Collation of Hydroxychloroquine Virological Clearance, Effectiveness, Safety in Covid-19 Patients with Control Group (Conventional Therapy) – a Systematic Review and Meta-Analysis

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Abstract

Objectives: Destitute of an effective treatment, several potential repurposed drugs have been tried in COVID-19. Despite unavailability of anecdotal evidence, several guidelines granted both Chloroquine (CQ) and Hydroxychloroquine (HCQ) in treatment. Clinical studies relating to those in COVID-19 disease has reported conflicting results. We sought to systematically evaluate the clinical effects of CQ and HCQ.

Methods: Extensive search was done using multiple databases to 22 October 2020. Proper hand searching of cross-references of original articles, pre-prints was also performed to find additional relevant articles. We summarized the effect of CQ or HCQ on viral clearance, occurrence of ADR, mortality outcomes.

Results: Out of 12 studies included in the systematic review, a total of 2,834 patients enrolled, 1326 patients received HCQ along with standard of care and 1508 patients received conventional standard of care.

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Background

The World Health Organization (WHO) declared COVID-19 (caused by Severe acute respiratory syndrome corona virus 2: SARS-CoV-2) as a global pandemic on 11 March 2020. In the absence of an effective treatment, several potential repurposed drugs have been tried in COVID-19. Meanwhile two drugs: Chloroquine (CQ) and Hydroxychloroquine (HCQ) took focus of attention, since initial studies showed that both CQ and HCQ inhibits SARS-CoV-2 effectively in vitro [1-3]. Vero-E6 cell lines, infected with SARS-CoV-2 were inhibited by low-micro molar concentration of CQ with high selectivity index. Mechanism of action of CQ and derivatives in vitro may be increasing endosomal pH, altering glycosylation of ACE-2 (angiotensin-converting enzyme 2) receptors [4], immunomodulation [1], enhanced regulatory T-cell activity [5].

A Chinese commentary on the basis of 15 human trials, profess that CQ Phosphate is superior to the control group in inhibiting exacerbation of pneumonia, improving lung imaging findings, promoting a virus-negative conversion, and shortening the disease course in more than 100 patients [6].

Despite the unavailability of anecdotal evidence, several guidelines granted both CQ and HCQ to be used in Covid-19 treatment [7]. A study conducted by Yao et al, it was found that HCQ (EC50 = 0.72 µM) is more potent than CQ in vitro and using physiologically based pharmacokinetic model, this concentration can be attained by a loading dose of HCQ 400 mg BD on the first day, followed by 200 mg BD for 4 days for SARS-CoV-2 [3]. Also, ICMR (Indian Council of Medical research recommended the potential use of CQ and HCQ prophylactically in people who are in close contact, mainly in health workers [8]. On March 30, 2020 FDA issued an Emergency Use Authorization (EUA) in order to use both CQ and HCQ in the treatment of COVID-19. FDA issued EUA for the second time in the history. Formerly it was given for an investigational neuraminidase inhibitor, Peramivir during 2009-2010 to treat severely ill patients with

Conclusions: The systematic review and meta-analysis revealed a reduced antiviral efficacy in reducing mortality, ADR occurrence and has a decreased virological clearance in patients with COVID-19.

Keywords
COVID-19; HCQ; CQ; Virological clearance; ADR; Mortality
H1N1 influenza [9].

Studies which aim to evaluate the HCQ use in Covid-19 have many pitfalls like small sample size, heterogeneity, inconsistent reports, early cessation of trials etc. Hence it is obligatory to systematically review and critically appraise the available literatures, which might help policy makers, clinicians to stick onto a decision [10].

**Objectives**

To evaluate the safety, efficacy and virological clearance of Hydroxychloroquine in Covid-19 patients when compared to those patients receiving conventional therapy.

**Methods**

This study was carried out in conformity with the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) [11].

Criteria for considering relevant studies for the review were as follows:

1. **Type of study**

   **Inclusion Criteria:** We included randomised/ non-randomised controlled trials, observational studies, case reports, case series, all studies conducted with Hydroxychloroquine in patients with Covid-19 that was compared to control arm.

   **Exclusion Criteria:** We excluded experimental *in vitro* studies, editorials & expert opinions, case series without control group, review articles, articles with unavailable full text and non – English articles.

2. **Type of participants**

   - Individuals with all ages and sexes.

3. **Intervention:** Hydroxychloroquine (HQ)

4. **Control Group:** Conventional therapy

5. **Outcome of Interest:**

   - Virological Clearance
   - Mortality
   - Safety outcome in terms of adverse events with HCQ

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6. Search Strategy
An extensive search was carried out using search engines like PubMed, Google search, NHS evidence data base up to October 22, 2020. The key term searched were “Hydroxychloroquine on Covid–19”. Proper hand searching of cross-references of original articles, pre-prints was also performed to find out additional relevant articles (Figure 1).

![PRISMA flow of study selection process](image)

**Figure 1:** PRISMA flow of study selection process.

Results
Out of 12 studies included in the systematic review, a total of 2,834 patients enrolled. Of which 1326 patients received HCQ along with standard of care and 1508 patients received conventional standard of care. Non-HCQ arm was considered as Control arm (Table 1).
<table>
<thead>
<tr>
<th>STUDY</th>
<th>TYPE</th>
<th>COUNTRY</th>
<th>CASE, CONTROL</th>
<th>INTERVENTION</th>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gautret\cite{12} et al</td>
<td>nRCT</td>
<td>France</td>
<td>Case=20 (6 patients received HCQ+ AZ) Control=16</td>
<td>600mg/day x 10 days</td>
<td>Virological cure on day 3.</td>
</tr>
<tr>
<td>Jun\cite{13} et al</td>
<td>RCT</td>
<td>China</td>
<td>Case=15 Control=15</td>
<td>400mg/day x 5 days</td>
<td>No significant difference in viral cure between 2 groups on day 7.</td>
</tr>
<tr>
<td>Chen\cite{14} et al</td>
<td>RCT</td>
<td>China</td>
<td>Case=31 Control=31</td>
<td>400mg/day x 5 days</td>
<td>Faster clinical recovery &amp; improvement of pneumonia in CT chest.</td>
</tr>
<tr>
<td>Bo Yu\cite{15} et al</td>
<td>Retrospective Cohort</td>
<td>China</td>
<td>Case=48 Control=520</td>
<td>HCQ 200 mg BD x 7-10 days</td>
<td>Mortality 18.8% (n=9) in HCQ group and 45.8% (n=238) in control group.</td>
</tr>
<tr>
<td>Geleris\cite{16} et al</td>
<td>Prospective Cohort</td>
<td>US</td>
<td>Case=811 Control=565</td>
<td>HCQ 600 mg on day 1 followed by 400 mg for 4 days</td>
<td>No benefit (Respiratory failure requiring intubation in 31% in HCQ group and 14.8% in control group).</td>
</tr>
<tr>
<td>Magagnoli\cite{17} et al</td>
<td>Retrospective cohort</td>
<td>US</td>
<td>Case=210 (of which n=113 received HCQ+AZ) Control=158</td>
<td>NR</td>
<td>No benefit. Risk of death was higher in HCQ arm.</td>
</tr>
<tr>
<td>Mahévas \cite{18} et al</td>
<td>Retrospective Cohort</td>
<td>France</td>
<td>Case=84 Control=97</td>
<td>HCQ 600mg/day in first 48 hrs of hospitalisation</td>
<td>No benefit. 27.4% in HCQ and 24.1% in non HCQ group respectively, developed ARDS within 7 days, mortality</td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Country</td>
<td>Case</td>
<td>Control</td>
<td>Intervention</td>
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<td>---------------------</td>
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</tr>
<tr>
<td>Barbosa [19] et al</td>
<td>qRCT</td>
<td>USA</td>
<td>32</td>
<td>31</td>
<td>HCQ 800mg/day on day 1-2 followed by 200-400mg/day on day 3-4.</td>
</tr>
<tr>
<td>Tang [20] et al</td>
<td>RCT</td>
<td>China</td>
<td>75</td>
<td>75</td>
<td>HCQ 1200mg/day x 3 days, then 800mg/day x 2 weeks</td>
</tr>
<tr>
<td>Jihad [21] et al</td>
<td>Retrospective Cohort</td>
<td>UAE</td>
<td>23</td>
<td>11</td>
<td>HCQ 400mg BD on day 1, followed by 400mg OD for 10 days.</td>
</tr>
<tr>
<td>Singh [21] et al</td>
<td>Retrospective Cohort</td>
<td>USA</td>
<td>910</td>
<td>910</td>
<td>HCQ dosage regimen is not mentioned. However, 799 received azithromycin.</td>
</tr>
<tr>
<td>Rosenberg [23] et al</td>
<td>Retrospective Cohort</td>
<td>USA</td>
<td>200mg-400mg OD or BD</td>
<td>Hospital Mortality, cardiac arrest, abnormal ECG findings.</td>
<td></td>
</tr>
</tbody>
</table>

: qRCT: Non-randomized controlled trial, RCT: Randomized controlled trial, HCQ: Hydroxychloroquine, AZ: Azithromycin, NR: Not reported, ARDS: Acute Respiratory Distress Syndrome

**Table 1:** Main characteristics of studies included in systematic review.

**Outcomes**

**Virological clearance**

Table 2: Virological clearance of SARS-CoV-2 in COVID-19 patients.

### Safety Outcomes

Certain studies had reported occurrence of adverse events with HCQ. Seen adverse events include: nausea, vomiting, variations in LFT, diarrhoea, rashes, head ache, blurred vision and ECG abnormalities (Table 3).
Author | Adverse Event In HCQ Arm
--- | ---
Gautret[12] et al | Despite of PCR negativity, one among the HCQ arm died. One patient from HCQ arm ceased the therapy due to nausea and vomiting.
Jun[13] et al | 4 patients (4/15, 26.7%) from HCQ arm had experienced transient diarrhoea and abnormal LFT.
Chen[14] et al | 1 patient experienced head ache and 1 patient had incidence of rashes. 4/62 patients progressed to severe Covid-19, all patients are from HCQ arm.
Tang[20] et al | Higher incidence of adverse events was noted in HCQ arm (30%) whereas in control group it is 8.8%. The most common adverse event was diarrhoea in HCQ arm compared to control arm. Also one patient among HCQ arm had experienced blurred vision.
Rosenberg[23] | Higher incidence was on HCQ arm. A greater proportion of patients received HCQ + AZ experienced cardiac arrest (15.5%) and abnormal ECG findings (27.1%), whereas in HCQ alone is 13.7% and 27.3% respectively. In those with no HCQ and AZ, 6.8% and 14.0% respectively.

Table 3: Studies those reported occurrence of ADR in the HCQ Arm.

Normalisation of body temperature
2 studies, had reported outcomes on time to temperature normalization (Table 4).

<table>
<thead>
<tr>
<th>Study</th>
<th>HCQ Arm</th>
<th>Control Arm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun[13] et al</td>
<td>0-3 days</td>
<td>0-2 days</td>
</tr>
<tr>
<td>Chen[14] et al</td>
<td>2.2±0.4 days</td>
<td>3.2±1.3 days</td>
</tr>
</tbody>
</table>

Table 4: Normalisation of body temperature.
Cough period
Among these, a study by Chen [14] et al had reported about the outcome on duration of cough. Here, the number of cough days was markedly lesser in HCQ arm than in Control arm (Table 5).

<table>
<thead>
<tr>
<th>Study</th>
<th>HCQ ARM</th>
<th>CONTROL ARM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chen[14]et al</td>
<td>2.0±0.2 days</td>
<td>3.1±1.5 days</td>
</tr>
</tbody>
</table>

**Table 5:** Studies which reported cough periods as outcome.

Discussion
The meta-analysis of 5 studies that reported rate of virological clearance or PCR negativity (n=312) found no benefit in HCQ arm, when compared to the control arm, i.e. did not observe any statistical difference between treatment and control group {OR, 1.863; 95% CI, 1.024 to 3.389; p=0.041} with a moderate heterogeneity (I²=70.3%, P=0.009) (Figure 2).

![Figure 2: Meta-analysis of Virological clearance of 5 studies (A = HCQ ; B = Control).](image-url)

Nevertheless, meta-analysis of 5 studies (n=1710) that reported about ADR outcomes found that, there
exist an increased risk of ADRs in HCQ arm when compared (OR, 2.648; 95% CI, 2.068 to 7.717; p=0.000), with no heterogeneity ($I^2 = 0\%$, $P=0.417$) (Figure 3).

**Figure 3:** Meta-analysis of occurrence of ADR of 5 studies.

However meta-analysis of 6 studies ($n=4,341$) showed a significant increase in mortality in HCQ arm when compared with control arm (OR, 1.182; 95% CI, 0.981 to 1.425; $p=0.079$), with substantial heterogeneity ($I^2 = 82.0\%$, $P=0.000$) (Figure 4).

Our systematic review and meta-analysis included 12 studies, with a total of 2,834 patients, $HCQ_n = 1326$ \\& $Std_n = 1508$. Non-HCQ arm was considered as Control arm. Meta-analysis of 5 studies did not exhibit a benefit on virological clearance. Moreover meta-analysis on other outcomes of interest like ADR occurrence, mortality was more on HCQ arm when compared to non-HCQ arm or conventional therapy.
Figure 4: Mortality with HCQ v/s Control arm in Covid 19: A meta-analysis (n=4,341) (A = HCQ; B = Control).

However our findings of lack of virological clearance efficacy, increased mortality, occurrence of ADR was consistent with various previously published articles which dealt with other viral diseases. CQ was ineffective in preventing and reducing influenza viral load in ferret models [24]. Also CQ did not prevent this infection (influenza) in a double- blinded placebo controlled human trial [25]. In a study, CQ shown to enhance Chikungunya viral load in various animal models [26].

Decreased efficacy of CQ/HCQ in COVID-19 can be of following reasons:
1. Most of the in vitro studies do pre-treatment protocols; here the cells are treated with the drug prior infecting with the tested virus. Whereas, in in vitro that compared pre treatment and post infection treatment shown CQ/HCQ have decreased antiviral efficacy if added after the infection. This may suggest that chronic prophylactic use of CQ/HCQ may be effective to prevent acquiring SARS-CoV-2 infection [27].
2. Two studies that did pharmacokinetics study revealed that the mean HCQ level was 0.46 μg/mL, in those treated with 600 mg/day which is lower than lowest effective in vitro concentration of 0.72 μM [12]. A study by Balevic et al [28] showed that average pdc of HCQ was below the lowest antiviral concentration for SARS-CoV-2 of 0.48 μg/mL in most studies [28].

Conclusion
This systematic review and meta-analysis revealed that HCQ has a reduced antiviral efficacy in reducing mortality, ADR occurrence and has a decreased virological clearance in patients with COVID-19. The drug should be used in patients with at most caution until there is positive results from RCTs with larger patient population.
References


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