) 2. LPVr (n=51) 3. Chloroquine (n=19)</td>
<td>Time to negative SARS-CoV-2 test was similar in the 3 groups (standard care 21.0 (15.0–28.8) days, LPVr 23.0 (17.0–35.5) days, chloroquine 16.0 (14.0–41.0) days).</td>
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<tr>
<td>14</td>
<td>Yu 2020</td>
<td>Single site, China</td>
<td>128 adults admitted with laboratory confirmed SARS-CoV-2 (64 adults also co-infected with influenza). Median 8.5 (IQR 7.0, 12.0) days since symptom onset.</td>
<td>Yu 2020 [34]</td>
<td>Retrospective cohort study</td>
<td>1. No LPVr (n=91) 2. LPVr (n=37)</td>
<td>Patients receiving LPVr had higher rate of resolution of lung involvement on CT scan (HR 1.878, p=0.020) and shorter time to SARS-CoV-2 negativity (median 13.0 days, IQR 10.0–16.0 in LPVr group vs median 16.5 days, IQR 12.25–23.75 in control group, p=0.003).</td>
</tr>
<tr>
<td>15</td>
<td>Yan 2020</td>
<td>Single site, China</td>
<td>120 patients with laboratory confirmed COVID-19</td>
<td>Yan 2020 [38]</td>
<td>Retrospective cohort study</td>
<td>1. LPV/r (n=78) 2. No LPV/r (n=42)</td>
<td>Risk of prolonged viral shedding over 23 days was higher in those not exposed to LPV/r, adjusted for age and sex (adjusted OR 2.42, 95% CI 1.10–5.36, p=0.03). Patients initiated on LPV/r within ten days of symptom onset had shorter viral shedding vs those not on LPV/r (19 days vs. 28.5 days, p &lt;0.001). Patients on LPV/r more likely to have severe COVID-19.</td>
</tr>
<tr>
<td>16</td>
<td>Lecronier 2020</td>
<td>Single site, France</td>
<td>80 patients with laboratory confirmed SARS-CoV-2 infection admitted to ICU and requiring high level oxygen. Median 8 (IQR 6–11) days since symptom onset.</td>
<td>Lecronier 2020 [27]</td>
<td>Retrospective cohort study</td>
<td>1. Standard care (n=22) 2. LPVr (n=20) 3. HCQ (n=38)</td>
<td>Treatment escalation (defined as initiation of mechanical ventilation, renal replacement therapy or ECMO) was similar in the three groups (standard care = 9 (41%), LPVr = 10 (50%), HCQ = 15 (39%), p = 0.567). No evidence for a difference between groups in ventilator free days, mortality, SARS-CoV-2 negativity at 7 days, liver function tests and acute renal failure were also similar between groups.</td>
</tr>
<tr>
<td>17</td>
<td>Karolyi 2020</td>
<td>Single site, Austria</td>
<td>67 adults hospitalised with laboratory confirmed severe COVID-19</td>
<td>Karolyi 2020 [32]</td>
<td>Retrospective cohort study</td>
<td>1. LPVr (n=47) 2. HCQ (n=20)</td>
<td>No difference between LPVr and HCQ groups by in-hospital mortality (8.5% vs 15%, p=0.418), ICU admission (12.8% vs 20%, p=0.470) or length of hospital stay (11 vs 9 days, p=0.340). 64.5% were</td>
</tr>
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</table>
(requiring oxygen or with bilateral lung consolidation & 2 comorbidities). Median 7 days (IQR 3–10) since symptom onset.

- **SARS-CoV-2 negative in LPVr group at median 17 days vs 58.3% negative in HCQ group at median 15 days.** In LPVr group, 25.2% complained of nausea, 14.9% developed diarrhoea, and 15.4% stopped LPVr due to side effects. 14.9% developed liver enzyme elevation.

<table>
<thead>
<tr>
<th>No.</th>
<th>Reference</th>
<th>Country</th>
<th>Patients with laboratory confirmed COVID-19</th>
<th>Study Type</th>
<th>LPVr (n)</th>
<th>HCQ (n)</th>
<th>Major Findings</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Kim 2020 [35]</td>
<td>Single site, Korea</td>
<td>65 hospitalised patients</td>
<td>Retrospective cohort study</td>
<td>1. LPVr (n=31)</td>
<td>2. HCQ (n=34)</td>
<td>Time to SARS-CoV-2 clearance was significantly lower in the LPVr group vs the HCQ group (median 21 vs 28 days, p = 0.029). LPVr use was associated with SARS-CoV-2 clearance after adjusting for age (aHR 2.28, 95% CI 1.24–4.21, p=0.008). No difference in time to clinical improvement between the two groups. Adverse events (especially increased bilirubin and lymphopenia) were higher in the LPVr group.</td>
<td>Very low due to small sample size &amp; risk of confounding</td>
</tr>
<tr>
<td>19</td>
<td>Zhu 2020 [39]</td>
<td>Single site, China</td>
<td>50 patients hospitalised with laboratory confirmed COVID-19</td>
<td>Retrospective cohort study</td>
<td>1. LPVr (n=34)</td>
<td>2. Umifenovir (n=16)</td>
<td>Proportion with negative SARS-CoV-2 RNA test by 14 days was lower in umifenovir group (0/16, 0%) vs the LPVr group (15/34 44.1%, p&lt;0.01). Time to negative test was quicker in the umifenovir group (9.5 days, IQR 5.3–11.0) vs the LPVr group (11.5 days, IQR 8.8–17.0, p&lt;0.01)</td>
<td>Very low due to small sample size &amp; risk of confounding</td>
</tr>
</tbody>
</table>

LPV/r = lopinavir/ritonavir; NEWS = National Early Warning Score; ARDS = Acute Respiratory Distress Syndrome; CT = Computed Tomography, OR = Odds Ratio, ICU = Intensive Care Unit, IQR = interquartile range
Appendix A: Search terms